

# Frequently Asked Questions

## Technology

### 1. Can I use any type of **Internet browser**?

The compatible browsers include 128-bit high encryption versions of:

- Microsoft's Internet Explorer 5.0, 6.0 and later versions
- Netscape's Navigator 6.0 and later versions
- Opera Software's 5.0, 6.0 and later versions

### 2. Does the Web submission process ensure that my **data is secure**?

Yes. Our security application includes:

- User authentication to verify the identity of users and determine access rights.
- 128-bit SSL certificate present on the web server to encrypt communication with users.
- Secure FTP Server – Using 128-bit SSL encryption

*Updated 9-20-06*

### 3. What should be **between records** in the file?

Carriage return and line feed (CRLF)

### 4. What would cause my **batch file** to not process successfully?

There are three criteria needed for a batch to be processed:

1. The file must have a .txt extension.
2. Record layout must be valid for EVERY record.
3. Patient Control Number must be valid (i.e., not a duplicate) for EVERY record.

### 5. How do I know when **the file upload** is complete? How will I be notified of the status of the file I submitted?

During the uploading of a file you will briefly see a thermometer image that indicates the file is uploading. When the file upload is complete you will be redirected to the Batch Review page. The file that you have just uploaded will not appear in the Batch Review screen until it has been processed.

When the file has been processed you will receive an e-mail message advising whether the batch was successful or invalid. If the batch is successful the message will include the total number of records, total valid records and the total invalid records along with the batch number assigned to your file. If there are a large number of invalid records in the batch you can have the batch deleted using the Batch Review screen, which will allow you to resubmit that file. See notes regarding batch deletion at the top of the Batch Review screen.

### 6. How do I **correct invalid records**?

Please refer to Appendix IV of the manual – Data Submission User Guide. Instructions on how to correct invalid records are on pages IV-9 and IV-10. *Updated 1-24-05*

7. How are **duplicate diagnoses codes** deleted?

Click the red “X” next to the diagnosis field that you want to delete and the entire line will be removed.

8. How do I correct the error “**invalid physician ID number does not correspond to accepted values?**”

E-mail the following information to WHAInfoCenter@wha.org:

- The valid NPI number with the physician name including middle initial and the credential (i.e. MD, DO). *Updated 03-22-10*
- The valid medical license number or UPIN with the name of the physician including middle initial and the credential (i.e. MD, DO).
- After verification, The WHA Information Center staff will add the information to the system and return a message to you stating the system has been updated.
- You will then be able to return to the invalid record. Click “Update” and the record will move to the valid file.

9. How do I notify WHA Information Center when the **data submission is complete** for the quarter?

When you have submitted all the records for the quarter and all the records are valid the “Mark Complete” button will appear on the Batch Review screen. You need to click the Mark Complete button in order to notify WHA Information Center that you have completed data submission for the quarter. *Updated 11-12-04*

10. How do I **delete a batch?**

A facility may submit a request to delete a batch by selecting **Delete** on the Batch Review screen. Please remember that this will request deletion of the entire batch file, not just the edit errors identified.

3rd Quarter 2003 Submit Batch

Batch Num	Upload Date	Total Records	Valid Records	Invalid Records		
103501	12/9/2003	689	651	38	View	Delete
103500	12/9/2003	3602	3598	4	View	Delete
103499	12/9/2003	1061	1060		View	Delete

The file will not be deleted immediately. WHA Information Center Staff will act on requested batch deletion at the close of each business day. If you wish to resubmit a batch on the same day a batch deletion is requested, please contact WHA Information Center at [WHAInfoCenter@wha.org](mailto:WHAInfoCenter@wha.org).

11. Does WHA Information Center require **case-specific data submission?**

No, data can be submitted using upper or lower case.

12. Can a user **correct fields** that are not highlighted on an edit record?

Yes, changes can be made to individual records until the quarter is completed. If a change is needed after completion of the quarter, contact WHA Information Center to reopen the quarter.

13. BHI allowed me to **enter my data manually**. Am I still able to do this?

Yes, there is a process for manual data entry. Please see Appendix XV in the updated data submission manual posted on our web site. *Updated 1-24-05*

**14. Is there a specific **naming convention** facilities will need to use for the files?**

The files must be variable-length, comma delimited with a .txt extension. File names can be assigned by the facility.

**15. Will **the submission tool** be different?**

The submission tool will operate and look the same as the current system.

**16. Are **leading zeroes** allowed with total charge and revenue charge values?**

Leading zeroes are allowed for the charge fields (TC, HCPCSRATE, REVCHG), however leading zeroes are not allowed on the diagnoses and or procedure fields. Leading and trailing blank spaces are not allowed for any field. *Added 10-27-04*

## Content and Data Definitions

Form locators for the UB-04 and the WHA Information Center record layout will be inserted in the FAQs in February 2007.

**1. Do I zero-fill or leave the field blank when a ZIP code is unknown?**

The field should be zero-filled ('00000') for persons with an address that does not include a valid United States ZIP code. *If the ZIP code is unknown*, such as for homeless patients, this field should be left blank and Condition Code 1 = '17' should be used for inpatient and outpatient records. *Updated 11-11-04*

**2. How do I handle an unknown birth date?**

If you know the patient's age use January 1 (0101) as the birth date and add the four-digit year based on the age. For example if a patient states he is 45 during a 2004 visit, and for some reason the patient is unable to give you a birth date, enter '01011959' as the birth date.

**3. Do I need to submit procedure codes on records of patients seen in the ED (place of service 2)?**

Yes, the record should accurately reflect all procedures performed in the ED. The primary record should include the procedures that meet WHA Information Center's definition of a principal procedure. The procedure record should include any procedures that meet WHA Information Center's definition of other procedures. ICD-9-CM procedure codes, CPT or HCPCS Level II codes are allowed in these fields through 12/31/06. As of 1/1/07 CPT/HCPCS codes are required in these fields. *Updated 11-11-04, 9-12-05, and 9-19-06*

**4. Do we need to continue to select our outpatient surgery records (place of service 1) based on ICD-9-CM procedure codes, CPT or HCPCS Level II codes**

No, the selection criteria for outpatient surgery records (place of service 1) are based on revenue codes. The revenue codes are 036X, 0480, 0481, 049X or 0750. All records from freestanding ambulatory surgery centers (FASCs) should be submitted.

**5. Are FASCs required to report type of admission?**

No, type of admission is not a required data element for FASCs.

**6. Are admission and discharge dates required on all records?**

No, 'admission and discharge dates' (fields 11 and 21 on the primary record) are required on inpatient and emergency department (outpatient place of service 2) records. Collection of this information allows WHA Information Center to calculate length of stay.

'Statement covers from and thru dates' (fields 34-35 on the primary record) are required on all hospital outpatient records with place of service 3, 4, 5 6 and 7. *Updated 11-14-05.*

**7. What order should the diagnosis codes be listed in the primary and diagnoses records?**

The 'principal diagnosis code' should be entered in the primary record (field 12). This is the ICD-9-CM diagnosis code describing the condition established **after study** to be chiefly responsible for occasioning the admission of the patient for care or for the outpatient services provided during the visit.

This definition does not apply to the coding of all **outpatient encounters**. If the physician does not identify a definite condition or problem at the conclusion of an outpatient visit or encounter the coder should report the documented chief complaint as the reason for the encounter/visit. When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication. When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis. When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses. *Updated 9-19-06*

Other reportable diagnoses' should be entered in the diagnoses record (field 4). They are defined as those conditions that coexist at the time of admission/outpatient visit or develop subsequently and affect patient care for the current episode of care. Usually reportable other diagnoses affect length of stay, total charges or accurate DRG classification. Diagnoses that have no impact on patient care during the hospital stay or outpatient visit are not reported even when they are present. **No particular order is mandated for sequencing other diagnoses since the number of diagnoses that may be reported is unlimited.**

**8. What order should the procedure codes be listed in the primary and procedure records?**

The 'principal procedure code' should be entered in the primary record (field 18). The principal procedure is one performed for definitive treatment (rather than for diagnostic or exploratory purposes) or one that is necessary to care for a complication. If two or more procedures appear to meet this definition, the one most related to the principal diagnosis is designated as the principal procedure. If both are equally related to the principal diagnosis, the most resource-intensive or complex procedure is usually designated as principal. When more than one procedure is reported, the principal procedure should be identified by the one that relates to the principal diagnosis. If the only clinically significant procedure performed is diagnostic or exploratory in nature (i.e. cardiac cath) it should be reported in the principal procedure field.

'Other procedures' performed during the principal operative episode (or during the length of stay for inpatients) that may include diagnostic or exploratory procedures should be entered in the procedure record (field 4). Procedures that affect DRG categorization must be included. **No particular order is mandated for sequencing other procedures since the number of procedures that may be reported is unlimited in nature.**

**9. Does WHA Information Center accept the license numbers of non-physician providers in the 'attending physician' and 'other physician' fields (fields 16-18 on the primary record)?**

Effective with Q1 2010 dates of service, only NPIs will be accepted of the physician who was primarily and largely responsible for the patient's medical care and treatment. Only doctors of medicine or osteopathy are considered physicians for inpatient records. Facilities may submit non-physician provider license numbers in the 'attending or other physician' fields for outpatient records with a place of service 3, 4, 5, 6 and 7. ~~NPIs will be accepted for these providers pending further notice, which will require receipt of the CMS dissemination policy.~~ *Updated 11-14-06, 12-13-06, 03-19-10*

**10. Why are there two fields (16 and 17) in the primary record for 'other physician ID'?**

Completion of field 16 is required if there is a procedure code entered in field 18. Completion of field 17 is optional and can be used when a facility wants to report a second procedure physician.

**11. Can a record be submitted without a 'type of bill?'**

Most hospital records should be submitted with a 'type of bill' code as identified in Appendix VIII. Hospitals may submit code '999' in this field on records of self-pay patients. FASCs may routinely use code '999' since type of bill is not a standard data element on the CMS-1500 form. *Updated 11-14-05*

**12. Should facilities submit records for services provided at no charge?**

Services provided at no charge for all patients using the service should not be submitted to WHA Information Center. An example of this would be a 'free blood pressure clinic.' Services that are provided and charged based on ability to pay should be submitted. If a patient is not billed because of inability to pay please submit the record with the charge, not expected payment.

**13. How will records qualify for submission in Wlpop?**

Inpatient records and outpatient ED records (place of service 2) will qualify based on discharge date. Outpatient surgery records (place of service 1) will qualify based on procedure date. All other hospital outpatient records will qualify based on the 'through date' in the statement covers period field (field 35).

**14. Should facilities report urgent-care services as ED services (outpatient place of service 2)?**

One facility reported it has a walk-in clinic at the hospital. Some payers require the facility to use rev code 0510 to report the services and other payers require the use of rev code 0456. Rev code 0456 falls in the current reportable range for ED services.

Facilities should use place of service 6 when revenue code 0456 appears on a record. Revenue codes to be included in place of service 2 are 0450, 0451, 0452 and 0459.

**15. Is it documented in the specifications that reference diagnostic laboratory services should be excluded?**

The exclusion is documented in Appendices VIII and IX of the data definitions.

**16. Will WHA Information Center accept medical license numbers of residents?**

Yes, **Effective with Q1 2010 dates of service, only NPIs will be accepted** WHA Information Center will accept valid ~~medical license numbers, UPINs, and NPIs (pending further notice and receipt of the CMS dissemination policy)~~ of residents. *Updated 9-19-06, 12-13-06, and 03-22-10.*

**17. How many CPT/HCPCS modifiers will WHA Information Center accept per code?**

WHA Information Center will accept two modifiers per code through 6/30/07. When there is only one modifier fill in two of the four allowable digits of the comma-delimited field. When there are two modifiers enter both modifiers in the same field with the modifier that has the most impact on payment listed first. As of 7/1/07 dates of service WHIAC will accept up to four modifiers per CPT/HCPCS code. A separate field is available in the record layout for each modifier. *Updated 11-11-04 and 9-19-06*

**18. Can you provide us with a list of critical access hospitals?**

Yes, the link to this document on the Office of Rural Health Web site is:

**19. Sometimes we do not have accurate and complete records available to meet the **data submission deadlines**.**

WHA Information Center extended the submission deadline for Wlpop for types of hospital outpatient records **that were not collected in previous years**. There is an additional quarter added prior to the submission deadline. For example, the submission deadline for first quarter IP, ED and OPS records is May 15 with edits due May 25. The data submission deadline for first quarter other hospital outpatient records is August 14 with edits due August 24. A one-month extension is available upon request for other hospital outpatient records, as it is for IP, ED, and OPS records.

**20. Some data elements like **type of bill** are not retained in facilities' information systems after the claim is submitted. This makes it difficult to efficiently provide the information in the data submission. McKesson and Siemens are examples of systems that do not retain Type of Bill.**

The statute requires collection of this data element from facilities.

**21. Will WHA Information Center be collecting the **National Provider Identification Number**?**

*Effective with Q1 2010 dates of service, only NPIs will be accepted* of the physician who was primarily and largely responsible for the patient's medical care and treatment. Only doctors of medicine or osteopathy are considered physicians for inpatient records. ~~Yes,~~ Facility NPI numbers may be submitted in Field 27 ~~pending further notice and receipt of the CMS dissemination policy.~~ Facilities will need to continue to submit the facility number assigned to them in field #2 in the primary, revenue, diagnosis and procedure records. Fields 15, 16 and 17 in the primary record will accommodate provider NPIs when the CMS dissemination policy is operational. As of 7/1/07 the facility NPI field must be filled, and provider identification fields must be filled with NPIs rather than UPINs or state license numbers, ~~assuming the NPIs are available and can be validated.~~ Updated 9-19-06, 12-13-06, 03-22-10

**22. Can facilities report **non-physician license numbers** in the ED record?**

*Effective with Q1 2010 dates of service, only NPIs will be accepted.* ~~NPI~~ License numbers of non-physician providers can be reported in fields 15, 16 and 17 of the primary record for emergency department or other hospital outpatient records (excluding outpatient surgery). WHA Information Center purchased other licensing databases from the Dept. of Regulation and Licensing. Statutory limitations prevent collection of non-physician provider IDs in inpatient and outpatient surgery records. ~~When there is a method to validate non-physician NPIs they will be allowed on the ED record.~~ Updated 9-19-06, 12-13-06, 03-22-10

**23. Since WHA Information Center has extended deadlines for submission of hospital outpatient data, is more time allowed for **editing records**?**

The deadline for correcting invalid records is 10 working days after the submission deadline. But, since the deadline for submission has been extended, this is in effect an extension of the edit correction deadline. Updated 9-28-05

**24. The WHA Information Center **data elements are claim-form-driven**. These data elements are not always available at the time of data submission and may need to be obtained elsewhere.**

The data elements may be obtained from anywhere in the facility that has a reliable source for the data elements, providing the content of the information is consistent with the WHA Information Center data definitions.

**25. Do hospitals need to submit records of hospital-based home health services?**

The records should not be submitted if the Medicaid number is different from the hospital or if the home health services are billed on a different financial system. *Updated 10-27-04*

**26. What clarification do you have on the ICD/CPT issue for outpatient records?**

As of 1/1/07 WHA Information Center will require CPT/HCPCS codes only on outpatient records to reflect standard billing regulations. For the near future the system will accept either ICD or CPT codes. However, you cannot submit both CPT and ICD codes for the same procedure on any one record. Submitting both would be considered duplicate reporting. There is a crosswalk we use to translate codes. A sample of the crosswalk is available on our Web site at <http://www.whainfocenter.com/wipop/CPT2ICD.pdf>. *Updated 11-14-05, 6-21-06*

**27. When are notices of missing data sent to the CEO of the facility?**

Email notices are sent to the CEO if 15 days prior to the deadline if facility has not completed the data submission process for the quarter by marking the QTR Complete.

**28. Must we enter into a HIPAA-compliant business associate agreement with WHA Information Center?**

The data collection that WHA Information Center is undertaking is a function of Chapter 153 of the State Statutes. Under HIPAA, a covered entity may use or disclose health care information “as required by law” without first obtaining an authorization from the patient. Chapter 153 requires the release of health care information to WHA. Further, WHA is not a business associate of the hospital as defined by HIPAA and, thus, a business associate agreement is not required.

**29. Will length of stay be part of the editing process (e.g. 1-day Inpatient Stay, or 35- day Psychiatric Inpatient)?**

No, length of stay will be an element of the validation process, not the editing process. WHA Information Center will only utilize the editing process to capture invalid, missing, or erroneous codes in order to streamline the data editing process.

In the validation process, WHA Information Center will look at the facility’s submission and identify if data is internally consistent, is consistent with historical norms, and is plausible given expected distributions within each data element.

**30. Should Critical Access Hospitals report hospital outpatient services as part of an inpatient discharge when a patient is admitted following outpatient services?**

Services may be separately reported. If you choose this option submit the outpatient data to WHA Information Center with the appropriate place of service code, and submit the inpatient data separately as an inpatient record type.

**32. Will WHA Information Center accept HCPCS codes?**

Yes, WHA Information Center accepts HCPCS codes.

**33. Are E-codes required for injury codes used on physical therapy records?**

E-codes are not required for hospital outpatient records (place of services 4-7). E-codes are required when injury codes are used on inpatient records and outpatient records with place of service 1, 2 and 3. E-codes are allowed on any record. *Added 10-27-04, Updated 9-19-06*

**34. When a patient receives a lab or x-ray service in urgent care or a hospital-based clinic what place of service applies?**

The place of service would be 5. However any published urgent care or clinic data will include these categories as a place of service 5. *Added 10-27-04*

**35. Can data be submitted in non-required fields?**

Yes, however the same edits will apply as if the data is required, and non-required data will not be reported on the profile. *Added 10-27-04 Updated 11-14-05*

**36. Will there be a separate affirmation statement for hospital outpatient records to coincide with the timeline for submitting hospital outpatient records?**

Yes, there will be a separate profile and affirmation statement for hospital outpatient records if they are not submitted at the same time as inpatient. *Updated 12-30-04*

**37. Should we submit records for rebills or late charges?**

No, for inpatient records WHA Information Center allows non-payment/zero records and admit-through-discharge records. For outpatient records, we allow non-payment/zero records, admit-through-discharge records, and records based on interim claims. *Added 10-28-04*

**38. Should we continue to exclude swing bed and hospice records from our data submission in 2005?**

The statute did not change with regard to inpatient services; therefore WHA Information Center cannot collect swing bed or hospice records at this time. Hospice records are typically determined by Type of Bill (TOB) – UB-04 Form Locator 4, see link for details on coding structure:

Source: <http://www.cms.hhs.gov/transmittals/downloads/R1885CP.pdf>

*Added 11-11-04, Updated 03-30-10*

**39. Is there a response option for an unknown gender, particularly in regard to infants?**

Yes, as of 1-1-06 WHAIC added a response option of “U” (unknown). This may be used when it is documented in the medical record that the gender is clinically unknown. *Added 11-11-04 Updated 9-19-06*

**40. How will WHA Information Center accurately display bilateral procedures in the data sets and documentation when modifier 50 is used with a CPT code?**

When modifier 50 is used with a CPT code in the principal or additional procedure fields in the primary record, a yes/no indicator will be available in fields added to the fixed-width data sets. In the relational data sets, the original modifiers submitted will be available, in the order submitted (Modifier 1 vs. Modifier 2). *Updated 9-28-05*

**41. When a hospital submits CPT/HCPCS codes on outpatient records how does IT staff know which CPT/HCPCS codes should populate the principal procedure field on the primary record and the additional procedure field(s) on the procedure record?**

WHA Information Center thought hospitals could populate these fields based on what is coded on the medical record abstract. We were informed that some hospitals do not abstract every patient record where a principal and other procedure occurs, therefore the procedure codes are only identified in the revenue record. If one or more of the codes listed below is entered on the revenue record, hospitals should also report it in the principal or additional procedure fields of the primary or procedure records. If one or more of these codes applies the facility should decide which code to list as the principal procedure. When in doubt, the CPT/HCPCS code with the highest charge may be entered in the principal procedure field. Please exclude any of these codes that are submitted as a professional component.

Reportable CPT and HCPCS Level II Range

10021-69990, 77371-77373, 77401-77421, 77422-77423, 90760, 90765, 90772, 90774, 90779, C8957, 90870, 90901-90911, 90918-90999, 91000-91299, 92015-92287, 92502-92700, 92950-92998, 93501-93581, 93600-93662, 96401-96549, G0104, G0105, G0121, G0166, G0259, G0267, G0290, G0297-G0300, G0339-G0340, G0341-G0343, and G0364.

*Updated 12-30-04, 9-19-06, and 1-08-07*

**42. For outpatient data, how is WHA Information Center defining “attending physician?”**

The only type of outpatient record where the attending physician field must be populated is the emergency department visit record. However, if there is an entry in the principal or additional procedure fields for any type of record, then there must be at least one procedure physician identified. Examples: ~~the medical license number, UPIN, or the NPI (pending further notice and receipt of the CMS dissemination policy)~~ for an otolaryngologist would be appropriate for a myringotomy with tubes procedure, and the ~~license number, UPIN, or NPI (pending further notice and receipt of the CMS dissemination policy)~~ of a radiologist would be appropriate for an interventional radiology procedure. *Updated 12-01-04 and 9-19-06, 03-22-10*

**43. Should facilities still report ED services on a separate record when the patient is discharged from the ED and admitted within 72 hours?**

You may report the two services on two separate records, however the fact that facilities are submitting revenue codes that identify ED services on a subsequent IP admission provides the option for facilities to submit one record. WHA Information Center will be able to accurately identify and count all ED services by revenue code regardless of whether the revenue code appears on an ED record or an IP record. This same concept applies to other services that are combined on one record. Examples include but are not limited to outpatient surgery patient converted to inpatient and observation patients converted to inpatient. *Updated 12-1-04*

**44. Are there any circumstances when professional charges should be included in the data submission?**

The professional charge is usually combined with the facility charge for OT, PT and ST services, and billed under the therapy revenue codes (042X).

For other types of services such as emergency department, and EKG services there are separate line items on the bill for the facility and professional components, if the facility bills the professional component. Many of the professionals who provide these services independently bill on the CMS 1500. Those that don't bill independently should have a contract with the facility that allows the facility to bill the professional service.

The Data Submitter Users Group agreed it is appropriate for WHA Information Center to continue to edit for revenue codes that reflect professional charges (0961-0989) to ensure that the related charges are comparable across facilities. All facility-related charges will be included in the total charges, whereas line-item professional charges will continue to be excluded. When therapy professional services are combined with facility services under the therapy revenue codes the related charges will be included.

**45. How does a facility correct **service date edits** when the services on the record are all related?**

A service date edit will occur on an **inpatient record** when a service date is greater than three days prior to the admission date or after the discharge date. An example of this is when pre-op labs and x-rays are done more than three days prior to admission. One way to correct this is to delete the service date on the Wlpop inpatient record since it is not a required field. Another way to correct this is to change the service date on the Wlpop record to three days prior to the admit date. The service dates will not be included in the data sets we distribute. They will only be used internally to identify related services that occur on the same day.

A service date edit will occur on **outpatient surgery records** when the service date is more than seven days prior to the procedure date (10 days for 030x revenue codes) and more than one day after. An example of this is when pre-op labs and x-rays are done more than seven days prior to admission. The only way to correct this is to change the service date on the Wlpop record to seven days prior to the procedure date. The service dates will not be distributed in the data sets we distribute. They will only be used internally to identify related services that occur on the same day.

A service date edit will occur on emergency department visit records when the service date is more than three days prior to the admit date and after the discharge date.

**46. When are the race and ethnicity code changes effective?**

The race and ethnicity code changes are effective with records submitted in the Q1 07 data submission. For patients admitted in 2006, but discharged in 2007 the new codes should be used. Examples are below:

- IP Record – When a patient is admitted to IP status 12/23/06 and discharged 1/1/07 the **new** race codes should be used because the record should be submitted in Q1 07 data submission.
- OPS Record – When a patient has surgery 12/31/06 and is discharged from outpatient surgery on 1/1/07 the **old** race codes should be used, because this record should be submitted in the Q4 06 data submission.
- ED Record – When a patient is admitted to the ED on 12/31/06 and is discharged 1/1/07 the **new** race codes should be used, because the record should be submitted in the Q1 07 data submission.
- Observation Record – When a patient is admitted to observation on 12/31/06 (this should be the statement covers from date) and discharged from observation on 1/2/07 (this should be the statement covers through date) the **new** race codes should be used, because the record should be submitted in the Q1 07 data submission.
- Other Hospital Outpatient Record – When a patient starts outpatient services in 2006, the last service date is in 2007, and the 2006 and 2007 services are combined on one record, the **new** race codes should be used.

**47. Which race response option is appropriate when a patient selects Hispanic or Latino as the ethnicity response option?**

The **most appropriate** response option for race when a patient selects Hispanic or Latino as their ethnicity is the response option the patient self-identifies. The **most common** response options for race in this situation are ‘other,’ ‘white,’ and ‘unknown.’ Again, the patient should choose the option he/she feels is appropriate.

**48. Who should select the race and ethnicity response options for newborns?**

The mother should select the response options for the newborn.

**49. Which response option should be selected if the patient is multiracial?**

Response option ‘6. Other’ should be selected if the patient is multiracial.

**50. What is included in a Present On Admission Report?**

There are currently 4 reports sent each quarter;

- Total for all facilities and selected facility by volume group totals
- Selected facility summary for POA by condition, by attending physician
- Selected facility summary of POA by condition, by operating physician
- Selected facility listing of POA other than “yes” by condition, by patient control number showing both attending physician and operating physician

**51. How do I request a copy of our facilities POA reports?**

If you wish to receive this information, WHAIC would produce a written special report as a supplement to the standard profiles that you receive at the end of each quarterly data cycle. Please contact Brian Competente at [bcompetene@wha.org](mailto:bcompetene@wha.org)

**52. Are only Medicare records included in the report?**

WHAIC collects data on all payer types. Your reports will not be based on Medicare patients only, it will include all payers.

**53. What guidelines are used to provide the information in the reports?**

The CMS guidelines we are utilizing for generating the reports. For Q1, Q2 and Q3 FY 2008 we are utilizing the following reference codes from CMS: *Last updated 03-22-10*

Foreign Object Retained After Surgery	998.4 998.7
Air Embolism	999.1
Blood Incompatibility	999.6
Pressure Ulcers Stage III & IV	707.00-707.09
Falls and Trauma	800-829, 830-839, 850-854, 925-929, 940-949, 991-994
Catheter-Associated Urinary Tract Infection	996.64 and 112.2, 590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0
Vascular Catheter-Associated Infection	999.31
Surgical Site Infection-Mediastinitis after	519.2 and one of the following procedure codes:

Coronary Artery Bypass Graft (CABG)	36.10-36.19
Manifestations of Poor Glycemic Control <ul style="list-style-type: none"> <li>• Diabetic Ketoacidosis</li> <li>• Nonketotic Hyperosmolar Coma</li> <li>• Secondary Diabetes with Ketoacidosis</li> <li>• Secondary Diabetes with Hyperosmolarity</li> </ul>	250.10–250.13 250.20-250.23 251.0 249.10-249.11 249.20-249.21
Surgical Site Infection Following Certain Orthopedic Procedures <ul style="list-style-type: none"> <li>• Spine</li> <li>• Neck</li> <li>• Shoulder</li> <li>• Elbow</li> </ul>	996.67  998.59 And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity <ul style="list-style-type: none"> <li>• Laparoscopic Gastric Bypass</li> <li>• Gastroenterostomy</li> <li>• Laparoscopic Gastric Restrictive Surgery</li> </ul>	Principal Diagnosis – 278.01 and 998.29 And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures <ul style="list-style-type: none"> <li>• Total Knee Replacement</li> <li>• Hip Replacement</li> </ul>	415.11, 415.19, 453.40-453.42 And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

These codes changed with the Q4 data (10/01/08) and the new “Hospital Acquired Conditions” (HAC) codes are found here: <http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf>

#### 54. Why is “Operating Procedure Physician” included in the POA reports?

It is important to list the Operating Procedure Physician for the surgical HACs in the reports. Please note that if an Operating Procedure Physician is submitted they will be listed on the report but may not be directly related to the hospital acquired condition being reported. (Ex Stage III & IV Pressure Ulcers may not be directly related to an additional procedure performed during that stay).

#### 55. Why did the Patient Status codes change?

WHAIC recently identified 3 discharge status codes (40, 41 and 42) that represent hospice patient discharge status only. WHAIC does not accept hospice patients and therefore removed these codes from Wlpop. Appendix VI was updated to reflect what is considered acceptable values for WHAIC. (Last updated 06/18/10)

#### 56. What Point of Origin code should we use on the record/claim if the services rendered take place in two different quarters?

The Wlpop Manual, Section 1-3 Data Parameters (Inpatient Discharges and Emergency Department Visits), addresses this question (*Per Wisconsin law, WHAIC requires Point of Origin to be submitted only on Inpatient and ED records*): “The discharge date is used to determine which quarter to use when reporting to WHA Information Center. For example, if service started on 06/30 and ended on 07/01, then the record would be included in the third- quarter data submission”.

With this in mind, all portions of the record should be reflective of the quarter in which it was submitted for. In other words, if the account is discharged on or after 07/01/10, please be sure the Point of Origin code is compliant with the new NUBC standards. (Last updated 06/18/10)

**57. If we can no longer use “Code 7, Emergency Room” to define point of origin, what should we use for a patient who is admitted after being treated in our facility’s ER?**

The code should indicate where the patient came from before presenting at the facility. The Wlpop Manual, Appendix III – Point of Origin, has been updated to reflect the changes to the language and definitions. Generally speaking, according to Todd Omundson, Secretary, NUBC, “There is no replacement code for 7; people are to use one of the remaining codes that best fits the situation.” “Code 7 was overused and misused. The Point of Origin (PoO) is simply where the patient came from before presenting to the health care facility. (The ED is within the facility.)”

The most common Points of Origin will be 1 (home or workplace) and 2 (clinic or physicians office). If the patient came from another facility’s ER, code 4 (transfer from a hospital) should be used. (Last updated 06/18/10)

**58. Can a facility begin submitting the new point of origin codes to WHA Information Center for dates of service prior to the beginning of third quarter?**

No. Wlpop will not accept the new codes for dates of service prior to July 1. (Last updated 06/18/10)

**59. If our facility submits Condition Codes, is there a specified order of precedence in which to report the conditions (i.e., if a patient has all four conditions which one(s) should be reported? And, how many codes will fit in each field?**

The Wlpop Manual (Inpatient/Outpatient Submittal Data Dictionary) has been updated to reflect Condition Code changes, and a newly created Appendix IV (Condition Codes) is available for your reference. In Wlpop, Condition Code1 field corresponds to unknown ZIP code (homeless). It will continue to be exclusively used for reporting Condition Code 17 – there is no change. Condition Code 1 should only be populated if the ZIP code field is blank.

As of July 1st, the remaining Condition Code fields (2 and 3) may be populated with any of the following condition codes - 60, 61, P7 and 47 (which are all optional.) Only one code is allowed per field. WHAIC does not prescribe which code(s) to use or the order of priority for the condition code fields. The Uniform Billing standard is to report them in alphanumeric sequence. (Last updated 06/18/10)