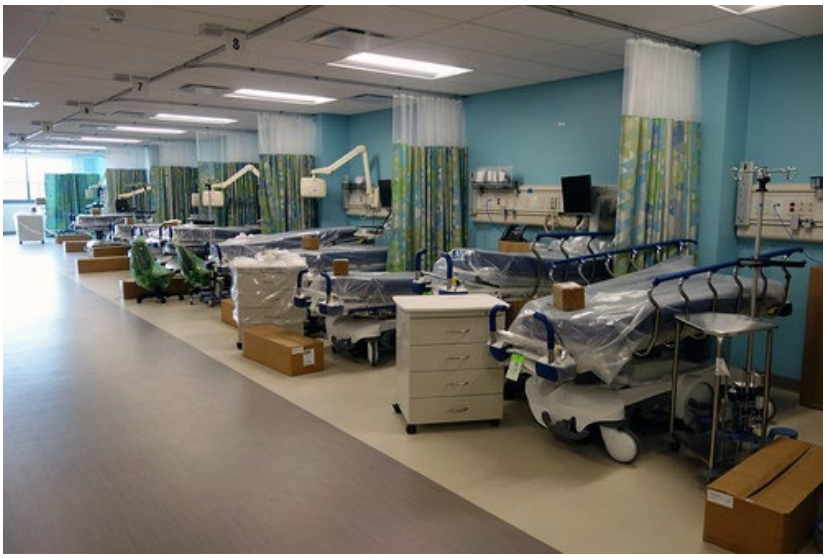
WHAIC Ambulatory Surgery Center Technical Document & Tips to Create a File



WHAIC Data Submission and General Questions

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DISCLAIMER: This document supports the freestanding ASC file Development for an 837P file. The full manual along with all the detailed technical specifications and appendices can be found on the WHA Information Center website and also here: https://www.whainfocenter.com/Data-Submitters/WiPop/Hospitals

A. WHAIC Data Submission in a HIPAA Complaint 837 claims file format

Wisconsin Hospital Association Information Center (WHAIC) collects data from **Medicare Certified Wisconsin Hospitals and Freestanding Ambulatory Surgery Centers.**

Pursuant to Chapter 153, Wisconsin Statutes , the WHAIC has been authorized by the Wisconsin Department of Administration to collect and report hospital and freestanding ambulatory surgery center data. WHAIC collects data quarterly and produces public use data sets, custom data sets and four annual publications.

Chapter 153 of the Wisconsin Statutes directs what information must be submitted to WHAIC; however, although health care has evolved tremendously over the past three decades, many sections of the statute had not been updated until April of 2016, when the Wisconsin Health Care Data Modernization Act was passed. The Health Care Data Modernization Act removed outdated provisions in Chapter 153 and included an opportunity to bring Chapter 153 into greater alignment with the national ANSI 837 standard.

The WHAIC WIpop Manual and Technical Specification Guide follows the national ANSI 837 standards and provides specifications for the submission of inpatient and outpatient hospital data, and FASC data to the WHAIC. Failure to comply with the requirements outlined in the Statutes, or submission deadlines as referenced in this Companion Guide, may result in a non-compliance letter to the Wisconsin Department of Administration and may include significant penalties and forfeitures.

The Statute also states facilities that use a third-party vendor shall provide a copy of the trading partner agreement if the service of a third-party vendor is used to prepare and submit patient claims/records to WHAIC. As per *Wisconsin Administrative Code* DHS 120.12 (5) (b) 6 (a) and 120.13(2) (d) 1. *"To ensure confidentiality, hospitals and freestanding ambulatory surgery centers using qualified vendors to submit data shall provide to [WHAIC]* ***an original trading partner agreement that has been signed and notarized by the qualified vendor and the hospital or ambulatory surgery center****. 2. Hospitals and [ASC] shall be accountable for their qualified vendor's failure to submit and edit data in the formats required by [WHAIC]".*

B. Freestanding Ambulatory Surgery Records (OPS)

Hospital outpatient departments, hospital-affiliated ambulatory surgery centers and freestanding ambulatory surgery centers (FASC) are required to submit selected items or aggregation of items on all ambulatory surgeries***, including records of self-pay patients***.

Outpatient surgery records submitted based on procedure date i.e., what quarter did the surgical procedure or service take place in. The **procedure date** (*not admit/discharge or statement from/through*) is used to determine which quarter to use when reporting OPS.

The date of services may cross a quarter by a day or two as long as the principal procedure falls in the current quarter. If a date on the record includes dates into the next quarter for OPS, it shouldn't throw an edit if the procedure date is in the right quarter and the revenue line-item dates match (if facility populates) the Adm/Discharge dates or Statement from/Through.

- For example, if the procedure is performed on 06/30, but the patient was discharged on 7/1, it should still be included in the Q2 data submission because the procedure happened in Q2.

WHAIC will assign the record to Place of Service (POS) '1' for services related to the definition of ambulatory/day/same day or outpatient surgery, including FASC when the following UB Revenue Codes are on the record/encounter:

Outpatient surgery is surgery that is completed in **one day** and does not require the patient to be hospitalized overnight.

- *A **principal procedure code is required on outpatient surgery records*** as per statutory requirements. WHAIC will assign and populate the principal procedure field and procedure date using the revenue line-item detail .
  - *Assignment of principal procedure is based on the highest qualifying CPT/HCPCS **code charge**. If two or more revenue line items have the same (high) charge, the earliest service date will be marked as the principal procedure.*
  - *Assignment of the procedure code will be based on official CPT and HCPCS coding guidelines, and when necessary, use of historical data and algorithms.*
- For OPS, the principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
  - *For purposes of discharge data submissions WHAIC considers most CPT codes located in the surgical section 15999 – 69979, with limited exceptions, eligible for assignment of a principal procedure.*
- Freestanding ambulatory surgery centers - (FASC) are not required to use OP revenue codes.
  - FASC bill on an 837P or CMS 1500 with the appropriate CPT or HCPCS codes for services, supplies, or other items.
  - *FASCs are not required to report type of bill on the claim; however, this field is required in WIpop per state statute. WHAIC has asked facilities to map the data to 0999 or 0831 or a version of this. Under certain circumstances as defined in the manual, WHAIC will automatically assign an acceptable TOB to this field in WIpop – see the 837P specification for more information.*
- *Exception Rules OPS:* Records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), are exempt from the edit.
  - A service date up to 90 days after the principal procedure date will be allowed if a Left (LT) or Right (RT) modifier is on record.

Note: Some FASC that create a file using an 837i (institutional format) WHAIC uses the revenue line-item detail (Revenue codes 036X (not 0361), 0481, 049X or 0750) and dates of service to pull out the principal and additional procedure codes and dates.

036X – OR Services *not 0361*	0481 – Cardiac Cath	049X – Ambulatory Surgical Care	0750 – GI Services

C. Discharge Data Collection Overview

This section defines the expectations and exceptions for the data submission requirements and limitations. See Section 5 for information on specific data submission and technical requirements.

Facilities must use the secured web-based submission tool known as WIpop [pronounced WHY POP] to submit its quarterly discharge data to WHAIC.

WIPOP users must register for and have an active WIpop account. Hospitals and ASCs are responsible **for managing access to WIpop and all registered users. Any changes to the list of users must be corrected in WIpop or communicated to WHAIC staff.**

1. Format failures

Data submission files must pass basic formatting and compliance checks to be processed in the WIpop database. If a file is rejected for failing the format requirements an email notification will be sent to submitter and primary contact detailing the reason for failed formatting. For more information on file failures see section 6.1 *Facilities are accountable for their qualified vendor's failure to submit data and/or create the 837 claims file required by WHAIC.*

Examples of format failures:

- File contains PHI - patient name or social security number.
- Greater than 10% of records missing address to complete the census block group detail.
- Greater than 25% of records with a race or ethnicity of unavailable / denied *effective Q318
- Structurally insufficient or missing segments, facility ID, etc. File size is over 100Meg.
- Duplicating patient control numbers / encounters in the file.

2. Timelines for Data Submission

Data must be reported quarterly, within 45 days of the close of the quarter. Calendar quarters end on March 31, June 30, September 30 and December 31. Monthly files are encouraged.

The WHAIC discharge data submission site includes both a **WIpop Test** site and a WIpop Production site.

**Edits should not be worked in the test site unless the facility is verifying something specific.*

3. Bill Types and Replacement Claims

FASC must submit Bill Types (Type of Bills) as per State Statute, although not required on the 837P: **WHAIC will accept 0831 or 0999 – programmed accordingly.**

- We do not accept replacement, voided or corrected claims/encounters in any of the data. Unlike insurance companies, we have no mechanisms in place to automatically search and replace a previously submitted encounter or record. *The data is submitted and released for use by hospitals, policy makers, researchers and consumers based on calendar quarters, therefore it is impractical to replace a record/claim from a previous quarter once the data is released.*
    - For example, types of bills ending in 7 (example 0837) will be assigned an edit.

External Cause of Injury (**ECI) Codes are required**, as per state statute, with a diagnosis code in S section and some T codes.

- External Cause Code required when diagnosis code is in this range: S00-T14, T20-T35, T69 see section 4.5.
- External Cause Codes are required on FASC records.

D. Ambulatory (day/outpatient) Surgery Records (OPS)

Freestanding ambulatory surgery centers (FASC) are required to submit encounters for ambulatory surgeries, **including records of self-pay patients, workers comp, charity care, etc.**

ASCs are not required to use a revenue code, but if one is provided, we ask they comply with the codes used by hospitals:

*036X – Operating Room Services *except revenue code 0361 – which is assigned to OHO POS 6 minor outpatient treatment. 0481 – Cardiology – Cardiac Cath; 049X – Ambulatory Surgical Care; and 0750 – GI Services*

A principal procedure code is required on outpatient surgery records as per statutory requirements.

WHAIC follows *official CPT and HCPCS coding guidelines* to assign and populate the principal procedure field and procedure date using the claims revenue line-item detail.

- *Assignment of principal procedure is based on the highest qualifying CPT/HCPCS **code charge**. If two or more revenue line items have the same (high) charge, the earliest service date will be marked as the principal procedure. Add-on codes will not be pulled as principal.*
    - *Modifiers will be carried over to principal procedure field as provided.*

Freestanding ambulatory surgery centers - (FASC) are not required to use (but will be accepted) select OP revenue codes. Revenue codes are not required as they are not produced and used on an 837P file. However, if an ASC uses a file that reports revenue codes: **Exclude revenue codes 096X to 098X**. As per state statute, we do not collect data for Professional Services.

- FASC typically bill on an 837P or CMS 1500 with the appropriate CPT or HCPCS codes for services, supplies or other items.
- *ASCs are not required to report type of bill; however, this field is required in WIpop per state statute. WHAIC has asked facilities to map the data to 0999 or 0831 or a version of this. Under certain circumstances as defined in the manual, WHAIC will automatically assign an acceptable TOB to this field in WIpop – see the 837P specification for more information.*

The **procedure date** (not the statement from and through) is used to determine which quarter to use when reporting OPS.

- For example, if the procedure is performed on 06/30, but the patient had follow-up or on rare occasion discharged on 7/1, it should be included in the second quarter data submission.
- *Dates of service are not included in the discharge data if a claim makes it way into the next quarter, we ask that you change the DOS to match the quarter the data is submitted for and not delete the record.*

- *Exception Rules OPS:* Records for claims that occur within the 90-day global surgical period (such as cataract surgeries that are often performed on both eyes within the 90-day global surgery period), are exempt from the edit.
  - A service date up to 90 days after the principal procedure date will be allowed if a Left (LT) or Right (RT) modifier is on record.

E. Create the 837P Data Submission File

This section provides additional detail about the file submission and specific characteristics about the file and file expectations. Review of this section will help the technical advisor, vendor or developer create the custom 837 claim file and format it according to WHAIC specifications. If you follow these guidelines, the file will process accurately, efficiently and with minimal edits.

Although this manual is intended to serve ASCs, some ASCs prefer to program the file using the 837I or 837R format, see the full hospital manual for those details. This document references the 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)

837P sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837P_SampleFile.pdf

The 837 WIpop claims file **does NOT have** file extension requirements.

1. *Interchange Control Header (ISA06)*

WHAIC manages two data submission environments - one for test and one for production, therefore the data submitter is choosing the environment; the use of the ISA15 segment is not necessary or required.

An uploaded 837 file must contain data for only one facility. The facility number in ISA06, GS02, and NM109 in loop 1000A must all match the facility number specified when the file is uploaded. In other words, if the user specifies that the uploaded file is for facility 043 (Aurora - Hartford) but the file contains data and field identifiers for facility 124 (Aurora - Sheboygan), the file will be rejected.

2. *Delimiters in the Segment of the file*

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered implementation compliant with this guide to be a 105 byte fixed length record, followed by a segment terminator.

- the data element separator is byte number 4;
- the repetition separator is byte number 83;
- the component element separator is byte number 105; and,

- the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown below in Delimiters Table, in all examples of the EDI transmissions.

File Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

3. *Special Characters in the Claims Data*

The use of the following special characters should be used within the claim data as defined below.

Period	Dash	Colon
.	-	:
Ex: Charges 111.11	**Ex:** source of payment, ex. AAA-01 Ex: Element format is **UCID-ECID** UCID is characters 1 – 64	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

4. *837P (ASC) Professional Claim Submissions - ASCs*

This section applies to freestanding ambulatory surgery centers (FASC/ASCs), with a three-digit ID in the range of 200 or 400 Appendix 7.1. FASCs are required to submit selected items or aggregation of items on all ambulatory surgeries, **including records of self-pay patients.** Most of these items are located on the National Uniform Claims Committee (NUCC) or CMS-1500 claim form. For more information on mapping to a 1500 claim form see NUCC MAP.

This document notes the loops and elements relevant to WHAIC Data Collection. It is not intended to serve as a complete 837 reference, not all requirements for a valid 837 file are specified. *See the main 837 Companion Guide and Tech Specifications Manual (Hospital Manual) for the 837I and 837R specs.*

Census Block Group	Time of Admission	Discharge Time
Auto Accident State (if collected)	Additional/Other Procedure Date	Condition Code 4
Occurrence Span Code 1-4	Occurrence Span Code Range of Dates	Occurrence Code Date
Value Codes 1-4	Value Code Amount	Rendering Provider NPI
Referring Provider NPI	Language (New Field: Q3 2019)	Marital Status

Claim Filing Indicator Code (New Field: Q32019)	Payer / NAIC # (New Field Q3 2019)	Payer Name (New Field Q3 2019)

Fields defined, created, or added by WHAIC from the 837 claims file

Patient Type (outpatient surgery)	Type of Encounter (OutPatient = 2)	Place of Service = 1
Principal Procedure on OP Records	Principal Procedure Date	Additional Procedures on OPS records
Principal Procedure Modifier(s)	Additional Procedure Modifier(s)	~~Leave of Absence Days *NA for ASC~~

Legend

Name	Field	Description
R	Required	Data Element Must be Submitted for the data type and must not be blank
S	Situational	Required based upon values in the claim/EMR or other elements
O	Optional	This element is not required and may be left blank, however, if submitted, it will be edited.
N	Not used/needed	Not required, not edited, not collected. If submitted, it will be ignored.
Gray shade	Blank	data is not stored, but may be sent, and may or may not be used to route data in WIpop

837P Crosswalk and WIpop Map - Summary Table of required elements

Additional Elements supplied and not mentioned in this document will be discarded by WHAIC prior to processing.

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
0000	ISA06	Interchange Sender ID (3 digit)	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match GS02 & 1000A/NM109
	ISA08	Receiver ID	O	Submitter choice: leave blank or use WHAIC837	
	GS02	Application Sender's Code	O	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102' WHAIC Permanent Facility ID - Appendix 7.1 Facility List	All claims must be from the same facility. Must match ISA06 & 1000A/NM109
	GS03	Application Receiver's Code	O	Submitter choice: leave blank or use WHAIC837	
0000	ST03	Implementation Guide Version	R	005010X222A1	Req but not stored.
LOOP ID 1000A/B and 2010AA Submitter and Billing (HOSPITAL / ASC) Detail LOOP 2010AA: BILLING PROVIDER NAME NM1*85*2*SAMPLE HOSPITAL PROVID*11****XX*9876543210~ N3*236 N MAIN ST~ N4*MADISON*WI*53717~ REF*EI*11-12345678~					
1000A	NM101	Entity ID code	O	41 = Submitter	
1000A	NM102	Entity Type Qualifier	R	"2" – non-person entity	
1000A	NM103	Organization Name	O	ASC name	
1000A	NM108	Identification Code Qualifier	R	46	
1000A	NM109	Identification Code of Submitter	R	Use 3-digit Facility ID assigned by WHAIC. Example: Osceola Medical Center is '102'	All claims must be from the same facility. Must match ISA06 & GS02

ASC Tech TIPS

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
				WHAIC Permanent Facility ID - Appendix 7.1 Facility List	
1000B	NM101	Entity ID code	O	40 = Receiver	
1000B	NM103	Receiver Name – WHAIC	O	Use WHAIC – identifies WHAIC as receiver	
1000B	NM109	Receiver (WHAIC) Primary Identifier	O	WHAIC 837	
2010AA	NM101	Billing/Service Provider Identifier code	R	85 = Billing Provider	
2010AA	NM108	Billing Entity ID Qualifier	R	"XX"	
2010AA	NM109	Billing Entity ID Code	R	Use Facility Billing NPI Number WHAIC has on File	Facility NPI number used to bill claims.
Patient/Subscriber Detail: Patient Detail Required when the patient is different from the Subscriber. ***If not required by this Implementation Guide, do not send.***					
Patient / Subscriber details cannot be determined until processing of UCID / ECID occurs – prior to submission					
LOOP 2000B: SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~ SBR*P**CERTNUM2222SJ~ LOOP 2010BA: SUBSCRIBER NAME NM1*IL*1*NULL*****MI*3CFD1B33ACBD5475CE36D8C439FEC42475B9ADBEC7B91A6926DACF0F45BE269F-S530J~ N3*123 OAK ST~ N4*MADISON*WI*53719~ DMG*D8*19830501*F*M*5:2~				**DO NOT SEND 2010CA IF PATIENT IS SUBSCRIBER**	
2000B	SBR03	Policy Number – Insurance SBR03 is Policy or Group Number	R	Send "NULL" if Self-pay Other terms: Policy #, Member ID, Insurance Card #, Group Number, certificate number.	Insurance Cert # - can only be NULL or blank for self-pay
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim	See Appendix 7.3.1 for list of codes associated with primary payer.
2010BA	NM103	Subscriber Last Name	R	Subscriber names are not accepted. Send "NULL". NM104 – NM107 must be blank.	Patient Detail Required when the patient *is different* from the Subscriber
2010CA	NM103	Patient Last Name	R	Patient names are not accepted.	Send "NULL". NM104 – NM107 must be blank.

				Send "NULL". NM104 – NM107 must be blank.	
2010BA	NM109	Subscriber UCID & ECID	R	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID-ECID if different from subscriber.
2010CA	NM109	Patient UCID & ECID	R	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Element format is **UCID** UCID is characters 1 – 64	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID if different from subscriber.
2010BA	N301	Subscriber Address 1	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 Address, City, State and Zip will be used to find the patient's census block group. **The block group**, but **not the address, will be saved** in WIpop. *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populate in WIpop during overnight processing. Files rejected if >10% missing address.
2010CA	N301	Patient Address 1	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 *File rejected if more than 10% of records missing address	Census Block Group -Typically, the block group number populate in WIpop during overnight processing. Files rejected if >10% missing address.
2010BA	N302	Subscriber Address Line 2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N302	Patient Address Line 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N401	Subscriber City	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	***File rejected if > 10% of records missing address**
2010CA	N401	Patient City	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	***File rejected if > 10% of records missing address**
2010BA	N402	Subscriber State	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Value not stored
2010CA	N402	Patient State	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Value not stored
2010BA	N403	Subscriber Zip code	R/S	Loop 2010BA, NM101 = IL	Zip Code Stored in WIpop

				Loop 2010BA, NM102 = 1	
2010CA	N403	Patient Zip Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Zip Code stored in WIpop
2010BA	DMG02	Subscriber Birth Date	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Birth Date
2010CA	DMG02	Patient Birth Date	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Birth Date
2010BA	DMG03	Subscriber Gender Code	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 F, M, U or O (U/O requires Condition Code 45)	F, M, U, O (U or O requires Cond Code 45)
2010CA	DMG03	Patient Gender Code	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 F, M, U or O (U/O requires Condition Code 45)	F, M, U, O (U or O requires Cond Code 45)
2010BA	DMG04	Subscriber Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.
2010CA	DMG04	Patient Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status optional field, supply if collected.
2010BA	DMG05 -1	Subscriber Race Code1 See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2 File rejected if > 25% of records = declined or unavailable.	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2.
2010CA	DMG05 -1	Patient Race Code1 See Appendix 7.2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3 DMG*D8*19830501*F*M*5:2 File rejected if > 25% of records coded as declined or unavailable.	DMG05 is a composite element, which repeats up to 10 times. The first two entries for race will be used for WIpop fields RACE and RACE2.

2010BA	DMG05 -2	Subscriber Ethnicity Code See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 File rejected if > 25% of records = declined or unavailable.	The first entry for ethnicity will be used for field ETHN.
2010CA	DMG05 -2	Patient Ethnicity Code See Appendix 2	R/S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	The first entry for ethnicity will be used for field ETHN.
2010BA	DMG05 -3	Subscriber Race 2	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Do not repeat race codes.
2010CA	DMG05 -3	Patient Race 2	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Do not repeat race codes.
2010BA	DMG10	Subscriber Language Qualifier	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 ZZ – Mutually Defined	DMG10 = ZZ
2010CA	DMG10	Patient Language Qualifier	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 ZZ = Mutually Defined	DMG10 = ZZ
2010BA	DMG11	Subscriber Language Code	S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	New Field Q319 See Appendix 7.3.1 for Code List Mapping
LOOP ID - 2010BB Payer Detail LOOP 2010BB: PAYER NAME NM1*PR*2*PRIMARY PAYER*****PI*A21-09~					
2010BB	NM101	Payer Entity ID Code	R	PR = Payer	
2010BB	NM102	Entity Type Qualifier	O	1 = Non-Person Entity *NM102 qualifies NM103	Discarded
2010BB	NM103	Payer Name	S	Name of Payer Organization	New Q32019: Stored on the database and used in the Unknown Payer Report to help data submitters correct data.
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code	R	Map Payer's to WHAIC Values in Appendix 7.3. Element format is **AAA-99**	Expected Source of Payment ID/ Type: characters 1-3 – Pay Type is characters 5-6

				Example A21-09 AKA: Primary Source of Payment ID Pay ID characters 1-3 – Pay TYPE is characters 5-6 The dash is preferred, but not required.	The dash is preferred, but not required *Self-pay requires OTH-61
2010BB	REF01	REF ID Qualifier for Payer ID Number	S	NF = NAIC Code	New Field Q32019: Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer ID Number	S	Enter the Value of the Payer / NAIC#	Refer to Appendix 7.3.2 for additional info.
LOOP ID – 2300 CLAIM INFORMATION (If Loop and Element are not included, do not send) LOOP 2300: CLAIM INFORMATION CLM*PCTRL535*2740.00***11:B:1*Y*A*Y*Y~ REF*EA*MRN123~ HI*ABK:Z85030*ABF:Z86010~					
2300	CLM01	Patient Control Number	R	ASCs often refer to this as Patient's Account No. or HAR *File rejected for Duplicate Patient control numbers. **IF duplicates are found, resubmit file with this phrase anywhere in the file name: Exclude_duplicates Example: Q320_ASCname_exclude_duplicates	Use Patient Control Number (PCONTROL or PCTRL) Do not use special characters <> in file
2300	CLM02	Total Claim Charge	R	Total Charges in SV1 must match this number. The total amount of all submitted charges of service for this claim.	Total Charges must match the services rendered. Do not submit PROFEE
2300	CLM05-1	Type of Bill – Facility Type Code	R	WHAIC Values in Appendix 7.4 TOB 83:B:1 (alternative 99:B:9)	ASCs can use 0831, 0999 – leading zero optional to use.
2300	CLM05 – 2	Facility Code Qualifier	O	B – Place of Service Codes for Professional or Dental	Ignored if supplied – WHAIC populates
2300	CLM05-3	Type of Bill – Claim Frequency Code	R	Titled Claim Frequency Code in the 837P. WHAIC Values in Appendix 7.4 TOB	Type of Bill - ASCs may refer to this as resubmission and/or orig ref number

2300	REF01	Ref ID qualifier for MRN	O	EA	
2300	REF02	Medical Record Number	R	MRN Number	Medical Record Number
2300	HI01-1	Principal Diagnosis Qualifier	R	ABK	
2300	HI01-2	Principal ICD-10 Diagnosis Code	R	ICD-10 Code – do not include decimal point. Field may be repeated up to 12 times. HI01-2, HI02-2, HI03-2, HI04-2, etc.	Principal/Primary diagnosis code or nature of illness or injury
2300	HI0X-1	Other Diagnosis Code Qualifier	S	ABF	
2300	HI0X-2	Other Diagnosis Codes – ICD-10	S	ICD-10 CM Codes ***External Cause Code Required on records with ICD-10 diagnosis Codes in S range*** and some T range.	Diagnosis Codes only and no decimals. See Appendix 4.6 for more info
2300	HI0X-1	Condition Code Qualifier	S	BG	
2300	HI0X – 2	Condition Code	S	Condition Code 45 is required when the Sex/Gender of the patients is either Unknown "U" or Other "O".	Condition Code 45 required with Unknown sex/gender
LOOP ID 2310 (A – B) PROVIDER INFORMATION LOOP 2310A: REFERRING PROVIDER NAME NM1*DN*1*REFERRING*****XX*9876543214~ LOOP 2310B: RENDERING PROVIDER NAME NM1*82*1*RENDERING*****XX*9876543213~					
2310A	NM101	Referring Provider Qualifier	S	DN = Referring Provider	
2310A	NM108	Referring Provider ID Code Qualifier	S	XX = NPI	
2310A	NM109	Referring Provider NPI	S	Use Referring Provider NPI if available	Referring NPI – eg. PCP NPI or "Other" specialist.
2310B	NM101	Rendering/Operating ID	R	82 = Rendering Provider	
2310B	NM108	Rendering/Operating Qualifier	R	XX = NPI	837P References Rendering not Operating
2310B	NM109	Rendering/Operating Provider NPI	R	Rendering means the same thing as Operating Provider NPI number.	Rendering NPI will equate to Operating NPI in WIpop and map accordingly.
LOOP ID – 2320 / 2330B OTHER SUBSCRIBER INFORMATION FOR SECONDARY PAYER Required if on claim LOOP 2330B: OTHER PAYER NAME NM1*PR*2*SECONDARY PAYER*****PI*A21-09~					

2320	SBR01	Payer Responsibility Sequence Code	S	S = Secondary	Include only if secondary payer applies.
2330B	NM101	Entity ID code	R/S	PR = Payer	
2330B	NM108	Payer Identifier Qualifier	R/S	PI = Payer ID	
2330B	NM109	Payer Identifier Code	R/S	WHAIC Values in Appendix 7.3 Secondary Source of Payment ID Element format is **AAA-99** PayID is characters 1-3 – Pay TYPE is characters 5-6	Expected Source of Payment ID and Type. Two fields in WIpop. Appendix 7.3
LOOP ID – 2400 SERVICE LINE DETAIL (*REVENUE LINE ITEM DETAIL) LOOP 2400: SERVICE LINE NUMBER LX*1~ SV1*HC:45380*2700.00*UN*1***1~ DTP*472*D8*20170202~					837P does not have a field for Revenue Code and ASCs typically do not report them. If ASC wants to report one, 0490 may be used.
2400	SV101-1	CPT / HCPCS Qualifier	R	HC (HCPCS)	
2400	SV101-2	CPT / HCPCS Procedure Codes	R	Procedures, Services or Supplies CPT Codes – AMA HCPCS – CMS	HCPCS/CPT/Rate *CPT or HCPCS required on 837P
2400	SV101-3	Procedure Modifier 1	S	Modifier 1 CPT/HCPCS	Do not duplicate modifiers
2400	SV101-4	Procedure Modifier 2	S	Modifier 2 CPT/HCPCS	
2400	SV101-5	Procedure Modifier 3	S	Modifier 3 CPT/HCPCS	
2400	SV101-6	Procedure Modifier 4	S	Modifier 4 CPT/HCPCS	
2400	SV102	Line Item Charge Amount	R	Line Item Charge Amount – Zero is a valid amount Charge for service, supply or drug	Facility charge amount in this field.
2400	SV103	Unit or Basis for Measurement Code	R	UN = Units	
2400	SV104	Service Unit Count	R	Quantity = positive whole numbers only	Unit field is required. Value must be 1 or >
2400	SV105	Place of Service Code	R	For ASC's *WHAIC maps to POS 1 for OPS**	Place of Service is assigned by WHAIC
2400	DTP01	Service Date Qualifier	R	472	
2400	DTP02	Service Date Qualifier	R	D8	
2400	DTP03	Service Date on Revenue Line Item	R	CCYYMMDD (example: 20180103)	Service Date

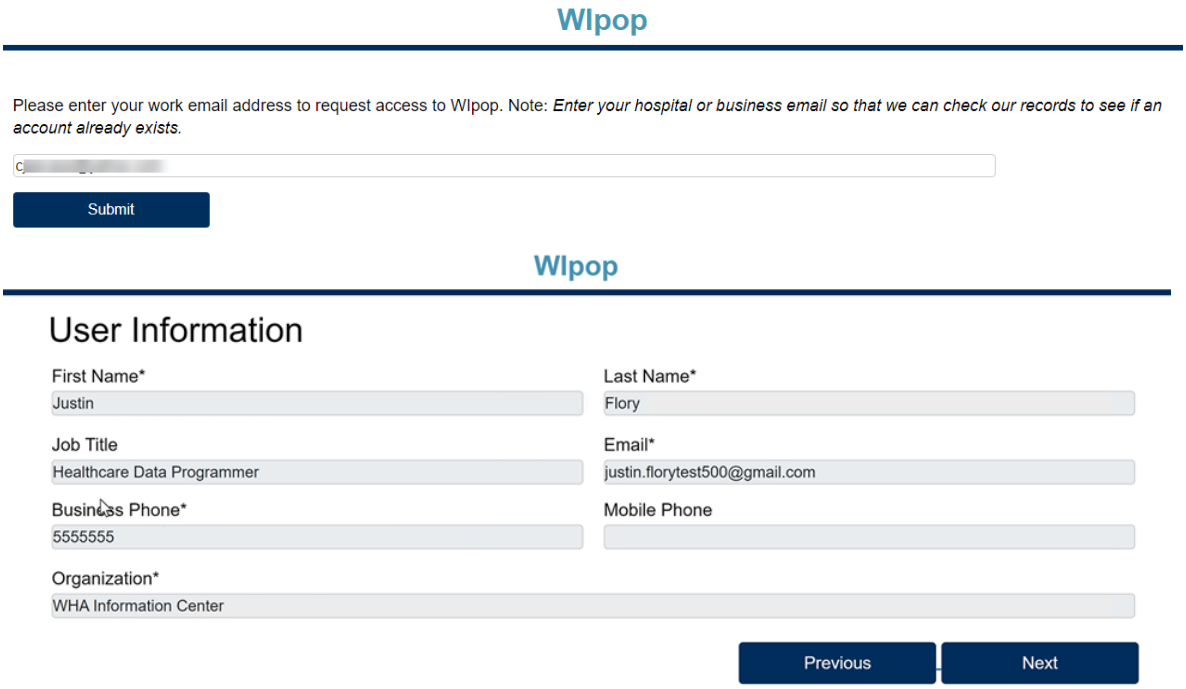
F. How to Register and Upload data into WIpop

New Users / Registration

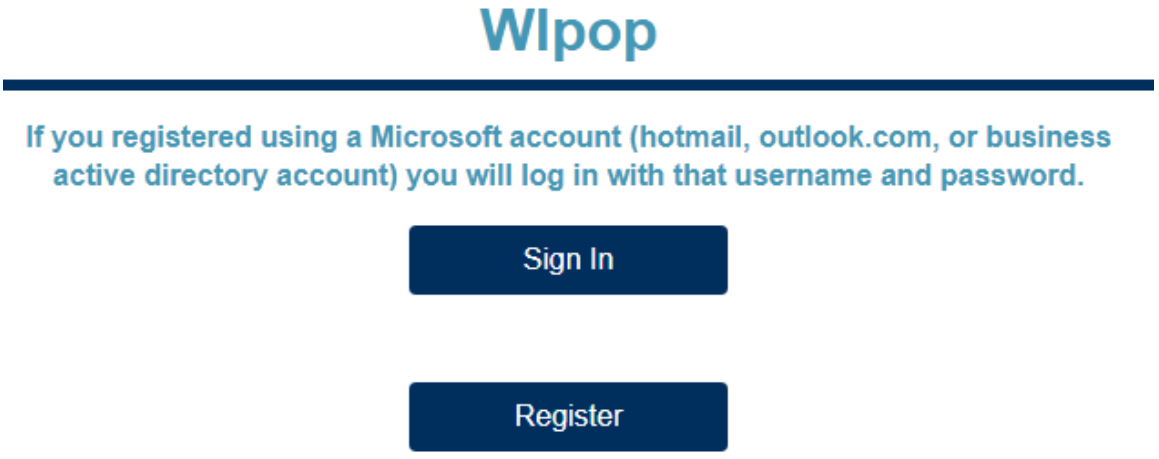
1. Go to: https://wipopicd10.whainfocenter.com
2. Click Register
3. Choose your Role (Primary, Secondary or User)
4. User account will be activated in 24-48 hours.

- Enter in email - WHAIC will first verify if user has an active account.
- If no email is found, the user will be required to register on the WIpop site and select a role based on primary or secondary contact (see WIpop Roles), as it relates to WHAIC Data Submissions.

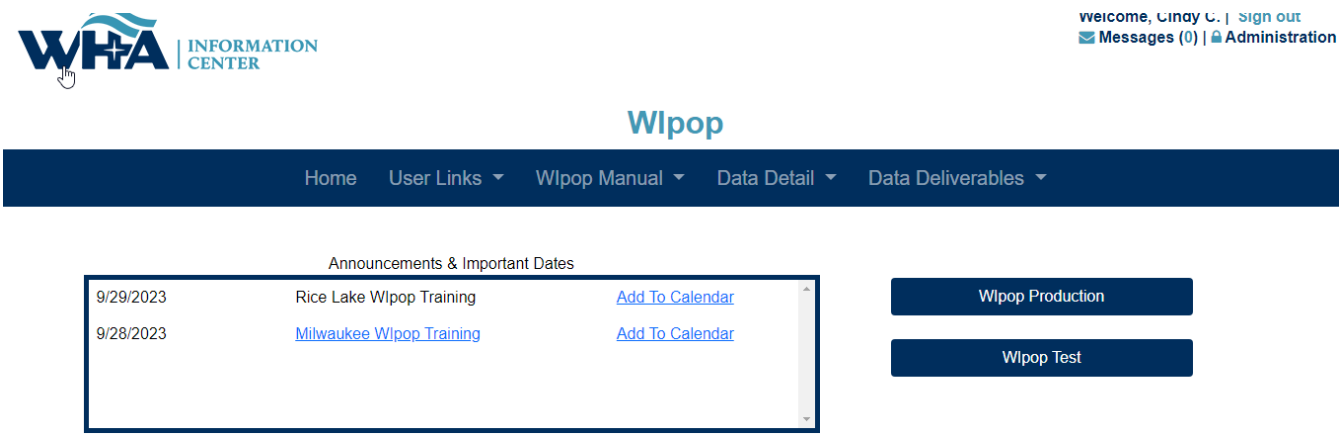
ASC Tech TIPS



- User will use their own facility email address, Username or PW
- Multi-factor and/or Single sign-on is an authentication method that allows users to sign in using one set of credentials to multiple software systems.



ASC Tech TIPS



Attention WIpop Users

Reminders:

- This is a secured website. WHAIC **DOES NOT** register new users. All users must register and create their own secured account in WIpop (pronounced WHYPOP). The WHAIC website has instructions for how to register in the online manual.
- If an existing user needs access removed or updated, email whainfocenter@wha.org.
- Effective Q42023 WHAIC will begin using multifactor authentication. Multi-factor authentication (MFA) is a multi-step account login process that requires users to enter a code sent to their email.

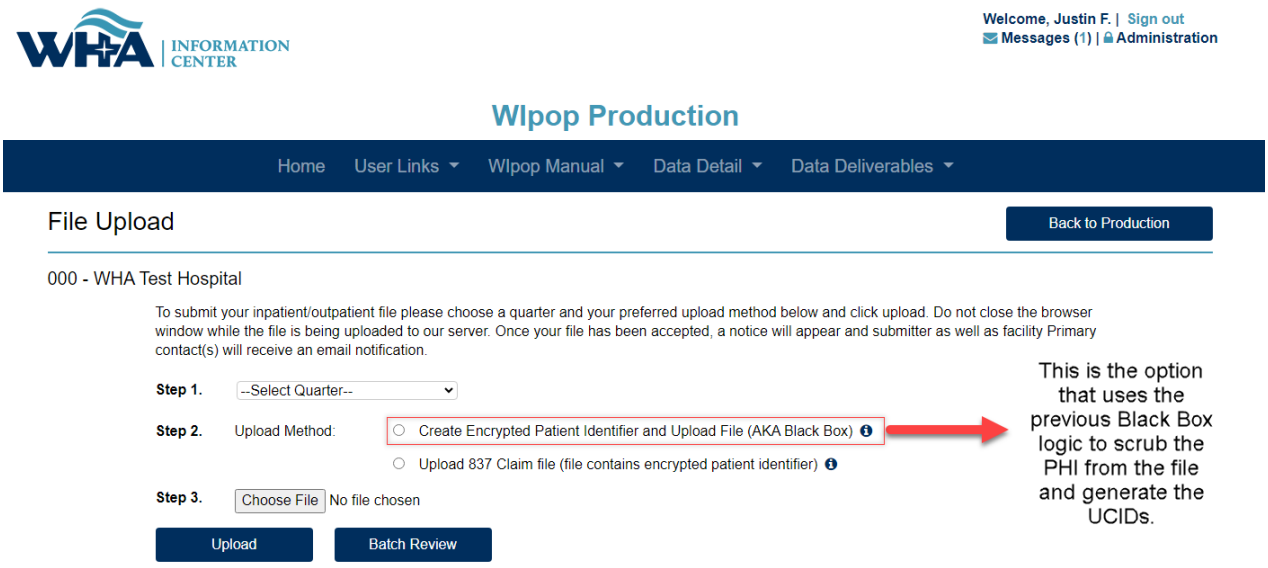
Quarterly Data Update:

Refer to the online calendar for more information. Please be sure to review your online reports in WIpop, correct edits and maintain the timelines below.

2023 Q3 Data Submission	
Standard Data Submission Deadline – Data Due	**11/14**
Standard Deadline fix Edits & Mark QTR Complete	11/28
Extended Deadline - Due Date for Data Submission	**12/1**
Ext. Deadline fix Edits & Mark QTR Complete	*12/13*
❖ **Validation Reports in Portal – review data!**	**12/15**
Deadline to Validate and Return Affirmation	12/29
Data Released	1/9/24

Thank you for all you do to make sure the data is timely, accurate and complete.

Upload the data!



All data submitted will receive a response email. If you get an email that says your batch was invalid, **read the message to determine what the issue is**. The email will never contain PHI, if the batch is invalid due to patient name or any other PHI in the file, the **user will receive a portal login message** with additional information. If you cannot figure out the issue using the error message, you can contact the whainfocenter@wha.org to direct your question. Files must be less than 3 days (72 hours) old in order for us to assist you because files are deleted after 72 hours.

G. Fixing Edits and Marking Batch Files Complete

Once you upload your data, this is where it populates into our database. Should you need to reach out to us for any reason, **please use your 3-digit facility ID and facility name when communicating with us either in the subject line or in the body of the email**..

- Once all edits are done, mark the batch complete.
- To fix edits in a closed batch, you need to click the “reopen” option
- Once the Batch is marked complete, you’ll be in Read ONLY mode

ASC Tech TIPS

Quarter 1, 2023 (Standard Data Due Date: 5/15/2023 12:00:00 AM) Data Enter New Batch

Batch Num #223011 (Uploaded 4/7/2023 10:44:01 AM) Delete Batch Mark Batch Complete	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
	Inpatient	701	701	0	Complete	219
	Outpatient Surgery	827	827	0	Complete	55
	Emergency Room	4658	4658	0	Complete	223
	Observation	278	278	0	Complete	22
	Therapies	4539	4539	0	Complete	245
	Outpatient Lab/Rad	9752	9752	0	Complete	780
	Other Outpatient	10403	10403	0	Complete	757

Batch Num #222847 (Uploaded 3/6/2023 6:57:20 AM) Reopen Batch Delete Batch	Patient Type	Total Records	Valid Records	Invalid Records	Available Options	Alert Records
	Inpatient (Completed)	764	764	0		256
	Outpatient Surgery (Completed)	907	907	0		48
	Emergency Room (Completed)	4867	4867	0		317
	Observation (Completed)	295	295	0		18
	Therapies (Completed)	4826	4826	0		257
	Outpatient Lab/Rad (Completed)	10829	10829	0		851
	Other Outpatient (Completed)	11601	11601	0		845

This concludes the summary of the ASC files. For the full manual click here.