

Inpatient/Outpatient Submittal Data Dictionary

In this section, specifications for individual data fields are defined, and a corresponding uniform billing form reference is given (where applicable).

Primary Record

Field Number	Description
1	Record Type: The alpha character used to identify the type of record. Record Type = 'A' for all Primary Records.
2	Facility Number: The unique identification number assigned to each facility by WHA Information Center. The code is based on the county, region and type of facility. Appendix I lists the identification number for each facility in Wisconsin.
3	Patient Control Number: The unique alphanumeric number assigned to the record by the facility to facilitate retrieval of individual financial records and posting of the payment. (UB-04 FL 3a) (CMS-1500 FL 26)
4	Date of Birth: The patient's month, day, and complete year of birth. This date should be recorded in numeric form with a two-digit entry for the month and day and a four-digit entry for the year (mmddyyyy). For example, if the birth date is July 10, 1950 record 07101950. The entire birth date should be provided. (UB-04 FL10) (CMS-1500 FL3)
5	ZIP Code: The five-digit code assigned by the U.S. Postal Service. Valid ZIP codes should be provided whenever possible. The field should be entered with five zeroes ('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' used on inpatient and outpatient records. (UB-04 FL 9) (CMS-1500 FL5)
6	Sex: (UB-04 FL 11) (CMS-1500 FL3) F = Female M = Male U = Unknown – To be used only when the sex is clinically unknown.
7	Race: See Appendix II for the appropriate one-digit code. This information should be collected from the patient, family member, or responsible party. (UB-04 FL81 B1)
8	Ethnicity: See Appendix II for the appropriate one-digit code. (UB-04 FL 81 B1)
9	Point of Origin (AKA Admit Source in Wlpop): A code indicating where the patient came from. See Appendix III for the appropriate one-digit code, which describes the source from which the patient was admitted. If Type of Admission '4' is used (Newborn), then Point of Origin Newborn coding structure must be used. See Appendix III for the appropriate one-digit code to be used with Type of Admission '4'.

Inpatient/Outpatient Submittal Data Dictionary

	This data element is not required for freestanding ambulatory surgery centers. (UB-04 FL 15)
10	Type of Admission: A code indicating the priority of the admission. If Type of Admission '4' is used (Newborn), then Point of Origin for Admission or Visit for Newborn coding structure must be used. See Appendix V for the appropriate one-digit code, which indicates the priority of the admission. This data element is required for inpatient records only effective 1-1-06. (UB-04 FL 14)
11	Admission Date: The month, day and year the patient was admitted to the hospital for <u>inpatient or emergency department care</u> . The date should be numeric with two-digit entry for month and day and a four-digit entry for year (mmddyyyy). For example, February 14, 2006 would be recorded as 02142006. (UB-04 FL 12)
12	<p>Principal Diagnosis: The ICD-9-CM 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. <u>Do Not Enter Decimals</u>. For example, a principal diagnosis code of 378.40 would be recorded as 37840. (UB-04 FL 67) (CMS-1500 FL 21-1)</p> <ul style="list-style-type: none"> • Use of the fourth and fifth digits are not optional • Certain codes may not be used as principal diagnoses, as determined by ICD-9-CM annotations and <i>Coding Clinic</i>
13	Present on Admission Indicator for Principal Diagnosis: The eighth digit of UB-04 FL 67. The purpose is to identify conditions known at the time of admission, and those that were clearly present, but not diagnosed, until after the admission took place. The five reporting options are: Y = yes, N = no, U = no information in the record, W = clinically undetermined, and blank or '1' = exempt from POA reporting. Please see Appendix XI for further information. Optional 7/1/07, required 1/1/08.
14	Admitting Diagnosis: The ICD-9-CM code describing the patient's diagnosis or reason for visit at the time of admission. <u>Do Not Enter Decimals</u> . For example, a diagnosis of 787.01 would be recorded as 78701. (UB-04 FL 69)
15-17	Patient's Reason for Visit: The ICD-9-CM diagnosis code describing the patient's reason for visit at the time of outpatient registration. One code required for TOB 013x and 085x, with Revenue Codes 045x, 0516, 0526, or 0762. Up to three codes allowed for any outpatient record. (UB-04 FL 70a-70c)
18, 20, 22, 24, 26, 28, 30, 32,	External Cause of Injury Code (E-code): The 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,

Inpatient/Outpatient Submittal Data Dictionary

<p>34, 36, 38, 40</p>	<p>and 995.7. One code required for inpatient records, and outpatient records with Place of Service 1-3. Allowed for Place of Service 4-7. Up to 12 codes allowed for any record. <u>Do Not Enter Decimals</u>. For example, E-code of E858.4 would be recorded as E8584. (UB-04 FL 72 1a-1c) (CMS-1500 FL 21-(2-4))</p>
<p>19, 21, 23, 25, 27, 29, 31, 33, 35, 37, 39, 41</p>	<p>Present on Admission Indicator for E-codes: The eighth digit of UB-04 FI 72 1a-1c. The purpose is to identify conditions known at the time of admission, and those that were clearly present, but not diagnosed, until after the admission took place. The five reporting options are: Y = yes, N = no, U = no information in the record, W = clinically undetermined, and blank or '1' = exempt from POA reporting. Please see Appendix XI for further information. Optional 7/1/07, required 1/1/08.</p>
<p>42</p>	<p>Attending Physician Identification Number: <u>Inpatient</u> – The ten-digit NPI is the only value accepted for 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. If primary responsibility is 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, the NPI only 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).</p>
<p>43</p>	<p>Operating Physician Identification Number: <u>Inpatient</u> - The ten-digit NPI only will be accepted of the physician who performed the principal procedure. 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) then this entire field should be zero-filled with ten zeroes. <u>Outpatient Surgery</u> – For outpatient surgery records, the NPI only will be accepted of the physician who performed the principal procedure. Only doctors of medicine and osteopathy are considered physicians for outpatient surgery 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) then the field can be entered with ten zeroes. <u>Emergency Department, Observation and Other Hospital Outpatient</u> - For emergency department, observation or other hospital outpatient records, only NPIs will be accepted of the physician who performed the principal procedure. Enter ten zeroes of a non-physician provider if the NPI number is unknown. If a principal procedure was not performed, the field should be left blank. (UB-04 FL 77) (CMS-1500 FL 17 A)</p>

Inpatient/Outpatient Submittal Data Dictionary

44	<p>Other Operating Physician Identification Number: The ten-digit NPI only will be accepted of the second procedure physician. This is not a required field. (UB-04 FL 78)</p>
45	<p>Principal Procedure: <u>Inpatient</u> - The procedure performed for definitive treatment rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. It is the procedure most related to the principal diagnosis. If more than one procedure is 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 or invasive procedure performed is diagnostic or exploratory in nature (i.e. cardiac cath) it should be reported in the principal procedure field (Use ICD-9-CM codes, updated biannually). <u>Outpatient</u> – The procedure most related to the principal diagnosis and performed during the episode of care. (Use ICD-9-CM, or CPT/HCPCS codes until 1/1/07. Do not submit both CPT and ICD codes on any one record. CPT/HCPCS codes required as of 1/1/07.) Please refer to Appendix XI for a recommended range of CPT or HCPCS Level II codes that may be selected for those hospitals reporting CPT/HCPCS Level II codes in this field. Do Not Enter Decimals. For example, a principal procedure code of 45.61 would be recorded as 4561. (UB-04 FL 74 for inpatient records) (CMS-1500 FL 24 D-1)</p>
46-49	<p>Principal Procedure Modifier: <u>Outpatient</u> – An optional data element for when CPT or HCPCS Level II codes are used in the principal procedure field. CPT or HCPCS Level II modifiers may be used in this field as appropriate. WHA Information Center will accept four modifiers per CPT/HCPCS code as of 7/1/07 dates of service. When there is more than one modifier that applies to a specific code, the modifier that has the most impact on payment should be listed first. (CMS-1500 FL 24 D-1)</p>
50	<p>Principal Procedure Date: Record the month, day, year the principal procedure was performed, with a two-digit entry for month and day and a four-digit for year (mmddyyyy). For example, a principal procedure occurring on May 8, 2006 would be recorded as 05082006. (UB-04 FL 74 for inpatient records) (CMS-1500 FL 24 A-1)</p>
51	<p>Discharge Date: <u>Inpatient and Outpatient ED</u> - Record the month, day and year of discharge, with a two-digit entry for the month and day and a four-digit entry for the year (mmddyyyy). The stay may have ended by order of physician, against medical advice, or by death. Transfers to SNF or ICF as well as to swing bed should be considered a discharge. For example, a discharge occurring on May 8, 2006 would be recorded as 05082006.</p>
52	<p>Patient Status: <u>Inpatient and Outpatient ED</u> - A two-digit entry indicating patient status as of the ending service date of the period covered in the record. For example, a patient discharged to home or self care would be recorded as '01'. See Appendix VI for appropriate codes. (UB-04 FL 17)</p>
53	<p>Expected Source of Payment ID: The first three characters from the primary payer code from the UB-04 form. All Wisconsin Medical Assistance (Medicaid) patients</p>

Inpatient/Outpatient Submittal Data Dictionary

	must be coded as "T19," whether payer type is fee-for-service or HMO. See Appendix VII for appropriate codes. (UB-04 FL 50a) (CMS-1500 FL 1)
54	Expected Source of Payment Type: The fourth and fifth characters of the payer code from the UB-04 form. See Appendix VII for appropriate codes. (UB-04 FL 50a) (CMS-1500 FL 1)
55	Secondary Source of Payment ID: The first three characters from the secondary payer code from the UB-04 form. See Appendix VII for appropriate codes. (UB-04 FL 50b) (CMS-1500 FL 1)
56	Secondary Source of Payment Type: The fourth and fifth characters of the secondary payer code from the UB-04 form. See Appendix VII for appropriate codes. (UB-04 FL 50b) (CMS-1500 FL 1)
57	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.
58	Total Charge: Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. The charge should be entered with two place decimal (-)nnnnnnnn.nn. This is always assumed to be positive. For example, \$8204.05 would be recorded as 8204.05 or \$155,327.00 would be recorded as 155327.00. The field should equal zero ('0') if there are no charges. (UB-04 FL 47) (CMS-1500 FL 28)
59	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 (charges for holding a room while the patient is temporarily away from the hospital). These are the total number of leave days for the entire length of stay.
60	Type of Bill: A code indicating the specific type of bill (inpatient, outpatient, interim claims, etc.). The first digit is an optional leading zero. The second and third digits combined are a facility code. The fourth digit defines the frequency. Code '0999' may be used in limited situations when the actual type of bill code is unavailable at the time of data submission. FASCs may routinely use '0999' since type of bill is not a standard data element on the CMS-1500 form. See Appendix VIII for appropriate codes. (UB-04 FL 4)
61	Type of Encounter: One-digit entry identifies the status of the patient at the time of discharge. Use the following codes: 1 = Inpatient

Inpatient/Outpatient Submittal Data Dictionary

	2 = Outpatient
62	<p>Place of Service: <u>Outpatient Only</u>. One-digit entry identifies the area where the patient received outpatient treatment. Use the following codes in this hierarchy (See Appendix IX for further instructions):</p> <p><u>Outpatient</u></p> <ul style="list-style-type: none"> 3 = Observation Care 1 = Outpatient Surgery 2 = Emergency Department 4 = Therapy (PT/OT/ST) 5 = Outpatient (Lab/Radiology excluding referenced diagnostic services) 6 = Other outpatient 7 = Repetitive (recurring, serial) services
63	<p>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. (UB-04 FL 3b)</p>
64-65	<p>Statement Covers Period: <u>Hospital Outpatient other than ED and OP Surgery</u> - The beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same. Enter dates as month, day, and year (mmddyyyy). For example, a patient starting physical therapy May 8, 2006 and finishing physical therapy on May 12, 2006: "From" should be recorded 05082006 and "Through" should be recorded as 05122006. (UB-04 FL 6)</p>
66	<p>Condition Code 1: Code '17' should be entered for all inpatient and outpatient cases where a patient is homeless at the date of admission for inpatients, or date of service for outpatients when there is an unknown ZIP code. (UB-04 FLs 18-28)</p>
67	<p>Condition Code 2: Effective Q3 2010 dates of service, WHAIC will accept any 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'. (UB-04 FLs 18-28)</p>
68	<p>Condition Code 3: Effective Q3 2010 dates of service, WHAIC will accept any of</p>

Inpatient/Outpatient Submittal Data Dictionary

	<p>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'. (UB-04 FLs 18-28)</p>
69	<p>Certificate Number: Insured's unique identification number assigned by the payer organization. Only the number for the primary payer is recorded. If this is a self-pay case, the field can be zero-filled or left blank. (UB-04 FL 60) (CMS-1500 Form Locator 1A)</p>
70	<p>Encrypted Case Identifier: An encrypted code based on the patient's last name and initial of first name. It is designed to help protect the confidentiality of a patient. This item does not enable WHA Information Center or anyone else to identify the patient. Data submitters may enter the encrypted case identifier in two ways – using WIpop's encrypted case identifier generator, or using the manual method.</p> <p>This field must contain five characters in the following format:</p> <ul style="list-style-type: none"> 1st Digit = Alpha 2nd Digit = Numeric 3rd Digit = Numeric 4th Digit = Numeric 5th Digit = Alpha <p>See Appendix X for the manual encryption methodology that can be used to generate the Encrypted Case ID.</p>

Revenue Record

Field Number	Description
1	<p>Record Type: The alpha character used to identify the type of record. Record Type = 'R' for all Revenue Records.</p>
2	<p>Facility Number: The unique identification number assigned to each facility by WHA Information Center. The code is based on the county, region and type of facility. Appendix I lists the identification number for each facility in Wisconsin.</p>
3	<p>Patient Control Number: Patient's unique alphanumeric number assigned by the</p>

Inpatient/Outpatient Submittal Data Dictionary

	facility to facilitate retrieval of individual financial records and posting of the payment. (UB-04 FL 3a) (CMS-1500 FL 26)
4	Revenue Code: A code, which identifies a specific accommodation, ancillary service or billing calculation. This data element is not required for freestanding ambulatory surgery centers. (UB-04 FL 42)
5	HCPCS/CPT/Rates/HIPPS Rates: <u>Inpatient:</u> The Room and Board (Rates) should be reported. The rates should be entered with two-place decimal. For example, a charge of \$455.00 would be recorded as 455.00. Under the Inpatient Rehabilitation Facility PPS a five-digit HIPPS Rate/CMG Code (AXYY-DXYY) may be reported with revenue code 0024. Rates are always assumed to be positive. <u>Outpatient:</u> HCFA Common Procedure Coding System (HCPCS Level I (CPT) and Level II) applicable to ancillary services. HCPCS/CPT codes are required for outpatient services. (UB-04 FL 44) (CMS-1500 FL 24 D)
6, 7, 8, 9	HCPCS Level I or II Modifiers: <u>Outpatient</u> – An optional data element for when CPT or HCPCS Level II codes are used in the HCPCS field. CPT or HCPCS Level II modifiers may be used in this field as appropriate. WHA Information Center will accept four modifiers per CPT/HCPCS code as of 7/1/07 dates of service. When there is more than one modifier that applies to a specific code, the modifier that has the most impact on payment should be listed (UB-04 FL 44) (CMS-1500 FL 24 D)
10	Service Date: The date that a service was provided (mmddyyyy). Required on outpatient records only. If used on an inpatient record the service date must be within 3 days prior to the admit date and cannot be after the discharge date. For outpatient surgery (place of service 1 records) the service must be within 7 days prior to the procedure date and 1 day after the procedure date. For OPS records with revenue code 030x service may be within ten days prior to the procedure date. For ED (place of service 2 records) the service date must be within 3 days prior to the admit date and cannot be after the discharge date. For all other hospital outpatient records the service date must be on or between the from and through dates. (UB-04 FL 45) (CMS-1500 FL 24 A)
11	Units of Service: A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, or renal dialysis treatments, etc. The value must be an integer other than zero and may be negative only if the total charge (field 9) is negative. The value must be positive and a minimum of '1' if the line is submitted with a zero charge (whether the charge is zero or greater than zero). (UB-04 FL 46) (CMS-1500 FL 24 G)
12	Total Charges (By Revenue/HCPCS/CPT Code): Total charges related to the revenue code or HCPCS/CPT code recorded. Total charges include both covered and non-covered charges. Positive charges should be entered with two-place decimal. For example, \$2456.50 should be entered 2456.50. Any adjustment or credit to revenue service line should be entered with signed negative character (-) and two-place decimal. For example a negative adjustment of \$10.00 should be

Inpatient/Outpatient Submittal Data Dictionary

	entered as -10.00. (UB-04 FL 47) (CMS-1500 FL 24 F)
	<p>Note Regarding Units of Service and Total Charges by Revenue Line</p> <p>The following three formats are acceptable for submitting service units and total charges per revenue line:</p> <ul style="list-style-type: none"> • Positive service units with positive charges • Positive service units with negative charges • Negative service units with negative charges

Diagnosis Record

Field Number	Description
1	Record Type: The alpha used to identify the type of record. Record Type = 'D' for all Diagnosis Records.
2	Facility Number: The unique identification number assigned to each facility by WHA Information Center. The code is based on the county, region and type of facility. Appendix I lists the identification number for each facility in Wisconsin.
3	Patient Control Number: Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. (UB-04 FL 3a) (CMS-1500 FL 26)
4	Additional Diagnosis: The ICD-9-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis listed on the Primary 'A' Type Record, and which have an effect on the treatment or length of stay. Facilities should submit all additional diagnosis codes that apply to each record. Wlpop will accept an unlimited number of diagnosis codes. <u>Do Not Enter Decimals</u> . For example, an additional diagnosis code of 378.40 would be recorded as 37840. (UB-04 FLs 67a-q) (CMS-1500 FL 21-(2-unlimited))
5	Present on Admission Indicator for Additional Diagnosis Codes: The eighth digit of all additional diagnosis codes submitted on the record. The purpose is to identify conditions known at the time of admission, and those that were clearly present, but not diagnosed, until after the admission took place. The five reporting options are: Y = yes, N = no, U = no information in the record, W = clinically undetermined, and blank or '1' = exempt from POA reporting. Please see Appendix XI for further information. Optional 7/1/07. Required 1/1/08.

Procedure Record

Field Number	Description
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Inpatient/Outpatient Submittal Data Dictionary

1	Record Type: The alpha used to identify the type of record. Record Type = 'P' for all Procedure Records.
2	Facility Number: The unique identification number assigned to each facility by WHA Information Center. The code is based on the county, region and type of facility. Appendix I lists the identification number for each facility in Wisconsin.
3	Patient Control Number: Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. (UB-04 FL 3a) (CMS-1500 FL26)
4	Additional Procedures: <u>Inpatient</u> - The ICD-9-CM codes corresponding to additional procedures in addition to the principal procedure listed on the Primary 'A' Type Record, that were performed during the episode of care. Facilities should submit all additional procedure codes that apply to each record. <u>Outpatient</u> - The ICD-9-CM or CPT/HCPCS codes corresponding to additional procedures in addition to the principal procedure listed on the Primary 'A' Type Record, that were performed during the episode of care. <i>Do not submit both CPT and ICD codes on the same record. As of 1/1/07 only CPT/HCPCS codes are allowed on outpatient records. Please refer to Appendix XI for a recommended range of CPT or HCPCS Level II codes that may be selected for those hospitals reporting CPT/HCPCS Level II codes in this field. Do Not Enter Decimals.</i> (UB-04 FLs 74a-e) (CMS-1500 FL 24 D (2-unlimited)).
5 – 8	Additional Procedure Modifier: <u>Outpatient</u> – An optional data element for when HCPCS Level I (CPT) or Level II codes are used in the Additional Procedures field. Level I or Level II modifiers may be used in this field as appropriate. As of 7/1/07 dates of service WHA Information Center will accept four modifiers per CPT/HCPCS code. When there is more than one modifier that applies to a specific code, the modifier that has the most impact on payment should be listed first. (CMS-1500 FL 24 D (2-unlimited))