4. SPECIFIC BUSINESS RULES, MAPPING AND LIMITATIONS

General Business Rules for 837 Processes that all facilities are required to follow. These guidelines are intended to facilitate the processing of the file and minimize the number of edits.

The intent of using an 837 claims file is to receive as much detail that goes out on the claim as possible without much mapping intervention from the facility technical side.

> If your vendor or file developer asks what the file type should be, we say the file should look like a claim file format. The file must be structurally correct with loops and segments to meet the 837 standards, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide. We do not have or require file extensions like.txt.

4.1 Unique (Encrypted) Case Identifier (UCID)

As per state statute, WHAIC cannot accept patient names or social security in the data. Facilities must include a 64-character Unique Case Identifier **(UCID)** in their 837 claims file. Its primary purpose is to securely deidentify patients and assist facilities in identifying when a readmission occurs at a different facility than where the original admission or ambulatory surgery occurred. ***Batch Files will be rejected if a patient's name is detected*.**

4.2 Race and Ethnicity

Collection of race and ethnicity is **a state mandate** and required for all data types. WHAIC follows the guidance provided by the OMB and collect based on the minimum requirements. https://wonder.cdc.gov/wonder/help/populations/bridged-race/Directive15.html

In May 1995, the Bureau of Labor Statistics (BLS) sponsored a Supplement on Race and Ethnicity to the Current Population Survey (CPS). The findings were made available in a 1996 report.

We encourage collection and reporting of more than one race as applicable. See **Appendix 7.2** for detailed mapping tables.

4.3 Expected Source of Payment/Payer Mapping

WHAIC requires payer name, claim filing indicator, and Payer ID # if reported on the claim. Details for required payer mapping are located in Appendix 7.3 For example, a commercial payer format is **A##-## – (**SOPID is characters 1-3-SOPTYPE is characters 5-6).

Expected Source of Payment ID (SOPID): The first three characters from the primary payer code (expected to pay the greater share) from the claim file. For example, Wisconsin Medical Assistance (Medicaid) is coded as "T19," and commercial or private insurance payers are a 3-digit alpha number code A## for example A15 = Cigna Insurance.

Expected Source of Payment Type (SOPTYPE): The fourth and fifth characters of the payer code. This field identifies the payer type, for example, HMO/PPO, Workers Compensation = (OTH -41), Self-pay (OTH-61), etc.

Payer ID is expected for Medicare, Medicare Advantage, Medicaid, BadgerCare and Commercial Payers

4.4 Type of Bill (TOB)

WHAIC is statutorily limited by the types of bills (TOB) we can collect and supply in the data sets. The TOBs in the table below **are not to be included in the data**, if provided, an edit will occur. These types of facilities as defined by the State of Wisconsin do not meet the criteria of a "hospital" or "Surgery Center" and must be excluded.

Type of Bill Codes are Required in WIpop. Type of bill (TOB) codes are published in the UB-04 National Uniform Billing Committee guidelines (NUBC). As with most fields on the 837 claims file format, these codes should come directly from the claim that is sent to the payer.

TOB is a four-digit field on the institutional paper claim and in WIpop, but a three-digit field on the EDI 837 Claims File. WHAIC requires a leading zero but will accept the 3-digit code as provided on the 837 claims file format and assign a leading zero in WIpop.

The TOB gives three specific pieces of information after a leading zero. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the sequence of the bill in any episode of care. It is referred to as a "frequency" code.

Edits applicable to TOB:

1160	Type of Bill is a required field.
3180	Type of Bill does not correspond to accepted values.
3181	Type of Bill 0999 is not allowed for hospitals
3185	Zero charge records require Nonpayment/Zero charge Bill Type
3186	Type of bill must match the record type. Edit 3186 will apply when either of these is true: • The record is inpatient and the type of bill is NOT in the 110-121 range • The record is outpatient and the type of bill is in the 110-121 range

This table displays the TOB codes that **WHAIC cannot statutorily collect** as they are y not allowed in the data.

14X – Hospital – Lab services provided to non-patients. Example – worksite drug testing, contracted lab work.	21X – 23X – Skilled Nursing Inpatient and Outpatient facility. Example, long term care in a nursing home 28X – Skilled Nursing swing bed (ICF and SNF)	34X – Home Health Services NOT under a Plan of Treatment
41X – 43X – Religious Institutions (e.g. Catholic charities)	65X – 66X – Intermediate Care Level I & Level II: Institutional Long Term Care (LTC) for intellectual disability, residential facility services support and specialized training.	71X – Clinic – Rural Health – A certified facility located in a rural medically underserved area that provides primary medical care.
73X – Clinic Freestanding NOT associated with a Hospital as a PBC	77X – Clinic – Federally Qualified Health Center	79X – Clinic – Other
76X – Clinic – Community Mental Health Center	81X – Hospice (non-hospital based) 82X – Hospice (hospital based)	86X – Residential facility – non-hospital based providing therapy for substance abuse, mental or behavioral health illness
089X – Specialty Facility – Other		

4.5 Revenue Codes

Most revenue codes are accepted. WHAIC assigns a Place of Service (POS) to each record based off the revenue codes in the line item claims detail and our own POS Hierarchy. Certain revenue codes such as supplies, patient convenience items, ambulance transports, or other services that do not generate a face-to-face encounter should not be submitted as a stand-alone record. Other records that represent data from facilities that are not considered, by definition, a hospital such as hospice records or straight

nursing home records should be excluded too. The table below represents revenue codes that **are not accepted** when submitted alone (such as the ambulance or supply codes) or in combination with other records such as hospice or professional fees.

054X – Ambulance as a stand-alone record	065X – Hospice records when submitted with a TOB 81X or 82X	096X – 098X Professional Fees when submitted on any record

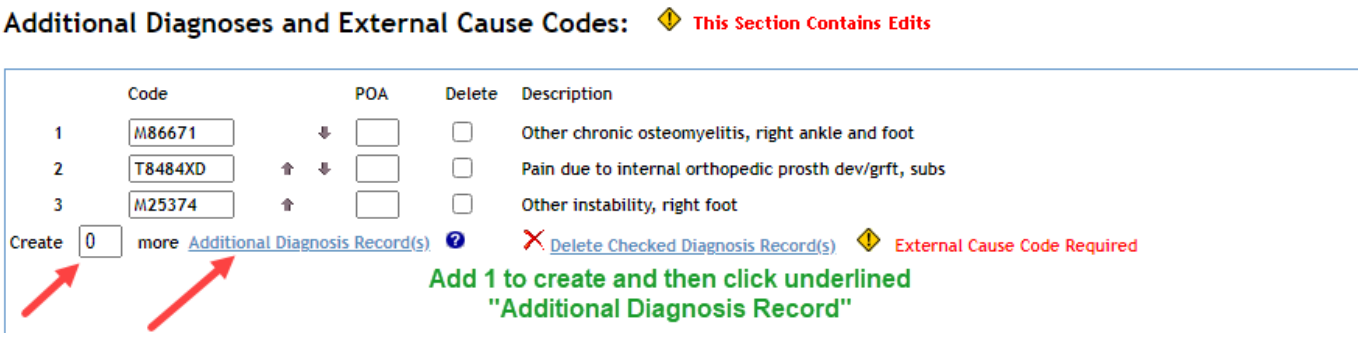
4.6 External Cause of Injury (ECI) Codes

Diagnosis codes in the "S" Injury section and a few of the "T" range of the ICD-10-CM require an external cause diagnosis code in the V through Y range. At least one external cause of injury (ECI) code must be specified when a diagnosis exists as defined in table below.

State Statute dictates the use of external cause codes on inpatient, emergency room, observation, and outpatient surgery records, including FASC. External Cause Codes in the V00-Y99 permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects.

External cause code is required with a diagnosis code in this range:
S00 – S99: Injury, Poisoning, & Certain Other Consequences of External Causes
T07 – Injuries involving multiple body regions.
T20 – T25 Burns and corrosions of external body surface, specified by site.
T26 – T28 – Burns & corrosions confined to eye/internal organs.
T30 – T32 – Burns and corrosions of multiple and unspecified body regions.
T33 – T34 – Frostbite
T69 - Other effects of reduced temperature
To get a code added or removed from the edit list or to fix an edit, contact ccase@wha.org

How to add an additional diagnosis code:



4.7 Language

The primary language of the patient, if collected, should be submitted in the file. Collection of language is useful to data users, policy makers and market researchers to allow analysis of neighborhoods and impact of other social determinants in receiving health care. Much like all other data elements we collect and use, language is another valuable tool data users have asked us to continue to improve upon in the datasets. Just as hospitals and ASCs report race and ethnicity out of the EMR, please be sure to include language in the file as well. See Appendix 7.2.1 for proper file mapping.

- Data Element 837 Field: Loop 2010BA / 2010CA, DMG10 = ZZ (Mutually Defined), DMG11 = Language Code
- Situational field – if collected, report the code. Map according to Language table in WHAIC Manual

ABRV	Language
AFR	African Language(s)
ALB	Albanian
ARA	Arabic
ASI	Asia (Other Asia)
ASL	American Sign Language
BEN	India-Bangladesh
BOS	Bosnian
BUR	Burmese
CHI	Chinese
ENG	English
FRC	French-Creole
FRE	French
GER	German/Deutsch
GRE	Greek
GUJ	India (Gujarati)
HAI	Haitian Creole
HEB	Hebrew
HIN	Hindi
HMO	Hmong
ICE	Icelandic
IND	Indonesian
ITA	Italian
JPN	Japanese
KOR	Korean
LAO	Laos / Laotian
MAN	Mandarin
MON	Mongolian
NA	Unknown or Unavailable
NAV	Navajo
OIE	Other Indo-European
ONA	Other Native - North American
OPI	Other Pacific Island
OTH	Other
OWG	Other West Germanic
PER	Persian
PHI	Philippine
POL	Polish
POR	Portuguese
PUN	Punjabi
ROM	Romanian
RUS	Russian
SCA	Scandanavian
SCC	Serbo-Croatian (Cyrillic)
SER	Serbian
SIG	Sign Language
SPA	Spanish
SWE	Sweedish
TAG	Tagalog
THA	Thai
UNK	Unknown or Unavailable
URD	Urdo (Pakistan & India)
VIE	Vietnamese
YAO	Yao (Hmong-Mien)