2. DISCHARGE DATA COLLECTION OVERVIEW

Quarterly discharge data is required by State Statute 153.

WHAIC uses a single sign-on process. All users must register to use the Secure Portal to submit and/or fix edits. Inpatient and outpatient discharge data for all encounters must be submitted on a HIPAA compliant modified 837 claim file as defined by WHAIC within 45 days of the quarter end; however, monthly data is encouraged. WHAIC sorts the data by record type, number of records in each data type, and valid/invalid records based on edits.

Correcting edits/errors Edits are based on current coding guidelines and use of the Medicare Coding Edits. Authorized WIpop users are responsible for correcting edits contained in the records within the timeline provided in the Data Submission Calendar. Once edits are worked, the batch must be marked complete. WHAIC encourages facilities to run real-time validation reports in WIpop.

Throughout the quarter and at the end of the quarter, WHAIC performs internal validation and focuses on historical trends within all datatypes in the data submission. Internal validation performed by WHAIC staff is intended to evaluate if the data is consistent with historical norms and if trending is plausible given expected quarterly and annual distributions of records within each data element. Inconsistencies are identified and shared with the facility. The facility must respond or take appropriate action within a reasonable period, preferably within 48 hours, and review the data in question, make corrections and/or verify the records are accurate.

Validating quarterly data Approximately 4 to 6 weeks after the data submission deadline, each facility will receive multiple validation reports via the secure portal. The facility staff should run internal census or abstract or audit reports to compare data based on patient volume, charges, percentage of change within the dataset, and unusually high or low monetary figures.

Potential problems or inconsistencies identified by the facility must be corrected as explained on the report download.

Reviewing the profile and electronically submitting the affirmation statement Finally, at the completion of the validation process the facility is required to submit an electronic Affirmation Statement affirming the accuracy of the data. DHS statutorily requires this.

WHAIC does not create user accounts or add users, this is a secure application that houses facility discharge data. **WIPOP users must register for and have an active user 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 within WIpop or communicated to WHAIC staff.

Data submission files must be created using a modified 837 claim file format. They 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 the submitter and primary contact detailing the reason for failed formatting. For more information on file failures see section 6.1. The WHAIC discharge data submission site includes both a *WIpop Test* site and a WIpop Production site. **Do not work EDITS in the test site unless the facility is verifying something specific.*

Types of format failures:

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

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**.

Discharge data includes the following patient type of records and place of service:
**Do not include data provided for the sole purpose of drug testing, ambulance transfer/service, professional fees, patient convenience items or reference lab.*

Patient Type Assigned by WHAIC	Place of Service Assigned by WHAIC	Acronym	Description
1	Blank	INP	Inpatient Encounter

2	1	OPS	Ambulatory/Outpatient Surgery/Same Day surgery
2	2	ER or ED	Emergency Department
2	3	OBS	Observation Status
2	4	PT/OT/ST	Physical Therapy, Speech Therapy, Occupational Therapy
2	5	OLR	Outpatient Lab and Radiology
2	6	OHO/PBL	Other Outpatient Hospital Data, PBL Data, Urgent Care, etc.

2.1 Discharge Data Parameters and Limitations

The following data parameters and limitations **apply to all records/claims** data submitted to WHAIC:

- Limitation on some Bill Types (TOBs): as much as possible, do **not send replacement, voided, or corrected claims/records in any of the data.** Unlike insurance companies, we have no mechanisms in place to 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.*
- **Exclude revenue codes 096X to 098X**. As per state statute, we do not collect data for Professional Services.
- State Statute required the collection of Race, Ethnicity, and patient sex.
- Include collection of Marital Status and Language.
- Patient Sex may be listed as M, F, X, O or U. **If** O or U, Condition Code 45 must be on the record.
- **Place of service (POS)** is assigned by WHAIC based on revenue codes and hierarchy defined in Appendix 7.5.
- External Cause of Injury (ECI) Codes V-Y are required, as per state statute, with a diagnosis code in S (T) section codes.
  - External Cause Code required when there is an injury diagnosis code see section 4.6.
  - External Cause Codes are required on INP, ER, OPS (FASC) and OBS only (Place of Service (POS) of 1-3).
- Social Determinants of Health (SDOH) codes are required if coded and available. The codes may be in the EMR or on the claim, verify they are getting into the file.
- NPI numbers are not required in all fields for every datatype: If an NPI number is provided in the operating NPI field, WHAIC will look for a valid CPT code to populate the principal procedure. *If a valid CPT or HCPCS is not found, an edit will occur on the operating NPI field.*

  Attending NPI is required for inpatient and emergency department records. If subpart NPI numbers are used, and an edit occurs, contact WHAIC to add the subpart NPI to our tables.
- **Alerts** are intended to generate discussion and allow submitters to find improvement in the data before the end of the quarter. ***Alerts are not Edits or Errors.*** *Alerts create an opportunity to review the data more closely and timely and update records.*

  * The **Alert bell** may draw a submitters attention to specific areas of race, ethnicity, payer, inpatient and observation stays. *Examples might include patients over 65 reported as non-Medicare, other/unknown payer, race declined/unavailable, OBS over 5 days, IP under 2 days, unknown payer, etc.*

2.2 Inpatient Discharge Records (INP)

Acute care, critical access, orthopedic, children's hospitals, mental and psychiatric/behavioral health, and other specialty hospitals are required to submit selected items or aggregations of items for each patient discharged including records of self-pay patients as per the definition of hospital. The use of a claims file is intended to provide a full representation of what services were provided in your facility for all inpatient claims. If your hospital provides inhouse swing bed patient care, you may include those encounters in the data – specifically swing bed type of bill 18X – SNF.

- **Discharge date** is used to determine which quarter to use when reporting to WHAIC. For example, if service started on 06/30 and ended on 07/01, the record should be included in the 3rd quarter data submission.
- Data are required for inpatient discharges whose three-digit "Type of Bill" (TOB) begins with "11x" or "12x." **Leading zero may or may not be used – depending on direct data entry from a claim form or 837 electronic files.*

- **Exclude Inpatients for the following:** Skilled Nursing patients, Intermediate Care Facility Patients, Religious Institutions, Intermediate Care Level I and II, Hospice patients, Residential Facility, and Specialty Facility.
- **Exclude Inpatient Revenue Codes**: 055X – Skilled Nursing, 065X – Hospice, 096X – 099X Professional Fees.
- WHAIC will assign Inpatient Place of Service using the following revenue codes: 0100-0189, and 0200-0219.
- **Hospitals only**
  - *Value codes:* A code structure to relate amounts or values to identify data elements necessary to process the claim as qualified by the payer organization. The Value Code fields allow for the reporting of numeric expressions. These expressions can be categorized as monetary amounts as well as percentages, units, integers, and other identifiers. Value codes required in WIpop data file uploads if supplied on the claim.
  - *Occurrence Code:* The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date and are required in the WIpop file if supplied on the claim.

- **Common INP errors and fixes:** Inpatient records that **change to outpatient** after the claim has been generated and data submitted. The fix and change are easy if the CPT codes and DOS are on the record.
  1) Make sure that batch is open and not in read only status. Otherwise, you will not be able to move the records to the correct data type.
  2) Update patient type from 1 to 2 and change the Place of Service (POS) to either 1 = OPS or 3 = OBS – refer to the POS Appendix.
  3) Change the INP rev code for room and board from 011X to 0762 for Observation and remove any POA codes.
  4) Hit update.

2.3 Outpatient (Ambulatory) Surgery Records (OPS) POS = 1

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.

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. If a date on the record includes dates into the next quarter for OPS, it should not 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.

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

- *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 as described above.
  - *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 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. Facilities should 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.

2.4 Emergency Room/Department Records (ER/ED) POS = 2

Emergency departments (ED) are required to submit selected items or aggregations of items for all visits to the emergency department including records of self-pay patients.

- **Discharge date** determines selection for emergency department records**.** For example, if service started on 06/30 and ended on 07/01, the record would be included in the 3rd quarter data submission.
- Place of Service code "2" is assigned to records that have at least one ED Revenue Code (0450, 0451, 0452 or 0459).
- When an ED visit results in an inpatient discharge or an outpatient surgery, the facility can choose to submit the ED services as a separate record or combine them with the inpatient or outpatient surgery record.
  - Medicare requires that critical access hospitals (CAH) bill emergency department services separate from the inpatient record. WHAIC will honor this requirement.
- For hospitals that perform minor outpatient surgery procedures (revenue code 0361) such as a suture in the ED, the record will be counted and included in the ED data provided there is also a ED rev code.
- *Exception Rules ER/ED:* To accommodate the wide variety of services that occur in the ED for both GMS and CAH hospitals that provide recurring specialty type services e.g., injections, infusions, or dialysis:
  - Bypass edits are set-up for ED records with multiple dates of service, i.e., a statement 'From and Through' date has a seven-day span of service, and that span matches the service dates in the revenue line-item detail.

    To clarify:
    - If the encounter/record has less than seven (7) days of service line items, the record is ED.
    - If the encounter/record has more than seven (7) days of service line items, the place of service will be determined by the POS hierarchy and revenue codes.

2.5 Observation Records (OBS) POS = 3

Observation *encounters are outpatient services* commonly *ordered for* patients who typically present to the emergency department and subsequently require a significant period (24-48 hours) of monitoring to allow for attending provider to decide if patient should be admitted or discharged.

- Place of Service (POS) '3' assigned to records with **revenue code 0762**
- The **statement covers period** is used to determine 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.
- When an outpatient surgery or emergency room encounter results in a transfer to observation care and has Revenue Code 0762, WHAIC will assign it to an observation record type (POS 3), as defined by the POS hierarchy.
- *OBS: **Fixing INP records that change to OBS*** – in general, most INP to OBS records have OP codes on them i.e. use of CPT/HCPCS codes.
  - User will have to change the revenue code from INP room and board such as 0111 to 0762 and remove and POA codes of Y,N,U, W, and update POS to 3 and Pt. Type to 2.

2.6 Other Hospital Outpatient Records (OHO) POS 4-6

Hospital outpatient departments are required to submit selected items or aggregations of items for all outpatient visits, *except* hospital reference diagnostic services (TOB 0141). **Records of self-pay patients must be included**. Most of these items are from uniform billing forms (UB-04). *Records from a hospital outpatient department (AKA Provider Based Location (PBL)) with the same Medicare provider number see 2.7.*

- Exclude Professional Services (revenue codes 096x-098x).

- Exclude services that are not a direct face-to-face encounter (does not include telehealth) such as ambulance transport, supplies or DME exchanges.
- The **statement covers period** is used to determine the 'from and through' service dates on the record submitted.
- For services received on the same day, the "From" and "Through/To" dates will be the same.
- Repetitive Series accounts may be submitted at the end of treatment, monthly, or according to billed services, etc.
- Interim bill types are acceptable.
- Place of Service is assigned based on the Revenue Code on the record and hierarchy as defined by *Appendix 7.5.* this includes services for therapies, lab/radiology and other outpatient hospital encounters.
- If the encounter is not classified as OPS, but an operating NPI is supplied, the system will look for a valid CPT/HCPCS code in the revenue line- item detail. If a valid code is found, the code with the highest charge is assigned as principal procedure.
- Encounters that have an operating NPI number but do not have an acceptable principal procedure code will receive edit 1375 on the Principal Procedure. "1375 = *Principal Procedure required if Operating Provider NPI 1 is reported*." *To fix, delete the operating NPI.*

2.7 Provider-based location (PBL) ID

Hospitals that have off-campus, outpatient, provider-based department must bill the correct service facility PBL ID and address on the file. Splitting a hospital outpatient charge into professional and facility components is called "provider-based billing." Patients receive two charges on the bill for services provided; one charge represents the facility or hospital charge, and the other charge represents the professional or physician fee. Since PBLs are outpatient departments of the hospital WHAIC is required by statute to collect the facility component of all services and claims billed **regardless of whether the payer accepts provider-based billing or not**.

> *Records from a hospital outpatient department/PBL with the same Medicare provider number should be submitted according to the 837I or R Technical specifications outlined in Loop 2310E, Element NM101, NM108 and NM109.*

WHAIC assigns PBLs a unique site number in a simple 1,2,3…format. This number, combined with the parent hospital facility ID, forms a unique identifier for each PBL. Hospitals that acquire, add, or intend to change internal practices to submit claims using provider-based billing, or close / no longer bills as PB, should contact WHAIC to update our tables.

Provider-Based Clinics/Locations

The bottom line, if your hospital bills for an off-campus provider-based clinic and you are not reporting it correctly, it could affect payment to your facility, click here to link to the NGS Medicare documentation for more information. This article specifically references how providers billing for Provider-Based services must include the applicable and appropriate modifiers to the claim and file. And, as stated above, if you are reporting outpatient clinic facility charges on an 837I those services must be reported to WHAIC as outpatient services.

PBL data is provided in the public datasets and includes the site number, which allows data users to distinguish between patients seen at the hospital or at a PBL.

To add or update a PBC/PBL Hospitals must email WHAIC with the following information:

> Facility ID and Name of Hospital
> PBL Name (what do you want it called in your reports or what did you call it in the PECOS system)
> PBL Address (try to use the one used in the PECOS system)
> Date PBL opened or became a PBL.