6. BATCH DETAILS, VALIDATION AND AFFIRMATION PROCESS

To maintain our contractual agreement with the State of Wisconsin and continue to provide exceptional data in a timely fashion, facilities must comply with the data submission requirements and timelines as defined by the Wisconsin Statute and WHAIC calendar.

WHAIC staff make every effort to participate in the review and validation of the data through internal reports and historical trending.

- If a month(s) of data is missing, we contact the facility and inform them of the missing month(s) and provide a snapshot of the report.
- When data is under-reported, we notify the facility and provide snapshots from the previous quarter / year's submission.
- When there are unusual changes in data from one quarter/year to the next, we look to the primary contact at the facility to provide explanations in and/or clarification.
- If there are inconsistencies with historic trends, we reexamine individual cases until either the reported data is validated, or we identify a specific problem and rectify it or write a caveat to explain it.

According to the Wisconsin Statutes, failure to comply with the data submission deadlines may result in or be subject to non-compliance issues. WHAIC staff may write a letter of non-compliance to the CEO/Administrator or send a letter to the DHS.

Examples of non-compliance issues include, but are not limited to:

- Failure to notify WHAIC of third- party data submission vendor. *Hospitals and freestanding ambulatory surgery centers are accountable for their qualified vendor's failure to submit data in the formats required.
- Failure to submit patient data electronically with physical specifications, format, and record layout in accordance with the technical components as provided in the data submission manual.
- Failure to meet data submission deadlines or correcting edits timely as outlined in the WHAIC data submission calendar.
- Failure to respond to inquiries on data validation issues.
- Failure to submit Electronic Affirmation Statement timely.

6.1 File (Batch) Failures

Initial validation is conducted at a batch level. If the batch file is not syntactically valid, the submitter will need to resubmit the corrected batch in its entirety. In other words, the file must be formatted correctly to process throughout the WHAIC Database system.

Reasons for batch failures

1) The file is not structurally correct.
2) Patient / Subscriber Name or Subscriber Social Security Number is detected in the file.
3) Greater than 10% of addresses are missing from the file.
4) Greater than 25% of records are submitted with an unknown or declined race or ethnicity.
5) File submitted with claims from multiple hospitals or ASC sites – i.e. no grouping facility data. An uploaded 837 file must contain data for only one facility. In addition, 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 for facility 124 (Aurora - Sheboygan), the file will be rejected
6) Uploaded files are not limited in total size to 20 million characters, but a single transaction (ST – SE envelope) can have no more than 5,000 CLM segments or 10 million characters. Files exceeding either limit will be rejected.
7) Duplicate Patient Control Numbers will result in a file failure. WHAIC cannot accept replacement/void or other adjusted type of bill. Effective with Q318 New Process to remove duplicate patient control numbers:

REMOVING DUPLICATES FROM FILE SUBMISSION

There are two types of batch file rejects as it relates to duplicate records that apply to this process.

- **Duplicates within same file - two records with the same patient control number:**
    a. **Resubmit the batch with the phrase "exclude_duplicates" somewhere within the file name.**
        i. Example file name: Q220_WHAIC_ facilityname_ exclude_duplicates.txt
    b. We will keep the original encounter/record if it has a valid bill type.
    c. The batch file email response will include the number of records submitted and number of duplicates removed.

2. Duplicate patient control number of a record/encounter that already exists in WIpop:

- If the WIpop file contains a duplicate patient control number for an encounter that was previously uploaded, please rerun the batch file with the phrase "**exclude_duplicates" (see example above) to remove the duplicate record(s) in the new file.** We will not replace original file records/encounters because there are too many variables such as trying to locate a duplicate record that's in a batch marked complete, and/or edits have already been worked, or the record is from a previous quarter.

The process to remove duplicates does not require use of the black box/837 File Handler.

6.2 Batch File Edits

Only loops, segments, and data elements valid for the HIPAA 837 Implementation Guides will be translated. Submitting data not based on the Implementation Guide will either be ignored or cause the file to be rejected.

WHAIC validates the NPI numbers against the NPPES table. It is rare, but sometimes, the data comes in before the NPPES table is updated.

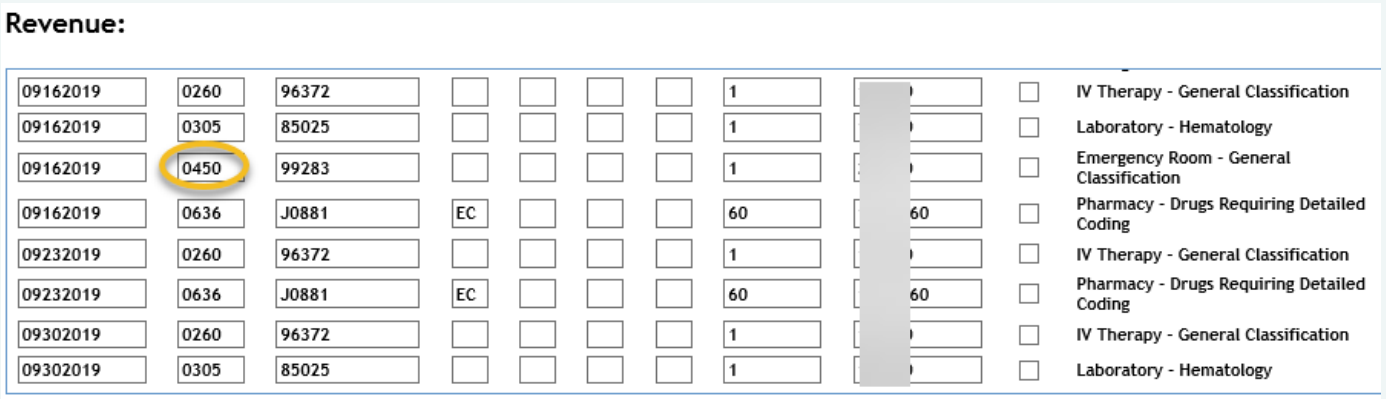
All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective quarter. For more information on edits see Appendix 7.9.

CUSTOM BYPASS EDITS

Bypass edits to accommodate facility and WHAIC place of service mappings, submission shortcomings, or standard claims requirements:

1. WHAIC set up the parser code to pull **statement from and through dates** from the earliest and latest revenue line service dates if the DTP*434 loop is not sent in the file.
2. Hospitals that use the emergency room (ER/ED) and an ER revenue code of 045X while also providing recurring specialty type services such as infusions, chemo or dialysis will be allowed to keep the record in the outpatient hospital data if the encounters contain *multiple revenue line items for outpatient lab/radiology or other outpatient services.*

   The rule states that if statement thru minus statement from is more than seven days, the record WILL NOT be assigned to ER POS. WHAIC will ignore the 045X revenue code and assign POS based on the remaining revenue codes.



For outpatient surgery (OPS) records:

3. To reduce the number of edits for services or encounters on 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), we have made an exception.
4. If there is an LT or RT modifier on any revenue line, then all revenue lines can have a service date up to 90 days after the principal procedure date. The program will look for the highest charge first to account for the initial service data. If two or more revenue line items have the same (highest) charge, the earliest service date will be marked as the principal procedure.

For more information on edits, corrections and explanations, review Appendix 7.9 Edit Codes and Descriptions.

COMMON ASC EDITS:

- Missing external cause codes – if the record contains a diagnosis for an injury – something in the "S" range – we are required to collect a reason for injury in the data. Review the MR documentation and look up the code in the ICD-10 coding book or contact coder.
- Revenue code has 0000 – delete the four zeroes or update it with 0490 and click update
- Missing operating NPI – review the rendering NPI number and put that into the operating NPI field.
- Unknown Gender or Other – user must add a Condition Code 45 – located on right side of Claims Section in WIpop screen

6.3 Correcting Edits

WIpop users must follow the Calendar timelines for clearing edits and marking batch(s) complete. For more information on specific edits, see Appendix 7.9. To clear an edit:

1. Choose the facility in which the edit applies (for those that manage multiple facilities.)
2. Click on Batch Review to see the data that was submitted and the number of invalid records that have edits and **click 'View'.**
3. On the Batch Detail Screen use the drop-down menus to work all edits in the batch or work edits based on a data type. The drop-down arrow in the (All Errors) box provides details specific edits in the records.
4. Click edit to get to the Edit Record Screen. Click on the Diamond to see the edit language and work the edit accordingly.
5. Once the edit is fixed, **click 'Update'** to clear the record and move to the next edit.
6. After all the edits are worked **mark the batch complete**.
7. Once the data is submitted, WIpop users have the option to run real-time reports from WIpop to validate their data.
    a. On the 'Batch Review' screen, in the upper right, click on **Batch/Reports** to create a report. Click on 'create report'.
    b. The Summary Profile Report takes several minutes to run due to the significant amount of data that must be processed.

6.4 Data Validation (Obtaining and viewing reports)

Primary contacts and signors are tasked with following the statutory requirements for validating the data at the close of the quarter. However, there is no need to wait for the reports in the portal 12 to 14 weeks following the close of the quarter, these same reports are available in real-time and downloadable in WIpop.

The secured WHAIC Portal, Data Deliverables Tab, contains the Validation Reports and Affirmation Statement. **Posted files remain online in the WHAIC Portal for 30 days.** Users are encouraged to download the reports and save them to their internal file locations.

Facility contacts are asked to download and save the profile and validation reports for a rolling five (5) quarters of data to accurately validate and trend the history of reporting.

Importance of Summary Report and Validation

The WIpop data submission system is role based. Each facility assigns a primary contact as the main go-to person directly responsible for quarterly discharge data. This person is the lead contact for making sure the data is submitted, correct, validated, and represents an accurate

number of patient encounters. He or she completes the affirmation statement and/or provides commentary, corrections, or caveats to thoroughly explain significant shifts in the data.

Directions:

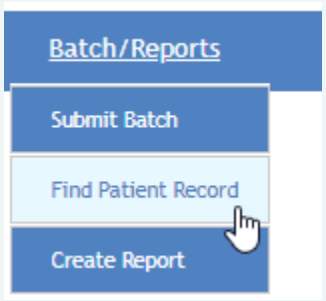
1. Carefully review each page of the **Summary Profile Report**. This report provides a high-level summary of the data using graphs, charts, and tables, including 12-month rolling totals for each data type submitted.
2. Validate the data using internal census or abstract reports from internal systems to compare data submitted. *Most data is consistent month to month.
3. Review previous quarters reports against the current quarter's volumes, monthly patient and records/encounters and document reason for any significant variance immediately.

To obtain facility VALIDATION and PROFILE reports:

Download and save each report before you get started. Save at least 5 rolling quarters of data for historical trending and analysis. This* ***is your opportunity to fix or update data inconsistencies found on the validation reports.*

Directions to review patient records/encounters:

1. Log into WIpop and go to the site you are working (if user manages multiple sites) otherwise simply login and go to batch review.
2. **Open** all the Batch files to make corrections to the data by clicking on **Reopen Batch**.
3. Go to Batch/Reports in the upper right of the WIpop screen and click on 'find patient record'.
4. Enter patient control number from the validation report and click enter or find.
5. Make necessary corrections – for example update a payer, and then **click 'Update'** to accept the changes.
6. Mark batch complete after all validation reports are reviewed and corrections finalized.
7. If shifts in the data signal it is under-reported or you recognize an entire month(s) is missing from the quarter, this should take priority over all other data reporting issues. Submit and correct any missing data immediately.



NOTE: Reports are automatically rerun and reposted (including the Affirmation Statement) once the quarter is reopened. If the Affirmation Statement is signed, before the quarter is validated, user will be required to resubmit a new Affirmation.

WHAIC processes over 3 million records per quarter and evaluates data for over 250 hospitals and ASCs across the state. Our role is not to find data submission errors, our role is to help identify, guide and address key issues in the data through internal reports with a variance of ± 20% change in the data. Once the data is released there is no fixing it, replacing it or submitting additional records. We do not give extensions for signing off and/or submitting the affirmation statements.

6.5 Affirmation Statement

The Affirmation Statement is in the Portal, in Data Deliverables, Data Affirmation. Do not sign until validation is complete, or a new one would need to be submitted if quarter is reopened.

The designated primary contacts and/or the person(s) responsible for affirming the correctness of the data acting in his or her capacity as a designated representative of an organization may sign off on the Electronic Data Affirmation Statement (EDAS). **To complete and submit an affirmation statement the primary contact must use the "Data Affirmations" tab via the data deliverables site in the portal.**

Although the EDAS is available immediately, the facility is responsible for validating the data in the reports before signing.

Affirmation Statement: The number of records submitted each month are included on the affirmation statement as well as the summary profile report. Users are encouraged to run a similar report the '**Data Integrity Report'** out of WIpop to review the data in real-time prior to the close of the quarter. Generally, the number of patients seen each month is relatively consistent. Any significant shifts in the data or inconsistencies should be investigated and data validated through census or audit reports or other revenue cycle/analytical reporting available at the facility.

An *explanation of findings indicating and confirming a formal review took place will be required in the comment field* for any deviations of records that have a ± 20% variance from quarter to quarter.

The login credentials of the person signing off on the EDAS will be recorded in the database, a date stamp recording the time of the affirmation and any comments. It is the facilities responsibility to manage internal processes for storage (i.e. save a copy), electronic or printing, of the approved affirmation statement(s). ***Wisconsin Administrative Code DHS 120:*** ***http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/120***

Please note, we discourage facilities to sign the Affirmation Statement before reviewing the data because any changes or updates (including opening the batch files) made once the reports and affirmation statement is posted to the portal will automatically prompt the entire quarter of reports, including the Affirmation Statement, to rerun. Any signed affirmation statements will need to be resubmitted.

6.6 Communication with External Sources and Data Set Release/Caveats

If you or a representative from your facility receives inquiries or questions about the data, data sets, or publications we produce, refer the external party to the WHAIC Vice President or Director of Operations. WHAIC would like the opportunity to address any questions your facility may receive from an external party (newspaper, insurance company, researcher, or other news outlet, etc.)

We do not re-issue quarterly data sets to correct errors once the data sets have been made public. We maintain a comprehensive list of caveats to the data sets that informs data users of any data submission errors that were brought to light after the data sets were released. The caveats are intended to explain any changes in data or omissions and include as much detail as possible about the type of error, the facility involved, the quarter involved, and, if possible, a summary of the correct data. Exceptions to this general policy may be made when the error is a result of our own internal processing or transformation of raw data into data sets, in recognition of our warranty to data consumers that the data is an accurate reflection of the data submitted to us.

Data that is caveated or misrepresented is not added or corrected in other data sources provided by WHAIC such as KAAVIO, PricePoint, Check Point or any of the publications.

6.7 Batch File Alerts

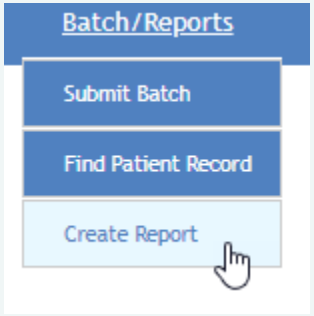
Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. You are not required to work all alerts.

** The alert bell may draw your attention to specific areas of race, ethnicity, payer and inpatient and observation stays.*

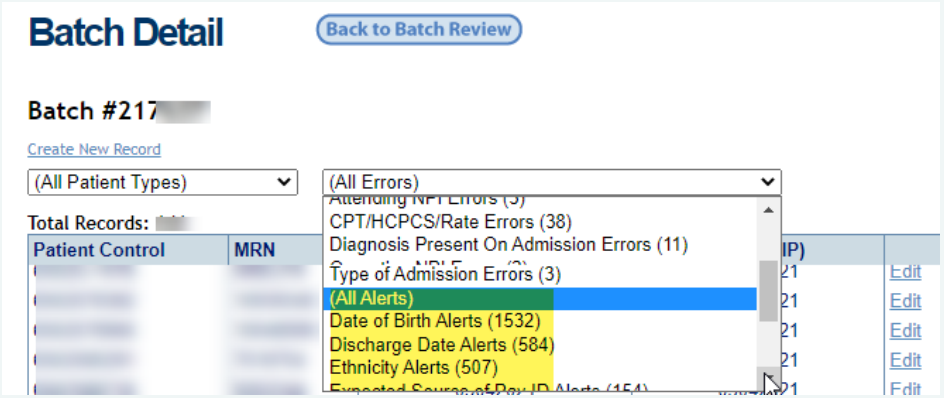
WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen.

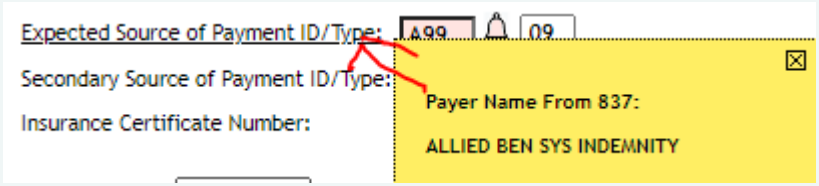
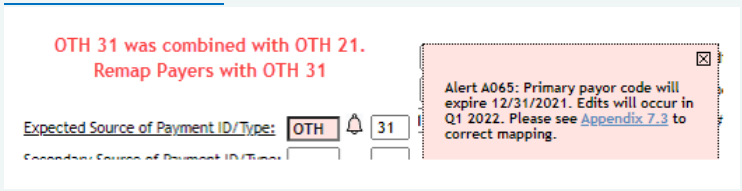
Alerts can be isolated and reviewed separately from other edits a couple of different ways:

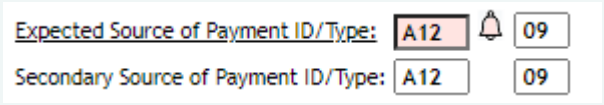
1. ***By running an inventory report from the Batch/Reports***



2. ***By viewing along with other invalid records in the Batch Detail Screen***



Alert Codes	Alert Defined	Alert reconciliation how to handle
A060	Unknown or Other Primary Payor. 	Verify the correct payer is assigned. In this record the Alert is produced for the A99 code. Clicking on the Expected Source of Payment will provide the name of the payer. A google search will lead the reviewer to noticing this is a Benefit Plan Admin. Or TPA. **The correct mapping should be OTH 21, NOT A99.**
A065	Primary Payor Code will expire 12/31/2021. See Appendix 7.3 for more information. 	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review the Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Advantage, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance. • CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to

Alert Codes	Alert Defined	Alert reconciliation how to handle
		commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. • *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A067	Primary and Secondary Payors are the same. 	Verify patient has the same payer as primary and secondary. It's not uncommon to list two (2) Medicare payers if the patient has a dual Medicare plan. Typically, it is not common for patients to have the same duplicate plans such as BC Anthem.
A070	Unknown or Other Secondary Payor	Review claim and update patient account with the correct payer type plan type and ID. Reference A060 for additional information.
A075	Secondary Payor Code will be Invalid after Q12021. See Appendix 7.3 for more information.	Multiple payer codes have been combined or removed to reduce the amount of facility payer mapping required. Payer Alerts are set up to instruct submitters and editors to review the Appendix 7.3 and adjust codes accordingly. • MED and T18 – combined to MED-09 = Medicare, Medicare Advantage, Medicare Sup / MediGap, Medicare Part A, B, C - all Medicare patients. • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance.

Alert Codes	Alert Defined	Alert reconciliation how to handle
		• CHA 03 and OTH 55 – combined to CHA 03 = current and former military (insurance) benefits regardless of who is managing contract. • OTH 54, 59 & 71 – combined to OTH 54 = free/subsidized government programs, nonprofit organizations, health departments, and grant/research funds. • OTH 99 and 98 – combined to OTH 99 = TPL, MVA, state funded crime victim or safe funds, and some other unknown payers that are not related to commercial, private, or other forms identified in the mapping table. From auto insurance to crime victim claims. ➢ *Facilities are no longer required to identify the Plan PayTypes: 01 – FFS and 02 - HMO/PPO for Medicare, Medicaid or BadgerCare. Please* ***report all payers using one option PayType = 09***
A080	Over 65 non-Medicare Payer. Medicare Advantage Plans should be mapped to MED. See Appendix 7.9	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage or Med Sup should be mapped to MED – 09.
A060	Unknown or Other Primary Payor	Verify payor assignment of A99, OTH 98 and OTH 99. Unknown commercial can be verified against this table and self-insured, BPA or TPAs should be googled and updated with OTH-21.

Alert Codes	Alert Defined	Alert reconciliation how to handle
A065	Primary Payor code will be expiring 12/31/2021. Edits may occur in Q1 2021. Please see Appendix 7.3 for correct mapping.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. It is unnecessary to remap / code or assign new codes. We may reconsider the requirement to combine all codes into pay type – 09.
A067	Primary and Secondary Payors are the same.	Verify payer mapping is accurate. It is not uncommon to list two (2) Medicare payers if the patient has a dual Medicare plan. *Alerts will not be triggered for two Medicare Plans.*
A070	Unknown or Other Secondary Payor	Review claim and update patient account.
A075	Secondary Payor Code will be Invalid after Q12021.	To make it easier on the submitter, we are trying to reduce redundancy in payer mapping and code usage. Comments and suggestions are welcome. We may reconsider the requirement to combine all codes into pay type – 09.
A080	Over 65 non-Medicare Payer. Medicare Advantage Plans should be mapped to MED-09.	This is not an edit, if the patient is still working and does not have Medicare, leave as is. However, most 65 and older patients have Medicare as a primary payer. Commercial plans offering Medicare Advantage or Med Sup should be mapped to MED – 09. Disregard Alert if patient is >65 and still has commercial insurance through an employer with 20 or more employees. https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
A090	Inpatient stay under 2 days	This alert is based on the CMS' Hospital Inpatient Admission Order and Certification requirements. Inpatient stays that are less than 2 days (excluding discharge status codes: 02, 05, 07, 20 and 66) will trigger alerts.