

Manual Data Entry

(Revised for UB-04)

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Instructions for Hospitals for Completing the Manual Entry Data Form (Revised for UB-04)

Data Element	Instructions
Patient Control Number	Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. Up to 24 digits allowed.
Type of Encounter	Identifies the status of the patient (inpatient or outpatient) at the time of discharge. Choose 'inpatient' or 'outpatient.'
Place of Service	One-digit entry identifies the area where the patient received outpatient treatment. Not used on inpatient records. Please see Appendix IX for appropriate codes.
Diagnoses Records Needed	Number of diagnosis codes to be entered in the revenue record. Unlimited number allowed.
Procedure Records Needed	Number of procedure codes to be entered in the procedure record. Unlimited number allowed.
Revenue Records Needed	Number of revenue codes to be entered in the revenue record. Unlimited number allowed.

Primary Record	
Medical Record Number	The unique number assigned to each patient by the facility that distinguishes the patient and their medical record from all other patients.
Certificate Number	Insured's unique ID number assigned by the payer organization. Only the number for the primary payer is recorded. If this is a self-pay case, enter zeroes or 'selfpay.' Do not enter SSN.
Birth Date	The patient's month, day, and year of birth (mmddyyyy).
Sex	F = Female M = Male U = Unknown
Race	See Appendix II for the appropriate one-digit code.
Ethnicity	See Appendix II for the appropriate one-digit code.
ZIP Code	The five-digit code assigned by the US Postal Service. The field should be zero-filled ('00000') for a person with an address that does not include a valid US ZIP code. If the ZIP code is unknown, such as for homeless patients, this field should be left blank and Condition Code 1 = '17' used on inpatient and outpatient records.
Patient Status	A two-digit entry indicating patient (discharge) status as of the ending service date of the period covered in the record. Applies to inpatient and outpatient ED records. See Appendix VI for appropriate codes.
Condition Code 1	Code '17' should be entered for all inpatient and outpatient cases where a patient is homeless at the date of service when there is an unknown ZIP code.
Condition Code 2	<p>Condition Code 2: Effective Q3 2010 dates of service, WHAIC will accept any one of the following four condition codes listed below:</p> <ul style="list-style-type: none"> • Code '60' should be entered for all cases where the hospital is reporting an inpatient stay as a day outlier. (Optional) • Condition Code '61' should be entered for all cases where the hospital is reporting an inpatient stay as a cost outlier. (Optional) • Code 'P7' should be entered for Public Health Reporting only. It is used to indicate a patient was admitted directly from the facilities Emergency Room/Department. (Optional) *This code does not go into effect until 1/1/2011 • Code '47' should be entered to indicate the patient was admitted to this facility's home health agency as a transfer from another home health agency. (Optional) <p>Prior to Q3 2010, the only accepted value for this field is condition code '60'.</p>

Primary Record	
	(UB-04 FLs 18-28)
Condition Code 3	<p>Condition Code 3: Effective Q3 2010 dates of service, WHAIC will accept any one of the following four condition codes listed below:</p> <ul style="list-style-type: none"> • Code '60' should be entered for all cases where the hospital is reporting an inpatient stay as a day outlier. (Optional) • Condition Code '61' should be entered for all cases where the hospital is reporting an inpatient stay as a cost outlier. (Optional) • Condition Code 'P7' should be entered for Public Health Reporting only. It is used to indicate a patient was admitted directly from the facilities Emergency Room/Department. (Optional) *This code does not go into effect until 1/1/2011 • Condition Code '47' should be entered to indicate the patient was admitted to this facility's home health agency as a transfer from another home health agency. (Optional) <p>Prior to Q3 2010, the only accepted value for this field is condition code '61'.</p>
Encrypted Case ID	An encrypted code based on the patient's last name and initial of first name. The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient.
Admit Date	The month, day and year the patient was admitted to the hospital for <u>inpatient or emergency department care</u> . Format = (mmddyyyy).
Admit Source	Also known as Point of Origin. A code indicating where the patient came from. See Appendix III for the appropriate one-digit code.
Admit Type	A code indicating the priority of the admission. See Appendix V for the appropriate one-digit code.
Principal Dx	The ICD-9-CM code describing the condition established after study to be chiefly responsible for the services provided during the visit. <i>Do not enter decimals.</i>
Present on Admission (POA) Indicator for Principal Dx	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to <u>inpatient records only</u> . Some exceptions for ICD-9-CM codes apply.
Admitting Dx	The ICD-9-CM code describing the patient's diagnosis visit at the time of admission. For inpatient records only. <i>Do not enter decimals.</i>
Reason for Visit 1	The ICD-9-CM code describing the first patient's reason for visit at the time of emergency department registration or observation visit. Required based on Type of Bill and Revenue Code combination (reference). <i>Do not enter decimals.</i>
Reason for Visit 2	An optional data element. The second ICD-9-CM code describing the second patient's reason for visit at the time of emergency department registration or observation visit. <i>Do not enter decimals.</i>
Reason for Visit 3	An optional data element. The third ICD-9-CM code describing the patient's reason for visit at the time of emergency department registration. <i>Do not enter decimals.</i>
Leave Days	The total number of days a room was held for an inpatient while away from a facility. Consists of all 018x revenue codes. These are the total number of leave days for the entire length of stay.
Discharge Date	<u>Inpatient and Outpatient ED</u> – Record the month, day and year of discharge, with a four-digit entry for the year. Format = (mmddyyyy).
Attending	<u>Inpatient</u> – The ten-digit NPI is the only value accepted for the physician who was

Primary Record	
Physician	primarily and largely responsible for the patient's medical care and treatment. Only doctors of medicine or osteopathy are considered physicians for inpatient records. If primary responsibility for a patient is of a non-physician caregiver (e.g. dentists, psychologists, podiatrists, nurse midwives, physician assistants, nurse practitioners, and chiropractors) the field can be zero-filled with ten zeroes. <u>Outpatient Surgery</u> – The attending physician field is not a required field for outpatient surgery records, however, if the field is filled, the edits for inpatient records will apply. <u>Outpatient ED and Observation</u> – For emergency department, only the NPI will be accepted of the physician that requested the surgery, therapy, diagnostic tests or other services. The NPI number of a non-physician provider is the only number accepted or zero fill with ten zeroes. <u>Other Hospital Outpatient</u> – The attending physician field is not a required field for other hospital outpatient records, however if the field is filled the edits for outpatient ED and observation records will apply. Additional provider types that may be submitted are chiropractors (012), dentists or oral surgeons (015), podiatrists (025) and optometrists (035). Please use the same format as for NPs and PAs. (UB-04 FL 76).
Other Physician 1	The NPI number of the physician who performed the principal procedure.
Other Physician 2	The NPI number of the second procedure physician when two physicians participate in a procedure.
Principal Procedure Date	Record the month, day and year the principal procedure was performed. Format = (mmddyyy).
Principal Procedure	The procedure most related to the principal diagnosis and performed during the episode of care. Use CPT or HCPCS Level II codes.
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.
Expected Source of Payment ID	The first three characters from the primary payer code. See Appendix VII for appropriate codes
Expected Source of Payment Type	The fourth and fifth characters of the payer code. See Appendix VII for appropriate codes.
Secondary Source of Payment ID	The first three characters from the secondary payer code when there is a secondary payer. See Appendix VII for appropriate codes.
Secondary Source of Payment Type	The fourth and fifth characters of the secondary payer code when there is a secondary payer. See Appendix VII for appropriate codes.
Provider ID	The unique identification number assigned to the provider submitting the bill – the NPI is the national provider identifier. When the billing provider is an organization health care provider the organization health care provider's NPI or its subpart's NPI is reported in this field. When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the billing provider. The subpart reported as the billing provider must always represent the most detailed level of enumeration as determined by the organization health care provider and must be the same identifier sent to WHAIC. (UB-04 FL 56).
Type of Bill	A code indicating the specific type of bill. Please see Appendix VIII for appropriate codes. Code '999' may be used in limited situations when the actual type of bill code is unavailable at the time of data submission.
Total Charges	Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. Assumed to be positive. Format = (-)nnnnnnnn.nn. Field = ('0.00') if no charges.

Primary Record	
Statement Covers From	<u>Inpatient and Hospital Outpatient other than ED and OP Surgery</u> – The beginning service date (month, day, and year) of the period included on the record submitted. Format = (mmddyyyy).
Statement Covers Through	<u>Inpatient and Hospital Outpatient other than ED and OP Surgery</u> – The ending service date (month, day, and year) of the period included on the record submitted. Format = (mmddyyyy).
E-Code 1	The first ICD-9-CM code for the external cause of injury, poisoning, or adverse effect. Enter an E-Code whenever an injury diagnosis code (principal or additional diagnosis code) in the range 800 to 995.89 is reported except when the following codes are used: 995.0, 995.1, 995.2, 995.3, 995.60-995.69, and 995.7. Additional E-Codes can be entered in E-Code 2 through 12 fields.
POA Indicator for E-Code 1	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 2	The second ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 2	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 3	The third ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 3	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 4	The fourth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 4	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 5	The fifth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 5	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 6	The sixth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 6	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 7	The seventh ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 7	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 8	The eighth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 8	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).

Primary Record	
E-Code 9	The ninth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 9	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 10	The tenth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 10	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 11	The eleventh ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 11	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).
E-Code 12	The twelfth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 12	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only (some exclusions for E-Codes apply).

Diagnosis Record	
Code	The ICD-9-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis listed on the Primary Record, and which have an effect on the treatment or length of stay. Unlimited number allowed.
POA Indicator for Additional Dx	A code indicating whether or not the condition was present on admission or was clearly present, but not diagnosed, until after the admission took place. Applies to inpatient records only. Some exceptions for ICD-9-CM codes apply.

Procedure Record	
Code	The CPT or HCPCS Level II codes corresponding to additional procedures in addition to the principal procedure listed on the Primary Record, that were performed during the episode of care. Unlimited number allowed.
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.

Revenue Record	
Service Date	Record the month, day, and year that the outpatient service was provided. Format = (mmddyyyy).
Revenue Code	A four-digit code which identifies a specific accommodation, ancillary service or billing calculation.
HCPCS/Rate	<u>Inpatient</u> – The room and board rates should be reported and any HCPCS/CPT Level I or II codes that reflect services provided outside of the composite rate. <u>Outpatient</u> – HCPCS/CPT Level I and II codes applicable to the service provided.

Revenue Record	
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.
Units	A quantitative measure of services rendered by revenue category to or for the patient to include items such as pints of blood or renal dialysis treatments.
Charge	Total charges related to the HCPCS code or rate recorded on a specific line.

Data Entry Form – Hospitals (Revised for UB-04)

Patient Control Number: _____ **1** **2** **3**
 Patient Type: **Inpatient (1)** **Outpatient (2)** Place of Service: **4** **5** **6** **7**
 Diagnosis Records Needed: _____
 Procedure Records Needed: _____
 Revenue Records Needed: _____

Primary Record

MRN: _____
 Certificate Number: _____
 Birth Date: _____ (MMDDYYYY)
 Sex: _____ Race: _____ Ethnicity: _____
 ZIP Code: _____ Discharge Status: _____
 Type of Encounter: **(above)** Place of Service: **(above)**
 Condition Code 1: _____ Condition Code 2 (IP): _____ Condition Code 3 (IP): _____
 Encrypted Case ID: _____ First Initial of First Name: _____ Last Name: _____
 Admit Date: _____ (MMDDYYYY)
 Admit Source: _____ Admit Type: _____
 Principal Diagnosis: _____ Present on Admission¹: _____ Admitting Diagnosis: _____
 Diagnosis Reason for Visit 1: _____ Reason 2: _____ Reason 3: _____
 Leave Days (IP): _____ Discharge Date: _____ (MMDDYYYY)
 Attending Physician: _____ Other Physician 1: _____ Other Physician 2: _____
 Principal Proc Date: _____ (MMDDYYYY)
 Principal Procedure: _____ Modifier 1: _____ Modifier 2: _____
 _____ Modifier 3: _____ Modifier 4: _____
 Expected Source of Payment: ID (3 chars): _____ Type (2 chars): _____
 Secondary Source of Payment: ID (3 chars): _____ Type (2 chars): _____
 Provider ID: _____
 Type of Bill: _____
 Total Charges: _____
 Statement Covers From: _____ (MMDDYYYY) Statement Covers Through: _____ (MMDDYYYY)
 E-Code 1: _____ POA: _____ E-Code 2: _____ POA: _____
 E-Code 3: _____ POA: _____ E-Code 4: _____ POA: _____
 E-Code 5: _____ POA: _____ E-Code 6: _____ POA: _____
 E-Code 7: _____ POA: _____ E-Code 8: _____ POA: _____
 E-Code 9: _____ POA: _____ E-Code 10: _____ POA: _____
 E-Code 11: _____ POA: _____ E-Code 12: _____ POA: _____

Diagnosis Record– Additional Lines Available in Wlpop – use Additional Diagnosis/Procedure Form

Line	Code	POA	Line	Code	POA	Line	Code	POA
1			13			25		
2			14			26		
3			15			27		
4			16			28		
5			17			29		
6			18			30		
7			19			31		
8			20			32		
9			21			33		

¹ POA

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10			22			34		
11			23			35		
12			24			36		

Procedure Record– Additional Lines Available in Wipop – use Additional Diagnosis/Procedure Form

Line	Code	Mod	Mod	Mod	Mod	Line	Code	Mod	Mod	Mod	Mod
1						16					
2						17					
3						18					
4						19					
5						20					
6						21					
7						22					
8						23					
9						24					
10						25					
11						26					
12						27					
13						28					
14						29					
15						30					

Revenue Record – Additional Lines Available in Wipop – use Additional Revenue Record Form

Line	Service Date	RevCode	HCPCS/Rate	Mod	Mod	Mod	Mod	Units	Charge
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									

36									
37									
38									
39									
40									

Instructions for FASCs for Completing the Manual Entry Data Form
(Revised for UB-04)

Data Element	Instructions
Patient Control Number	Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. Up to 24 digits allowed.
Type of Encounter	Identifies the status of the patient (inpatient or outpatient) at the time of discharge. FASCs will always choose 'outpatient'.
Place of Service	FASCs will always enter '1'.
Diagnoses Records Needed	Number of diagnosis codes to be entered in the revenue record. Unlimited number allowed.
Procedure Records Needed	Number of procedure codes to be entered in the procedure record. Unlimited number allowed.
Revenue Records Needed	Number of revenue codes to be entered in the revenue record. Unlimited number allowed.

Primary Record	
Medical Record Number	The unique number assigned to each patient by the facility that distinguishes the patient and their medical record from all other patients.
Certificate Number	Insured's unique ID number assigned by the payer organization. Only the number for the primary payer is recorded. If this is a self-pay case, enter zeroes or 'selfpay.'
Birth Date	The patient's month, day, and year of birth (mmddyyyy).
Sex	F = Female M = Male U = Unknown
Race	See Appendix II for the appropriate one-digit code.
Ethnicity	See Appendix II for the appropriate one-digit code.
ZIP Code	The five-digit code assigned by the US Postal Service. The field should be zero-filled ('00000') for a person with an address that does not include a valid US ZIP code. If the ZIP code is unknown, such as for homeless patients, this field should be left blank and Condition Code 1 = '17' used on inpatient and outpatient records.
Patient Status	Not required for FASCs.
Condition Code 1	Code '17' should be entered for all inpatient and outpatient cases where a patient is homeless at the date of service when there is an unknown ZIP code.
Condition Code 2	Not applicable for FASCs.
Condition Code 3	Not applicable for FASCs.
Encrypted Case ID	An encrypted code based on the patient's last name and initial of first name. The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient.
Admit Date	Not required for FASCs.
Admit Source	Not required for FASCs.
Admit Type	Not required for FASCs.
Principal Dx	The ICD-9-CM code describing the condition established after study to be chiefly responsible for the services provided during the visit. <i>Do not enter</i>

Primary Record	
	<i>decimals.</i>
Present on Admission (POA) Indicator for Principal Dx	Not applicable for FASCs.
Admitting Dx	Not required for FASCs.
Reason for Visit 1	Not required for FASCs.
Reason for Visit 2	Not required for FASCs.
Reason for Visit 3	Not required for FASCs.
Leave Days	Not applicable for FASCs.
Discharge Date	Not required for FASCs.
Attending Physician	Not required for FASCs.
Other Physician 1	The NPI number of the physician who performed the principal procedure.
Other Physician 2	The NPI number of the second procedure physician when two physicians participate in a procedure.
Principal Procedure Date	Record the month, day and year the principal procedure was performed. Format = (mmddyyyy).
Principal Procedure	The procedure most related to the principal diagnosis and performed during the episode of care. Use CPT or HCPCS Level II codes.
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.
Expected Source of Payment ID	The first three characters from the primary payer code. See Appendix VII for appropriate codes
Expected Source of Payment Type	The fourth and fifth characters of the payer code. See Appendix VII for appropriate codes.
Secondary Source of Payment ID	The first three characters from the secondary payer code when there is a secondary payer. See Appendix VII for appropriate codes.
Secondary Source of Payment Type	The fourth and fifth characters of the secondary payer code when there is a secondary payer. See Appendix VII for appropriate codes.
Provider ID	National Provider ID.
Type of Bill	A code indicating the specific type of bill. Please see Appendix VIII for appropriate codes. Code '999' may be used in limited situations when the actual type of bill code is unavailable at the time of data submission.
Total Charges	Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. Assumed to be positive. Format = (-)nnnnnnnn.nn. Field = ('0.00') if no charges.
Statement Covers From	Not required for FASCs.
Statement Covers Through	Not required for FASCs.
E-Code 1	The first ICD-9-CM code for the external cause of injury, poisoning, or adverse effect. Enter an E-Code whenever an injury diagnosis code (principal or additional diagnosis code) in the range 800 to 995.89 is reported except when the following codes are used: 995.0, 995.1, 995.2, 995.3, 995.60-995.69, and

Primary Record	
	995.7. Additional E-Codes can be entered in E-Code 2 through 12 fields.
POA Indicator for E-Code 1	Not applicable for FASCs.
E-Code 2	The second ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 2	Not applicable for FASCs.
E-Code 3	The third ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 3	Not applicable for FASCs.
E-Code 4	The fourth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 4	Not applicable for FASCs.
E-Code 5	The fifth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 5	Not applicable for FASCs.
E-Code 6	The sixth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 6	Not applicable for FASCs.
E-Code 7	The seventh ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 7	Not applicable for FASCs.
E-Code 8	The eighth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 8	Not applicable for FASCs.
E-Code 9	The ninth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 9	Not applicable for FASCs.
E-Code 10	The tenth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 10	Not applicable for FASCs.
E-Code 11	The eleventh ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 11	Not applicable for FASCs.
E-Code 12	The twelfth ICD-9-CM code for the external cause of injury, poisoning, or adverse effect.
POA Indicator for E-Code 12	Not applicable for FASCs.

Diagnosis Record	
Code	The ICD-9-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis listed on the Primary Record, and which have an effect on the treatment or length of stay. Unlimited number allowed.
POA Indicator for Additional Dx	Not applicable for FASCs.

Procedure Record	
Code	The CPT or HCPCS Level II codes corresponding to additional procedures in addition to the principal procedure listed on the Primary Record, that were performed during the episode of care. Unlimited number allowed.
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.

Revenue Record	
Service Date	Record the month, day, and year that the outpatient service was provided. Format = (mmddyyyy).
Revenue Code	Not required for FASCs.
HCPCS/Rate	<u>Inpatient</u> – The room and board rates should be reported and any HCPCS/CPT Level I or II codes that reflect services provided outside of the composite rate. <u>Outpatient</u> – HCPCS/CPT Level I and II codes applicable to the service provided.
Modifier 1	An optional data element. CPT or HCPCS Level II modifiers may be used in this field as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Modifier 2	When there are two modifiers the second modifier should be entered here.
Modifier 3	When there are three modifiers the third modifier should be entered here.
Modifier 4	When there are four modifiers the fourth modifier should be entered here.
Units	A quantitative measure of services rendered by revenue category to or for the patient to include items such as pints of blood or renal dialysis treatments.
Charge	Total charges related to the HCPCS/CPT code or rate recorded on a specific line.

Wipop Data Form – FASCs – shaded fields are not required (Revised for UB-04)

Patient Control Number: _____
 Patient Type: Outpatient (2) Place of Service: 1
 Diagnosis Records Needed: _____
 Procedure Records Needed: _____
 Revenue Records Needed: _____

Primary Record – ‘grayed’ fields are not required for FASCs

MRN: _____
 Certificate Number: _____
 Birth Date: _____ (MMDDYYYY)
 Sex: _____ Race: _____ Ethnicity: _____
 ZIP Code: _____ Discharge Status: _____
 Type of Encounter: (above) Place of Service: (above)
 Condition Code 1: _____ Condition Code 2 (IP): _____ Condition Code 3 (IP): _____
 Encrypted Case ID: _____ First Initial of First Name: _____ Last Name: _____
 Admit Date: _____ (MMDDYYYY)
 Admit Source: _____ Admit Type: _____
 Principal Diagnosis: _____ Present on Admission²: _____ Admitting Diagnosis: _____
 Diagnosis Reason for Visit 1: _____ Reason 2: _____ Reason 3: _____
 Leave Days (IP): _____ Discharge Date: _____ (MMDDYYYY)
 Attending Physician: _____ Other Physician 1: _____ Other Physician 2: _____
 Principal Proc Date: _____ (MMDDYYYY)
 Principal Procedure: _____ Modifier 1: _____ Modifier 2: _____
 Modifier 3: _____ Modifier 4: _____
 Expected Source of Payment: ID (3 chars): _____ Type (2 chars): _____
 Secondary Source of Payment: ID (3 chars): _____ Type (2 chars): _____
 Provider ID: _____
 Type of Bill: _____
 Total Charges: _____

Statement Covers From: _____ (MMDDYYYY) Statement Covers Through: _____ (MMDDYYYY)

E-Code 1: _____	POA: _____	E-Code 2: _____	POA: _____
E-Code 3: _____	POA: _____	E-Code 4: _____	POA: _____
E-Code 5: _____	POA: _____	E-Code 6: _____	POA: _____
E-Code 7: _____	POA: _____	E-Code 8: _____	POA: _____
E-Code 9: _____	POA: _____	E-Code 10: _____	POA: _____
E-Code 11: _____	POA: _____	E-Code 12: _____	POA: _____

Diagnosis Record– Additional Lines Available in Wipop – use Additional Diagnosis/Procedure Form

Line	Code	POA	Line	Code	POA	Line	Code	POA
1			13			25		
2			14			26		
3			15			27		
4			16			28		
5			17			29		
6			18			30		
7			19			31		
8			20			32		
9			21			33		

² POA

Wipop Manual Data Entry

10			22			34		
11			23			35		
12			24			36		

Procedure Record– Additional Lines Available in Wipop – use Additional Diagnosis/Procedure Form

Line	Code	Mod	Mod	Mod	Mod	Line	Code	Mod	Mod	Mod	Mod
1						16					
2						17					
3						18					
4						19					
5						20					
6						21					
7						22					
8						23					
9						24					
10						25					
11						26					
12						27					
13						28					
14						29					
15						30					

Revenue Record – Additional Lines Available in Wipop – use Additional Revenue Record Form

Line	Service Date	RevCode	HCPCS/Rate	Mod	Mod	Mod	Mod	Units	Charge
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									

36									
37									
38									
39									
40									

Additional Diagnosis/Procedure Form (Revised for UB-04)

Additional Diagnosis

Line	Code	POA	Line	Code	POA	Line	Code	POA
37			59			81		
38			60			82		
39			61			83		
40			62			84		
41			63			85		
42			64			86		
43			65			87		
44			66			88		
45			67			89		
46			68			90		
47			69			91		
48			70			92		
49			71			93		
50			72			94		
51			73			95		
52			74			96		
53			75			97		
54			76			98		
55			77			99		
56			78			100		
57			79					
58			80					

Additional Procedure

Line	Code	Mod	Mod	Mod	Mod	Line	Code	Mod	Mod	Mod	Mod
31						62					
32						63					
33						64					
34						65					
35						66					
36						67					
37						68					
38						69					
39						70					
40						71					
41						72					
42						73					
43						74					
44						75					
45						76					
46						77					
47						78					
48						79					
49						80					
50						81					
51						82					
52						83					
53						84					

Wipop Manual Data Entry

54						85					
55						86					
56						87					
57						88					
58						89					
59						90					
60											
61											

Additional Revenue Record Form (Revised for UB-04)

Line	Service Date	RevCode	HCPCS/Rate	Mod	Mod	Mod	Mod	Units	Charge
41									
42									
43									
44									
45									
46									
47									
48									
49									
50									
51									
52									
53									
54									
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56									
57									
58									
59									
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61									
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81									
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83									
84									
85									
86									