WHA | INFORMATION CENTER

ASC Manual Only

ASC WIpop Data Submission Manual

ASC Instructions Related to 837 Health Care Claim/Encounter Requirements and Companion Guide/Technical Specifications

MAY 9, 2023

WHA INFORMATION CENTER

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NOTICE:

Preface:

This Companion Guide (CG) contains two types of data: Instructions for electronic communications with WHAIC and **supplemental information for creating transactions for statutorily required data submissions** while ensuring compliance with the associated ASCX12 IG (Transaction Instructions).

Disclaimer:

WHAIC strives to make the information in this document as current and accurate as possible at the time of writing and distribution. WHAIC makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of the contents of this document. The manual and contents contained herein are for educational purposes only and do not purport to provide legal advice or advice on constructing an 837claim file.

This document provides only the segments, loops and elements which are relevant to WHAIC data collection specifications as defined by the WI State Statute and mapped / defined by a field in WIpop. This document is not intended to serve as a complete 837 reference, and not all requirements for a valid 837 file are specified. Elements not mentioned in this document will be discarded by WHAIC prior to the file processing in WIpop, if supplied. For more information: http://store.x12.org/store/healthcare-5010-original-guides or http://www.wpc-edi.com

ABOUT US

WHA Information Center (WHAIC) is dedicated to collecting, analyzing and disseminating complete, accurate and timely discharge data and reports about charges, utilization, and quality of care provided by Wisconsin hospitals, ambulatory surgery centers and other healthcare providers.

WHAIC is a wholly owned subsidiary of the **Wisconsin Hospital Association** and was incorporated on October 1, 2003. WHAIC began collecting data in January 2004 under contract with the Wisconsin Department of Administration.

The WHAIC Web site at http://www.whainfocenter.com/ contains the latest information about WHAIC, the hospital and ASC data reporting process, and other WHAIC activities and publications. The WHAIC website also contains a Resource Tab related Wisconsin legislation. Chapter 153, Admin Code 120

WIpop Data Submission Manual / Companion Guide http://www.whainfocenter.com/Data-Submitters

WIpop Compliance and IC Updates (Newsletter)

As a subsidiary to the Wisconsin Hospital Association (WHA) we encourage all WHAIC data submitters to utilize the resources available to them as member hospitals and participate in educational opportunities and events such as Advocacy Day, Coding, Compliance and Educational Webinars as well as other events located on the WHA website.

> As stated by WHA Vice President of Education, "WHA offers quality, timely and cost-effective educational opportunities designed to assist our members in remaining current and able to respond to advances in health care. WHA aims to address the educational needs of member staff at various levels by offering a wide variety of on-site and web-based educational programs that assist hospitals in meeting state and federal regulations and maintain quality delivery of patient care."

In addition to collecting discharge data, WHAIC staff also collects and posts hospital rate increases, Milwaukee County Hospital Utilization Data, hospital's annual and fiscal data, uncompensated care data, and other system survey information.

CONTENTS

1. WHAIC DATA SUBMISSION WITH 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.

Effective with Q118 dates of services, hospitals and FASC, herein referred to as ("facilities") submit data in a modified HIPAA Complaint 837 claims file format. Data collection is based on valid HIPAA ASC X12 837I and 837P transactions (including 837R – Reporting) electronic data interface reporting (EDI) format.

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]".*

1.1 Background and Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

Create better access to health insurance

Limit fraud and abuse

Reduce administrative costs

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.2 Intended Use

Compliance according to ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are **not intended to be stand-alone requirements documents**. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

1.3 References information

The WHAIC 837 claims file format used to submit discharge data into WIpop draws from the American National Standards Institutes (ANSI) standards and the Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: For more information: http://store.x12.org/store/healthcare-5010-original-guides or http://www.wpc-edi.com

- 837 Institutional Health Care Claim – ASC X12N 837 (005010X223A2)
- 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)
- 837 Reporting Health Care Claim – ASC X12 837 (005010X225A2)

Only the sections required by the State of Wisconsin Statutory Requirements as define in Chapter 153 and collected by WHAIC or situational ANSI 837 Institutional and Professional Guide sections are reproduced in this manual.

1.4 Changes to this document

The following version history is provided to easily identify updates between Companion Guide Versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

Please check the WHAIC website at: http://www.whainfocenter.com/submitters/837-Implementation/ for the most recent version of this document and any supplemental resources.

Change Number	Version	Date	Author of Change	Update includes
1	1	05/01/2020	Cindy	Created ASC Manual
2	1	11/2/2020	CC	Updated payers
3	1	08/2021	Cc	Updated links, 837 file handler, Alert Codes, FAQs,

2. 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 communicated to WHAIC staff. See Section 3 and Appendix 7.10 for more information on WIpop registration.**

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.

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.*

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

Data must be uploaded through the 837 File Handler or through the secured portal.

837 File Handler/Black Box Instructions from http://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/WHAIC_837_Handler.zip

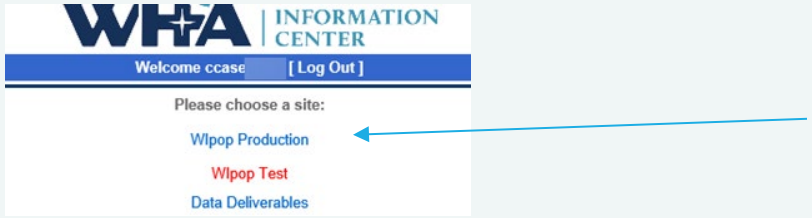
A. 837 File Handler / Black Box Functions

Function 1: Using the patient name, birth date and sex, the program will calculate and add the ECID and UCID to the 837file **and** remove the patient name.

Function 2: Transfer a file directly to WIpop, bypassing the need to upload the file using a browser.

- The program has a Windows installer and a graphical user interface end for ease of use. The GUI calls and passes parameters to a Windows console program, which performs the processing.
- The console program can be executed directly from automated batch processes.

B. Upload the discharge data to the **WIpop Production** site to be a valid submission and work edits for batch processing.



2.1 Discharge Data Parameters and Limitations

Freestanding ASCs are required to submit all types of ambulatory surgical procedures including cosmetic and self-pay services to WHAIC.

The benefit in submitting data using an 837-claim file format is all services rendered for each encounter are captured and reported on the claim.

- There is NO special CPT or HCPCS code mapping on ASC records. If it's on the claim and pertains to the outpatient surgery encounter, such as radiology / X-ray, laboratory and pathology codes, and any temporary codes they all need to be reported.
- There is no need to separate out services on patient encounters or submit multiple encounters for the same patient.

WHAIC assigns the principal and additional procedure in the WIpop system based on current coding guidelines. Our database program will not allow add-on codes to be pulled as a principal procedure.

Procedure Coding: Use Healthcare Common Procedure Coding System (HCPCS) Level I and II codes and Current Procedural Terminology (CPT) codes from the AMA to indicate services and/or procedures on all encounters.

As per DHS 120.13 Data to be submitted by freestanding ambulatory surgery centers.

1) DATA TO BE COLLECTED.

(a) *Types of procedures reported.* Freestanding ambulatory surgery centers shall report to the department information relating to any ambulatory patient surgical procedure within any of the following general types:

1. Operations on the integumentary system.
2. Operations on the musculoskeletal system.
3. Operations on the respiratory system.
4. Operations on the cardiovascular system.
5. Operations on the hemic and lymphatic systems.
6. Operations on the mediastinum and diaphragm.
7. Operations on the digestive system.
8. Operations on the urinary system.
9. Operations on the male genital system.
10. Intersex surgery.
11. Laparoscopy and hysteroscopy.
12. Operations on the female genital system.
13. Maternity care and delivery.

14. Operations on the endocrine system.
15. Operations on the nervous system.
16. Operations on the eye and ocular adnexa.

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.

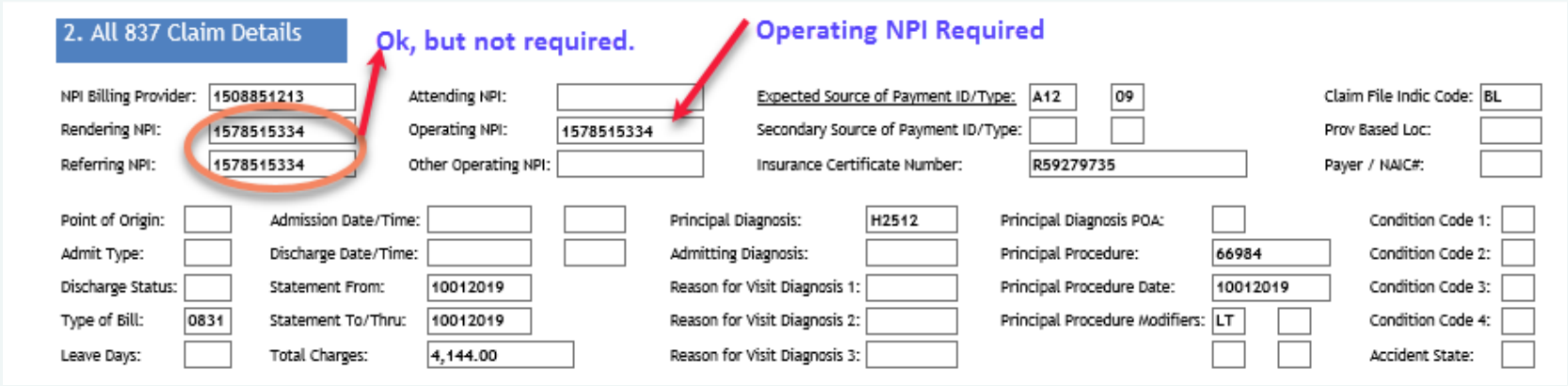
- We do not accept replacement, voided or corrected claims/encounters in any of the data. Unlike insurance companies, we have no mechanisms in place to automatically search and replace a previously submitted encounter or record. *The data is submitted and released for use by hospitals, policy makers, 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.

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.

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.

- **NPI numbers** in the **operating NPI field or Rendering NPI field**. If rendering NPI is the only NPI on claim in the file, WHAIC will copy that number during data processing to the Operating NPI field. Attending is NOT required/needed on ASC files.



Alerts are intended to generate discussion and allow submitters to find improvement in the data before the end of the quarter.

- Alerts were designed from the existing validation reports that are available in real-time following submission in WIpop under the Batch/Reports feature as well as part of the end of the quarter validation reports posted to the portal.
- ***Alerts are not Edits or Errors. Alerts create an opportunity to review the data more closely and timely.***
- * The **Alert bell** may draw a submitters attention to specific areas of race, ethnicity, payer and 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.*
- Further information and clarification about Alerts can be found on our website. http://www.whainfocenter.com/Data-Submitters/WiPop/Education-Training

2.2 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.

- 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.

3. WIPOP ACCESS AND DISCHARGE DATA SUBMISSION

This section covers access to WIpop (pronounced WHY-POP). ***All users must register to the secure portal site for access to submit or correct data. Once registered and approved a confirmation email is sent to both the user and primary contact(s).***

3.1 Access to WIpop - Portal Login

All data submitters, editors and other WIpop users are required to register for access to WIpop through the secure Portal. WIpop is a role-based system in which designations are assigned and decided by the facility.

All facilities are required to have at least one Primary Contact to oversee the quarterly discharge data process, receive notification of newly registered WIpop users, and access quarterly reports. *More than one primary contact encouraged!*

All registered users agree that use of the WIpop and Secure Portal system without authority, is strictly prohibited. **Sharing of passwords is not permitted.**

WHAIC staff does not add users to WIpop. All users must register through the secure WIpop portal site. See appendix 7.7 for details.

- To register, open site https://portal.whainfocenter.com in your web browser and click "Register" in the lower left.
- Enter the prompted phrase to defeat automated registrations. Read the security statement and click continue.
- Register as a WIpop User, or select a role based on primary or secondary contact (see WIpop Roles), as it relates to WHAIC Data Submissions. **Primary or secondary contacts must select both the WIpop and Facility-Specific Reports.**
- Check all facility(s) for which you submit or correct data for and click Next.
- Finally, complete the Registration Details and Create Account. An email is sent upon approval.

Questions about the registration process should be directed to the WHAIC Staff at 608-274-1820 or email whainfocenter@wha.org.

3.2 Summary of Data Submission Process

Submit quarterly discharge data for all encounters within 45 days of the quarter ending.

- The facility is responsible for identifying and documenting the workflow associated with creating a claims file (837 file format) containing all discharge data.
- Typically, the ASC vendor will create a process in which the facility can create a file and then run that file through the 837 file handler (blackbox) to create the UCID and submit the data directly to WIpop.
- Once the data is submitted a confirmation email is sent to the submitter and primary contact indicating a valid or invalid batch file submission.

Correct 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 WIpop contacts to run real-time validation reports in WIpop at the time of submission. However, WHAIC does provide validation reports at the close of the quarter in the secured portal under data deliverables.

To maintain data consistency and identify gaps or missing data WHAIC performs our own internal validation that focuses on historical trends of 2-5 quarters of data within the current data submission. If inconsistencies are identified they are 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.

Validate quarterly data once the data hits the portal after approximately 6 to 8 weeks after the data submission deadline. An automated email is sent explaining the data has been processed and reports are available in the secure portal. The facility is responsible for reviewing internal reports to compare data.

Variances <> 20% must be corrected or explained on the affirmation statement.

Electronically submit the affirmation statement at the completion of the validation process attesting to the accuracy of the data.

3.3 Security of Data Submission

The WHAIC WIpop system is a secure web based application. The Data Submission Process ensures a secure application by:

- User authentication to verify the identity of users and determine access rights.
- Secure Sockets Layer (SSL) certificate for establishing an encrypted link between the WIpop application and browser clients.
- Database server encryption.
- 837 files are uploaded to an isolated "edge" server, where only the necessary data is extracted and transferred to WIpop.

**All WIpop users will be prompted to reset Passwords annually. Sharing of passwords is not permitted.

WHAIC automatically deactivates all WIpop accounts that are not used within a specified period. * Contact *Whainfocenter@wha.org* If you or a member of your WIpop user team has difficulty logging in, or believe you were deactivated untimely to reactivate the account. Users must login to WIpop immediately following reactivation, or prior to the deactivation procedure that runs every weekend.

3.4 Testing HIPAA Compliant 837 File

All new facilities submitting discharge date for the first time are required to test with WHAIC prior to submitting data to the production environment. **Most facilities require resources from their vendor or IT department to create the modified 837 claims file**.

Testing the file with WHAIC provides the facility an opportunity to evaluate specifics of the modified claims file set up that may exclude payer mapping requirements or procedure codes in the revenue line-item detail and verify it adheres to the technical specifications contained in this *Companion Guide*. **On average it takes about 3-6 months to develop and test a file.**

Testing is based on individual locations and facility ID, **not** ASC affiliation or number of facilities in a system. Upon completion of a successful test file, the user should review edits and run several reports out of WIpop to verify results. Go to the Batch/Reports tab and choose any of the multiple validation reports.

When testing and communicating with WHAIC, do not include patient PHI such as names or SSN. This is your opportunity to make sure the file is structurally correct and includes the fields outlined in Section 5. *If specific fields (address, R/E) are missing on too many records, the file will be automatically rejected, and user will be notified.

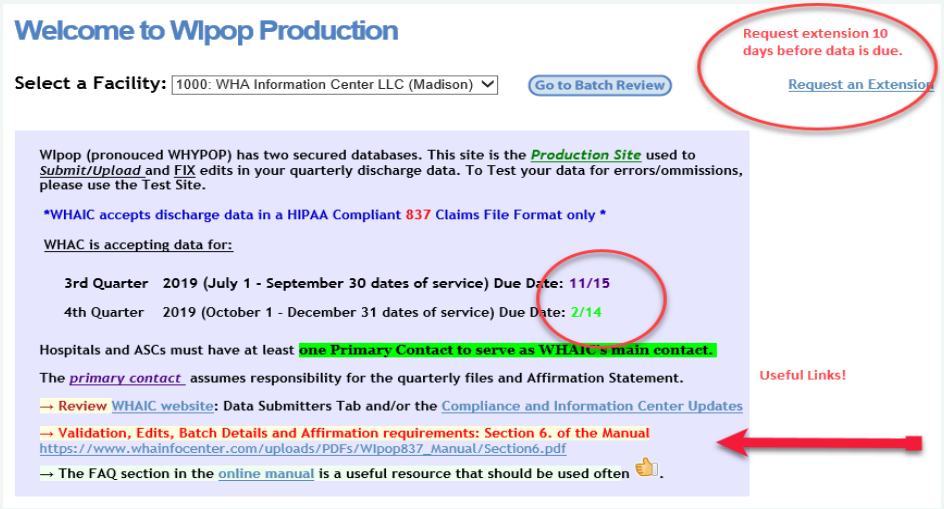
3.5 How to Submit Data in WIpop

There are two ways to submit discharge data.

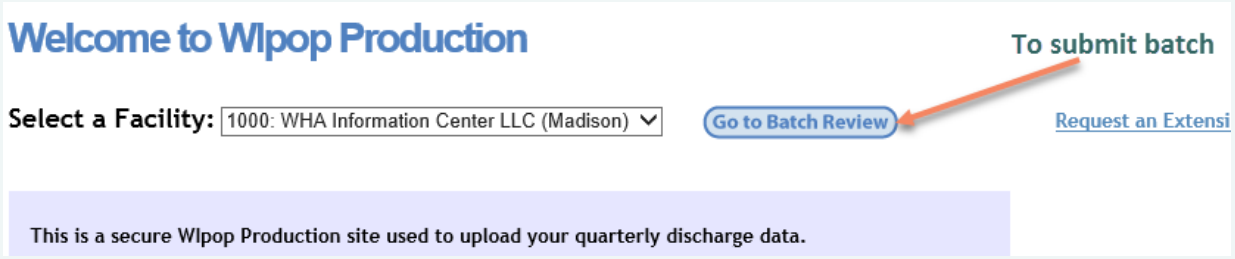
- Through the secured WIpop portal found through the website or through the online portal.
- Users can submit the entire file using the secure 837 File handler interface (AKA black box)

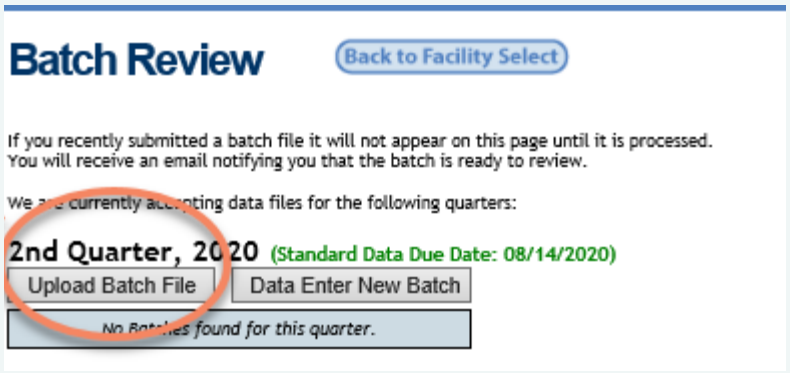
1. Go to WHAIC website: www.whainfocenter.com and login to WIpop (Test or Production) by clicking on the **Secured Site Link** or via your browser https://portal.whainfocenter.com

2. If you manage multiple facilities, make sure to select the facility your uploading data for.



3. To submit a file, click on "**Go to Batch Review**" to get to the "Batch Review" Screen. Choose the correct quarter for the data and using your internal browser locate your file. **Do not close the browser while the file is being uploaded to our server. After clicking 'submit', a status bar will appear with the progress of the batch file upload.

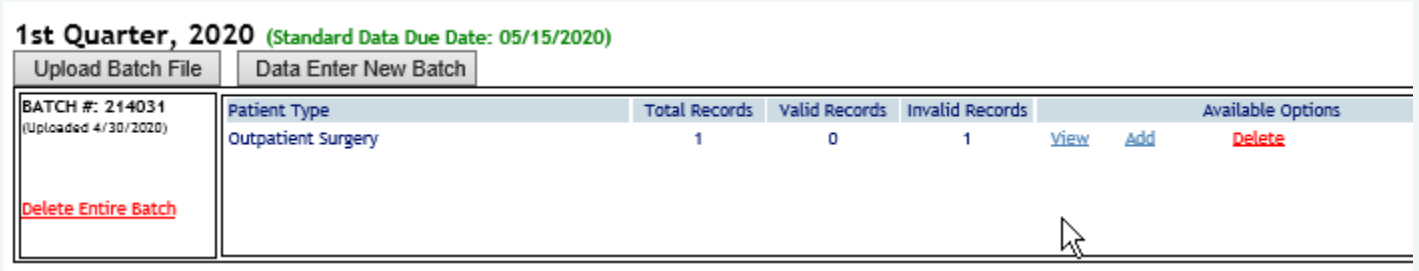




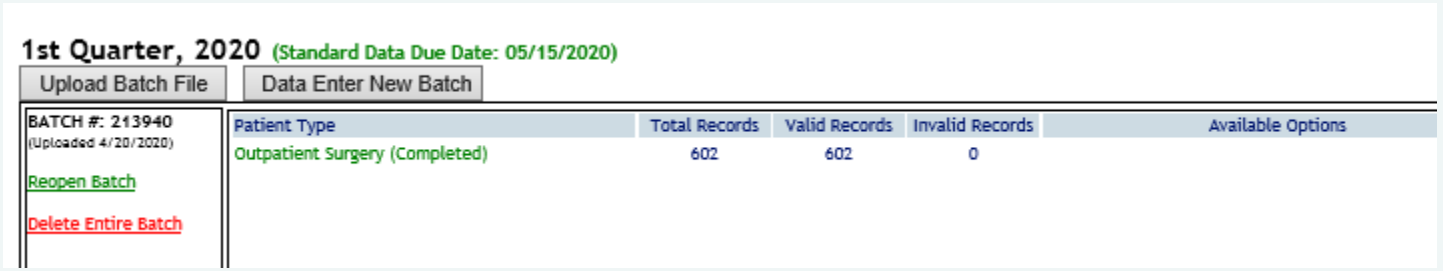
Tips:

1. Do not close browser while the file is being uploaded.
2. A status bar will appear with the progress of the batch file upload.
3. An acknowledgment email will be sent once batch is processed.

4. Distinct batch numbers are assigned to each batch file and edits may be worked once the file is uploaded.



5. Mark Data Complete once all edits are worked. Users may reopen or delete an entire batch using the keys under the Batch Number.



Most ASCs submit data using the 837 File Handler

It is relatively easy to create the UCID/ECID through use of the WHAIC 837 File Handler program, also known as the **"black box**". Our program has two functions.

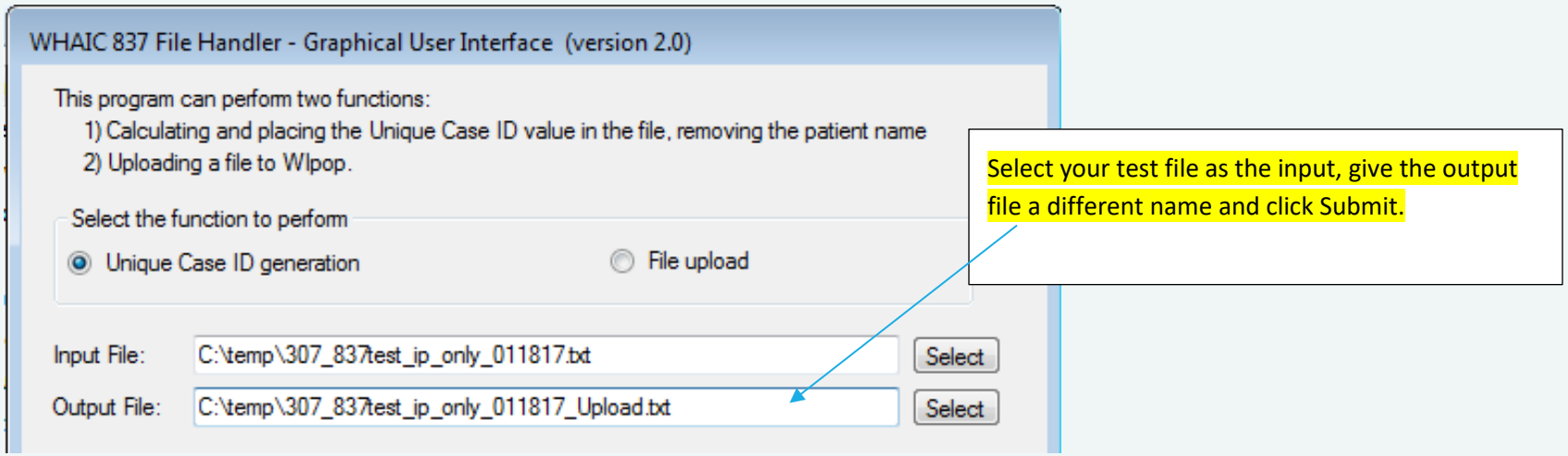
1) Remove the patient names and add the UCID and ECID.
2) Upload the file directly to WIpop using the 837 File Handler to WIpop.

To install the WHAIC 837 File Handler, run the file in this zip folder called **Installation.msi**. In most cases you can accept the installation defaults. Microsoft .NET Framework 4.5 is required. The framework can be downloaded from here: Black box: http://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/WHAIC_837_Handler.zip

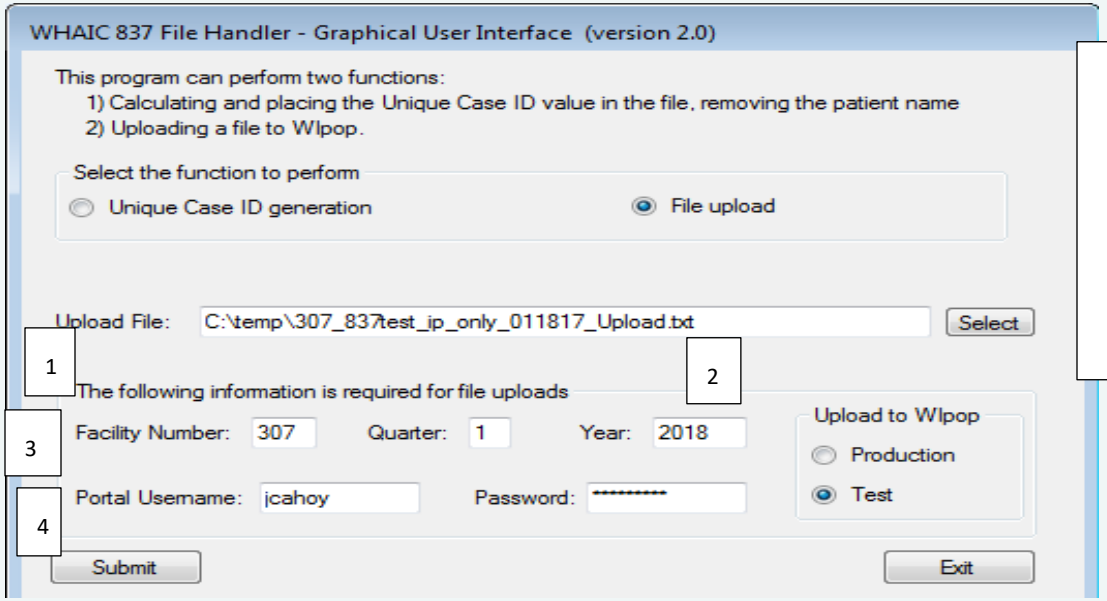
Once installation is complete, click on Start menu and run the program "WHAIC 837 File Handler GUI".

Note: If you cannot or do not wish to run the installation, you can instead copy the folder in the zip called **WHAIC 837 File Handler - No Install** to another location on your computer. You will then need to manually set up a shortcut to WHAIC_837_GUI.exe.

Data Submitters may need to contact their IT or tech support to download and install the current version of the black box.



The second function will upload the output file directly to WIpop, if desired. To do this, click the File Upload radio button. You will need to specify what facility and quarter the file is for, as well as your WHAIC portal username and password, then click Submit.



1. **Specify what facility and quarter**
2. **Identify Production or Test**
3. **Enter in WIpop User Name & Password**
4. **Click Submit to transmit the file to WIpop.**

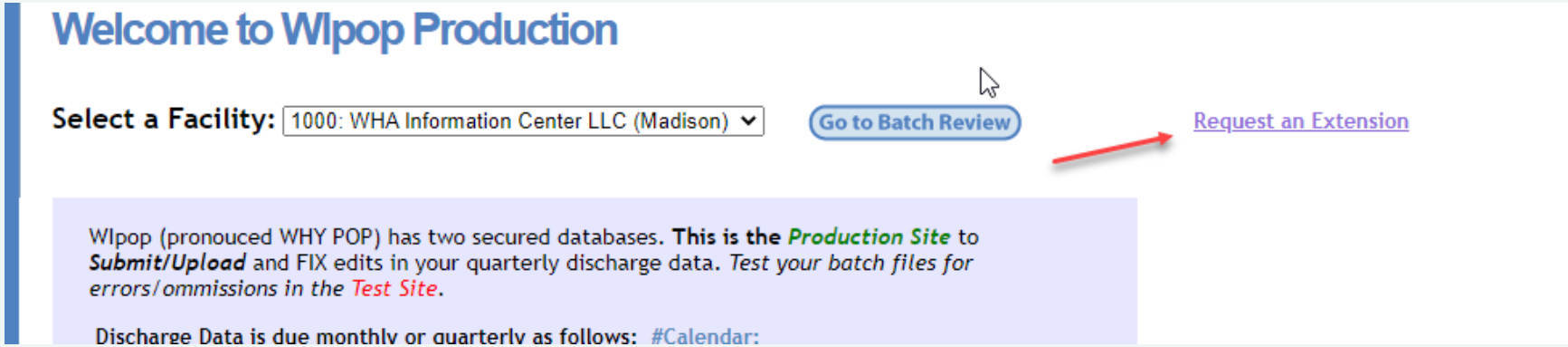
This GUI program executes a Windows console program which resides in the same folder. It is called **WHAIC_837_Console.exe**. The console program can be run standalone with passed parameters. This is to facilitate automated processes. Run the program in a command prompt window with parameter **/?** to see the available options.

3.6 How to file for an extension

Extension requests may be submitted under specific circumstances such as coding issues, vendor changes and catastrophic situations (fire, tornado, or flood) that prevent the facility from submitting timely data.

Extension requests must be filed 10 days before the data is due. Data is due 45 days after the close of the quarter. To file for an extension, log into WIpop secured portal and to the right of the Select a Facility, click on the “Request an Extension” to begin the process. Once the extension is filed, you will have an extra 20 days to submit the data.

Although a facility may file for an extension, WHAIC may continue to contact the facility to better gauge and understand when the data will be submitted.



3.7 WHAIC Support

If you cannot find the answers to your questions within this Companion Guide, FAQ or other available resources, please use the contact information below.

Cindy Case ccase@wha.org Director, Data Integrity - Compliance, Education and Training	837 Technical and File related whainfocenter@wha.org	Justin Flory – Technical Support jflory@wha.org Technical file issues, submission to WIpop or other related questions.

WHAIC Technical Support is usually available Monday through Friday, 8:00 a.m. to 4:00 p.m. The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day. Secured electronic system for notification is available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

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.

4.1 Unique / Encrypted Case ID:

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 assist facilities in identifying when a readmission occurs at a different facility than where the original admission or ambulatory surgery occurred. The five-character encrypted case ID **(ECID)** is also required, as the two data elements are used for different purposes. ***Batch Files will be rejected if a patient name is detected.***

To install the WHAIC 837 File Handler, run the file in this zip folder called **Installation.msi**. In most cases you can accept the installation defaults. Microsoft .NET Framework, version 4.5 or higher is required. the framework can be downloaded from here: http://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/WHAIC_837_Handler.zip

Once installation is complete, click on Start menu and run the program "WHAIC 837 File Handler GUI".

It is relatively east to create the UCID/ECID through use of the WHAIC 837 File Handler program, also known as the **"black box**". Our program has two functions.

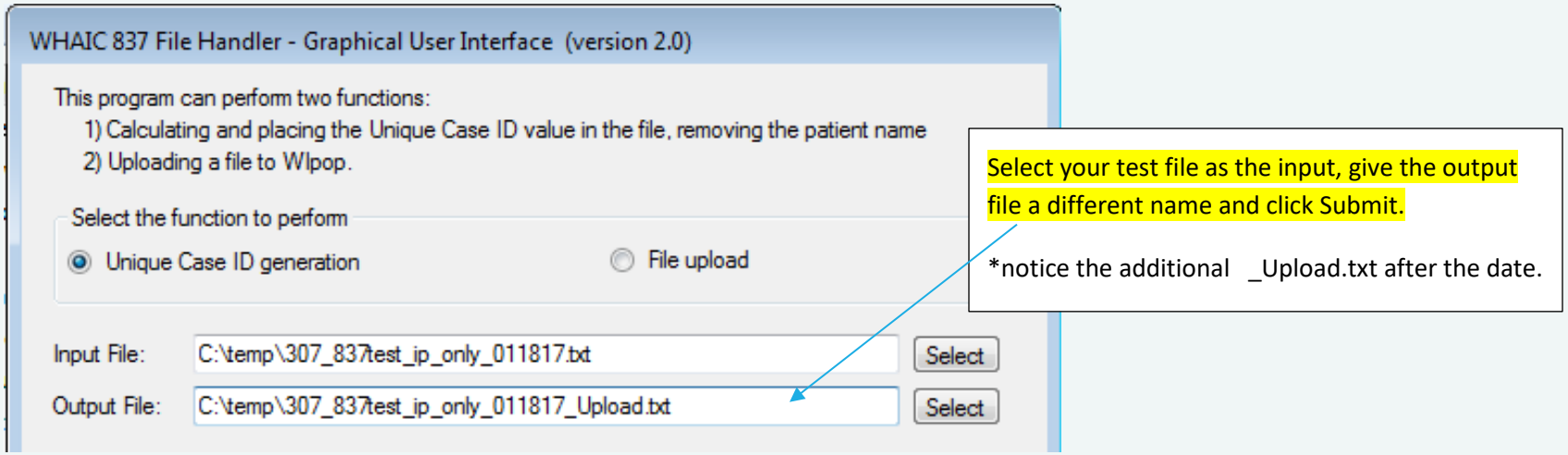
1) remove the patient names and add the UCID and ECID;
2) upload the file to WIpop.

To install the WHAIC 837 File Handler, run the file in this zip folder called **Installation.msi**. In most cases you can accept the installation defaults. Microsoft .NET Framework 4.5 is required. The framework can be downloaded from here: http://www.microsoft.com/download/en/details.aspx?id=17851

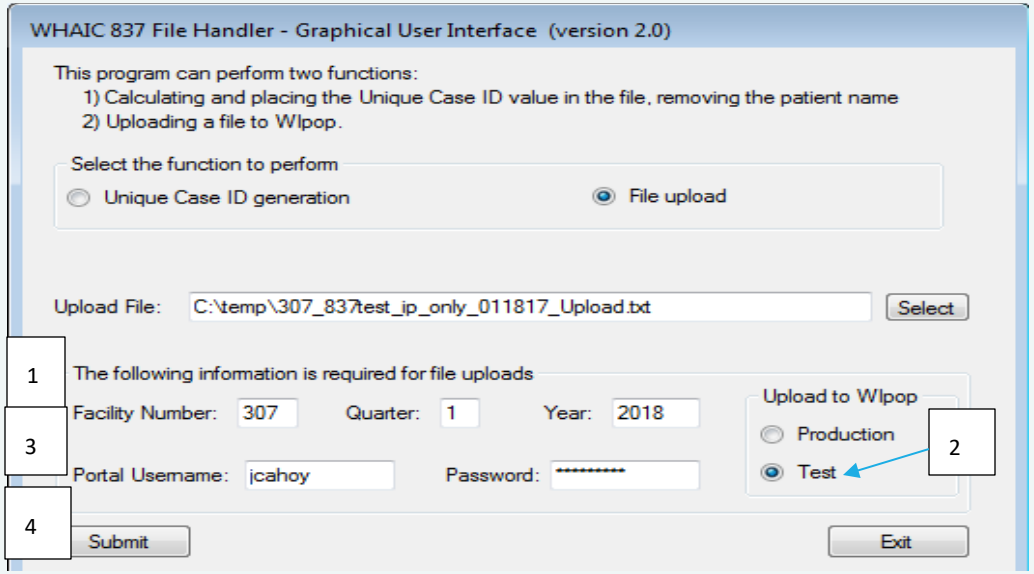
Once installation is complete, click on Start menu and run the program "WHAIC 837 File Handler GUI".

Note: If you cannot or do not wish to run the installation, you can instead copy the folder in the zip called **WHAIC 837 File Handler - No Install** to another location on your computer. You will then need to manually set up a shortcut to WHAIC_837_GUI.exe.

Data Submitters may need to contact their IT or tech support to download and install the current version of the black box.



The **second function will upload the output file directly to WIpop**, if desired. To do this, click the File Upload radio button. You will need to specify what facility and quarter the file is for, as well as your WHAIC portal username and password, then click Submit.



1. **Specify 3-digit facility ID and quarter.**
2. **Identify Production or Test.**
3. **Enter in Portal / WIpop UserName & Password**
4. **Click Submit to transmit the file to WIpop.**

This GUI program executes a Windows console program which resides in the same folder. It is called **WHAIC_837_Console.exe**. The console program can be run standalone with passed parameters. This is to facilitate automated processes. Run the program in a command prompt window with parameter **/?** to see the available options.

4.2 Race and Ethnicity:

More than one race may be collected and reported. See **Appendix 7.2** for detailed mapping tables.

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.

Office of Management and Budget (OMB) Standards | Office of Research on Women's Health (nih.gov)

Providers often ask us for a statement they can use when patients question the need for this detail.

Why are you asking me about my race and ethnicity?

Wisconsin Hospitals and Ambulatory Surgery Centers collect race and ethnicity data in accordance with State Statute Ch. 153. Race and ethnicity data are based on self-identification and patients are encouraged to indicate more than one race, if appropriate.

This data is often used to evaluate health outcomes and disparities in health care, with the goal of improving lives and creating health equity.

What is health equity? It means that all people have full and equal access to opportunities that enable them to lead healthy lives. It eliminates avoidable disparities in health care by reducing bias, acknowledging, and honoring diversity and by committing to helping each person achieve their best health status. In addition, these data elements are also used to evaluate government programs and policies to ensure that they fairly and equitably serve the needs of all racial groups. In addition, this information is used to monitor compliance with antidiscrimination laws, regulations, and policies.

4.3 Expected Source of Payment/Payer Mapping:

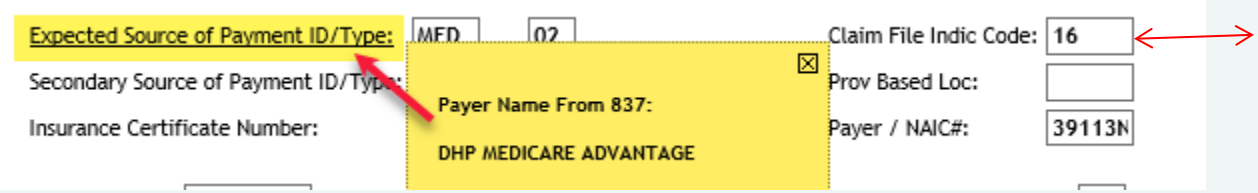
Effective Q1 2020 - WHAIC began requiring payer name, claim filing indicator, and Payer/NAIC # if collected and reported on the claim (see 2019 June Update) for more information. If a payer name is provided, it will be stored on the backend of the database to be used primarily for updating unknown payers, this field will not be shared with external customers. Details for required payer mapping in Appendix 7.3 *2010BB Primary Source of Payment ID – 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.

16 = Health Maintenance Organization – Medicare Risk

*See Appendix 7.3.1



2021 UPDATE: WHAIC reduced some of the payer redundancies to ease the mapping burden. See March 2021 News and Highlights

4.4 Type of Bill (TOB):

Although ASCs generally do not use Type of Bill (TOB) on their claims, WHAIC is statutorily required to collect them. ASCs may use TOB 0831 or 9999 to avoid edits in the file. This is one of the few fields that the 837P file may use automapping for.

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.

Effective Q2 2020, a new edit will be implemented that checks the type of bill against the type of encounter/record.

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; only FASCs/ASC
3185	Zero charge records require Nonpayment/Zero charge Bill Type

3186	**NEW EDIT**: 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

4.5 Revenue Codes

ASCs generally do not use revenue codes unless billing with an 837I format. Most revenue codes are accepted. WHAIC assigns a Place of Service (POS) to each record based off the Facility ID or 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..

4.6 External Cause of Injury (ECI) Codes

Injuries, complications, and other effects related to diagnosis codes in the S-T Injury section of the ICD-10-CM, with some exceptions 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. Codes in the V00-Y99 permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects. Where a code from this section is applicable, it is intended to be used secondary to a code from another chapter of the Classification indicating the nature of the condition.

External cause code is required with a diagnosis code in this range:	**External cause code is not required diagnosis code is in this range:**
S00 – S99 – Chapter 19 of ICD-CM: Injury, Poisoning, & Certain Other Consequences of External Causes **T07** – Injuries involving multiple body regions	T14 – T15 - T19 – Effects of foreign body entering through natural orifice T36 – T65 – Poisoning by, adverse effects / under-dosing of drugs, medicaments and biological substance

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	T66 – Radiation sickness T67 – Effects of heat and light T68 – Hypothermia T70 - Effects of air pressure and water pressure T71 – Asphyxiation/suffocation T73 – Effects of other deprivation T74 – T76 – Adult/child abuse, neglect & other maltreatment T78 – Anaphylactic reaction T79 – Early complications of trauma T80 – T88 – Complications of surgical and medical care, NEC

4.7 Language

WHAIC collects the patient's primary language if collected by the facility. Collection of language will be useful to data users, policy makers and market researchers to allow specific analysis of neighborhoods and impact of other social determinants in receiving health care.

- 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
- WIpop Manual: For full list and mapping table see Appendix 7.2.1

language_id	language
AFR	African Language(s)
ALB	Albanian
ASL	American Sign Language
ARA	Arabic
ASI	Asia (Other Asia)
BOS	Bosnian
BUR	Burmese
CHI	Chinese
ENG	English
FRE	French
FRC	French-Creole
GER	German/Deutsch
GRE	Greek
HAI	Haitian Creole
HEB	Hebrew
HIN	Hindi
HMO	Hmong
GUJ	India (Gujarati)
BEN	India-Bangladesh
IND	Indonesian
ITA	Italian
JPN	Japanese
KOR	Korean
LAO	Laos / Laotian
MAN	Mandarin
MON	Mongolian

Language Continued

NAV	Navajo
OTH	Other
OIE	Other Indo-European
ONA	Other Native - North American
OPI	Other Pacific Island
OWG	Other West Germanic
PER	Persian
PHI	Philippine
POL	Polish
POR	Portuguese
ROM	Romanian
RUS	Russian
SCA	Scandanavian
SER	Serbian
SCC	Serbo-Croatian (Cyrillic)
SPA	Spanish
SWE	Sweedish
TAG	Tagalog
THA	Thai
NA	Unknown or Unavailable
UNK	Unknown or Unavailable
URD	Urdo (Pakistan & India)
VIE	Vietnamese
YAO	Yao (Hmong-Mien)

5. 837 DATA SUBMISSION AND TECHNICAL REQUIREMENTS

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 samples below.

837I sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837I_Sample-File.pdf

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

837R sample file: https://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/837R-Sample-File.pdf

This manual references the 837 Professional Health Care Claim – ASC X12N 837 (005010X222A1)

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

5.1 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.

5.2 WHAIC 837 File Handler and De-Identification Program

Prior to uploading an 837 file, the following steps must be taken to remove and replace patients name with a 64-character Unique Case Identifier **(UCID)** in their 837 claims file. The primary purpose of the UCID is to assist facilities in identifying when a readmission occurs at a different facility from where the original admission or ambulatory surgery occurred. In addition, to preserve historical trending, the five-character encrypted case ID **(ECID)** is also required, as the two data elements are used for different purposes. Batch Files will be rejected if a patient name is detected.

5.3 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

5.4 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 ECID is characters 66-70	Ex: Race:Ethnicity DMG05 value of **5:2:3** is treated as Race = 5, Ethnicity = 2, Race2 = 3

5.5 Mapping Rules and 837 File Specifications

This section addresses a variety of issues that will facilitate the 837 Claims Submission Process. Only the sections and segments that are required or situational **and apply** to the WHAIC data collection requirements, or that are different from the ANSI 837 Guide sections are written in this manual. **The file must be structurally correct** to meet the 837 standards**, meaning our parser will not work if it does not meet the ASC X12 Implementation Guide.**

Fields marked Situational **does not** mean optional. For example, Insurance Certificate Number (Insurance ID Number) and Payer Name is required on all records, but the field says situational because not all patients have insurance and for self-pay, the field may be left blank.

- Only loops, segments, and data elements valid for the HIPAA 837I (005010X223A2), 837P (005010X222A1) and 837R (005010X225A2) will be translated. Deviating from the Technical Report Guidelines and submitting invalid data will cause the file/batch to reject.
- Uploaded files are not limited in total size, 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.
- WIpop's max upload size is currently 100 megabytes for facilities that do not use the black box/file handler to upload data.

When a HIPAA compliant ANSI 837 Institutional or Reporting formatted file with the additional required fields, including all mapped fields listed below, is submitted the data file should pass the WIpop Edits. Data elements listed as “Situational” or “Not Used” in the ANSI 837 Institutional Guide but REQUIRED by WHAIC are listed below.

5.6 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. **This is not intended to serve as a complete 837 reference, not all requirements for a valid 837 file are specified.** Vendor support is required and can take 3-6 months to develop and test files.

http://www.nubc.org/resources/PDFs/BillTypeFrequencyCodes837.pdf

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)	

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, if supplied.

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

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	

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
1000A	NM109	Identification Code of Submitter	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 ISA06 & GS02
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 associated with facility. Valid facility NPI number must be on file with WHAIC.	WIpop Field Name: NPI Billing Provider: NPI nbr 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**	

Loop	Element	Field Description	R, S, O	Values/Mapping Comments	WIpop Name / Notes
2000B	SBR03	Policy Number – Insurance SBR03 is Policy or Group Number	R	Send "NULL" if Self-pay Other AKA terms: Policy #, Member ID, Insurance Card #, Group Number, certificate number.	Insurance Cert # - can only be NULL or blank for self-pay. Self-pay is required.
2000B	SBR09	Claim Filing Indicator Code	S	Code identifying type of claim See Appendix 7.3.1 (Required if on claim) Effective date for submission of new field Q12020	See Appendix 7.3.1 for list of codes associated with primary payer. Do not pre-map this field.
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. See Section 5.2 for information on creating Encrypted UCID
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-ECID** UCID is characters 1 – 64 ECID is characters 66-70 837 File Handler/Black Box Instructions| DOWNLOAD	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID-ECID if different from subscriber. See Section 5.2
2010CA	NM109	Patient UCID & ECID	R	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 Element format is **UCID-ECID**	This field is to be used for encrypting the patient and/or subscriber name. Provide Patient UCID-ECID

				UCID is characters 1 – 64 ECID is characters 66-70 837 File Handler/Black Box Instructions| DOWNLOAD	if different from subscriber. See Section 5.2
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 - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 - the block group number processes on the edge server over a period of 12-24 hours before available in WIpop. 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 Loop 2010BA, NM102 = 1	Zip Code Stored in WIpop
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	Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status provide if collected & stored in EMR.
2010CA	DMG04	Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1 See Appendix 7.14 for Mapping	Marital Status provide if collected & stored in EMR.
2010BA	DMG05-1	Subscriber Race Code1 See Appendix 7.2	R/S	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	DMG05 is a composite element, which repeats up to 10 times. The first two

				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.	entries for race will be used for WIpop fields RACE and RACE2. File rejected if > 25% records = declined or unavailable
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	DMG10 = ZZ

				ZZ – Mutually Defined	
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	See Appendix 7.2.1 for Code List Mapping
2010CA	DMG11	Patient Language Code	S	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	See Appendix 7.2.1 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 The actual name of the payer going out on the claim	In WIpop: Click on the Expected Source of Payment to see or validate payer name
2010BB	NM108	(Payer) Identification Code	O	PI=Payer Identification	Discarded
2010BB	NM109	Primary Payer Identifier Code *Self-pay requires OTH-61	R	Map Payer's to WHAIC Values in Appendix 7.3. Element format is **AAA-99** Example A21-09 AKA: Primary Source of Payment ID Pay ID characters 1-3 – Pay TYPE is characters 5-6	Expected Source of Payment ID/ Type: characters 1-3 – Pay Type is characters 5-6 The dash is preferred, but not required

				The dash is preferred, but not required.	
2010BB	REF01	REF ID Qualifier for Payer/NAIC#	S	NF = NAIC Code	New Field Q32019: Payer Identifier in the EDI Claims file – routes claim to correct payer.
2010BB	REF02	Payer/ NAIC #	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. *File rejected for Duplicate Patient control numbers. **IF duplicates are found, resubmit file with this phrase **anywhere in the file name**: Exclude_duplicates Example: Q318 ASCname exclude_duplicates 1118	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	Use Rendering to mean the same thing as Operating Provider NPI number	If Rendering NPI is the only field populated, WHAIC will auto populate Operating NPI in WIpop.
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	*CPT or HCPCS required WHAIC follows correct coding guidelines and will populate the Principal procedure based on procedure codes in revenue line item detail.
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 1 is assigned by WHAIC for all ASC claims.
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

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.

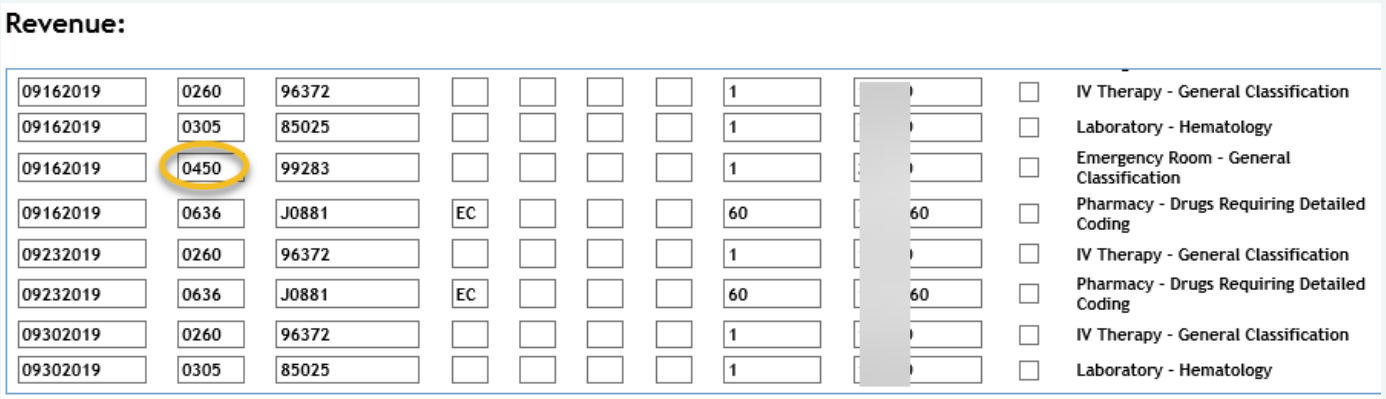
All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective quarter. For more information on edits see Appendix 7.9.

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:

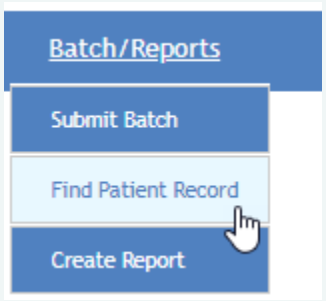
1. Carefully review each page of the **Summary Profile Report**. This report provides a high-level summary of the data using graphs, charts, and tables, including 12-month rolling totals for each data type submitted.
2. Validate the data using internal census or abstract reports from internal systems 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

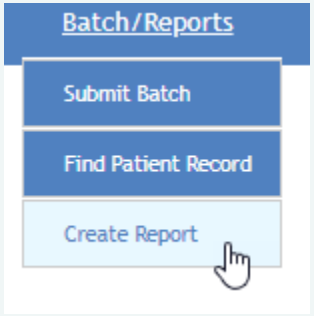
Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. You are not required to work all alerts.

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

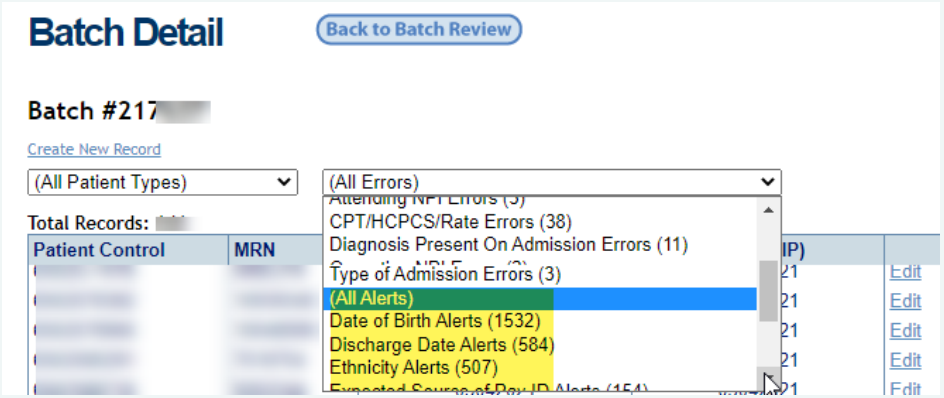
WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen.

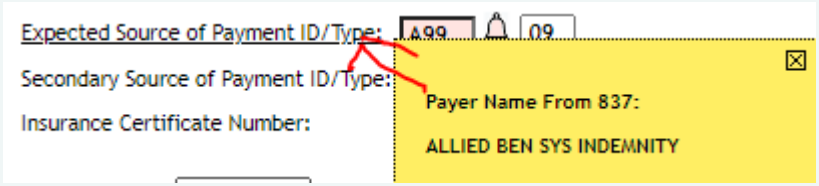
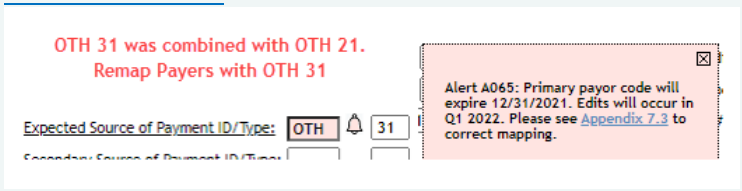
Alerts can be isolated and reviewed separately from other edits a couple of different ways:

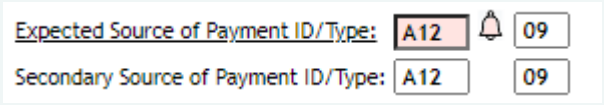
1. ***By running an inventory report from the Batch/Reports***



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.

7. APPENDICES

7.1 Facility List (Hospital and ASCs)

Facility ID: WHAIC assigns a unique 3-digit facility identification number to each facility. This number must be used in the 837 files to upload your data and when corresponding through email or phone communications.

Facility Number	Facility Name	Facility City
001	Amery Regional Medical Center	Amery
002	Aspirus Langlade Hospital	Antigo
003	ThedaCare Regional Medical Center – Appleton, Inc.	Appleton
004	Ascension NE Wisconsin - St Elizabeth Campus (NC Q118)	Appleton
006	Memorial Medical Center	Ashland
007	Western Wisconsin Health (NC: Q316)	Baldwin
008	SSM Health St Clare Hospital - Baraboo	Baraboo
009	Mayo Clinic Health System – Northland in Barron	Barron
010	Marshfield Medical Center - Beaver Dam (Name Change Q42020)	Beaver Dam
011	Beloit Health System	Beloit
013	ThedaCare Medical Center – Berlin, Inc.	Berlin
014	Black River Memorial Hospital	Black River Falls
015	Mayo Clinic Health System – Chippewa Valley in Bloomer	Bloomer
016	Gundersen Boscobel Area Hospital and Clinics	Boscobel
017	Ascension SE Wisconsin - Elmbrook Campus (NC: Q118)	Brookfield
018	Aurora Medical Center - Burlington	Burlington
019	Ascension Calumet Hospital (NC:Q118)	Chilton
020	St Joseph's Hospital	Chippewa Falls

022	Prairie Ridge Health (NC Q42019 from Columbus Community Hospital)	Columbus
024	Cumberland Healthcare (NC 0413)	Cumberland
025	Memorial Hospital of Lafayette Co.	Darlington
026	Upland Hills Health Inc.	Dodgeville
027	AdventHealth Durand	Durand
028	Aspirus Eagle River Hospital (NC from Ascension)	Eagle River
029	Mayo Clinic Health System - Eau Claire	Eau Claire
030	Sacred Heart Hospital	Eau Claire
031	Edgerton Hospital and Health Services	Edgerton
032	Aurora Lakeland Medical Center in Elkhorn	Elkhorn
033	Fond du Lac County Health Care Center	Fond du Lac
034	SSM Health St. Agnes Hospital – Fond du Lac (Part of SSM: 1/18) (NC 09/2021)	Fond du Lac
035	Fort HealthCare	Fort Atkinson
037	Gundersen Moundview Hospital & Clinics (NC 10/2017)	Friendship
038	Burnett Medical Center	Grantsburg
039	Bellin Hospital	Green Bay
040	Brown County Community Treatment Center	Green Bay
041	St Mary's Hospital Medical Center	Green Bay
042	St Vincent Hospital	Green Bay
043	Aurora Medical Center in Hartford	Hartford
044	Hayward Area Memorial Hospital	Hayward
045	Gundersen St Joseph's Hospital and Clinics	Hillsboro
046	Hudson Hospital & Clinics	Hudson
048	Mercy Health Hospital and Trauma Center – Janesville (NC 1/18/17)	Janesville
056	Gundersen Lutheran Medical Center	La Crosse

057	Mayo Clinic Health System – La Crosse (NC Q22021)	La Crosse
058	Marshfield Medical Center - Ladysmith (NC Q318)	Ladysmith
059	Grant Regional Health Center	Lancaster
060	Mendota Mental Health Institute	Madison
061	UnityPoint Health - Meriter (NC 1/16)	Madison
063	SSM Health St Mary's Hospital	Madison
064	UW Hospital and Clinics Authority (NC 10/17)	Madison
067	Aurora Medical Center - Bay Area	Marinette
068	Norwood Health Center	Marshfield
069	Marshfield Medical Center (NC 07/17)	Marshfield
070	Mile Bluff Medical Center	Mauston
071	Aspirus Medford Hospital and Clinics, Inc.	Medford
072	Froedtert Menomonee Falls Hospital	Menomonee Falls
073	Mayo Clinic Health System – Red Cedar in Menomonie	Menomonie
074	Aspirus Merrill Hospital (NC from Ascension Good Samaritan Hospital 11/2021)	Merrill
075	Children's Wisconsin Hospital - Milwaukee Hospital (NC 12/19)	Milwaukee
079	Froedtert Hospital	Milwaukee
082	Ascension Sacred Heart Rehabilitation Hospital	Milwaukee
085	Ascension St. Francis Hospital	Milwaukee
086	Ascension SE Wisconsin Hospital - St. Joseph Campus	Milwaukee
087	Aurora St Luke's Medical Center	Milwaukee
091	SSM Health Monroe Hospital (SSM Health: Q118) (NC 09/2021)	Monroe
092	ThedaCare Regional Medical Center - Neenah	Neenah
093	Marshfield Medical Center - Neillsville	Neillsville
094	ThedaCare Medical Center - New London	New London

095	Westfields Hospital & Clinics	New Richmond
098	ProHealth Oconomowoc Memorial Hospital	Oconomowoc
099	Rogers Memorial Hospital Inc.	Oconomowoc
101	St. Clare Memorial Hospital	Oconto Falls
102	Osceola Medical Center	Osceola
103	Ascension NE Wisconsin - Mercy Campus (NC: Q118)	Oshkosh
104	Mayo Clinic Health System – Oakridge in Osseo	Osseo
106	Marshfield Medical Center - Park Falls (NC Formerly Flambeau Hospital Q12021)	Park Falls
108	Southwest Health	Platteville
110	Ascension Columbia St Mary's Hospital Ozaukee	Mequon
111	Aspirus Divine Savior Hospital and Clinics (NC 10/1/2020)	Portage
112	Crossing Rivers Health	Prairie du Chien
113	Sauk Prairie Healthcare	Prairie du Sac
117	Reedsburg Area Medical Center	Reedsburg
118	Aspirus Rhinelander Hospital (NC from Ascension Saint Mary's Hospital 11/21)	Rhinelander
119	Marshfield Medical Center - Rice Lake (NC: Q318)	Rice Lake
120	The Richland Hospital, Inc.	Richland Center
121	SSM Health Ripon Community Hospital (NC 09/2021)	Ripon
122	River Falls Area Hospital	River Falls
123	ThedaCare Medical Center - Shawano	Shawano
124	Aurora Sheboygan Memorial Medical Center	Sheboygan
125	St Nicholas Hospital	Sheboygan
127	Mayo Clinic Health System – Sparta (NC formerly Franciscan Skemp Q12021)	Sparta
128	Spooner Health	Spooner
129	St. Croix Regional Medical Center	St Croix Falls

130	Aspirus Stanley Hospital (NC from Ascension Our Lady of Victory Hospital 11/21)	Stanley
131	Aspirus Steven's Point Hospital (NC from Ascension Saint Michael's Hospital 11/21)	Stevens Point
132	Stoughton Health (NC 3/2020)	Stoughton
133	Door County Medical Center (NC 11/16)	Sturgeon Bay
134	St Mary's Hospital of Superior	Superior
135	Tomah Health (NC 10/19)	Tomah
136	Aspirus Tomahawk Hospital (NC from Ascension Sacred Heart Hospital 11/21)	Tomahawk
137	Aurora Medical Center of Manitowoc County	Two Rivers
138	Vernon Memorial Healthcare	Viroqua
139	Watertown Regional Medical Center	Watertown
140	Waukesha County Mental Health Center	Waukesha
141	ProHealth Waukesha Memorial Hospital (Q218)	Waukesha
142	ThedaCare Medical Center – Waupaca	Waupaca
143	SSM Health Waupun Memorial Hospital (SSM Health: 1/18 - NC 09/2021))	Waupun
144	North Central Health Care	Wausau
145	Aspirus Wausau Hospital	Wausau
~~**147**~~	~~Milwaukee County Behavioral Health Complex~~ (Closed Q322)	Milwaukee
149	Aurora Psychiatric Hospital	Wauwatosa
150	Aurora West Allis Medical Center	West Allis
151	Froedtert West Bend Hospital	West Bend
152	Gundersen Tri-County Hospital and Clinics	Whitehall
153	ThedaCare Medical Center - Wild Rose	Wild Rose
154	Winnebago Mental Health Institute	Winnebago
155	Aspirus Riverview Hospital and Clinics, Inc.	Wisconsin Rapids
156	Howard Young Medical Center	Woodruff

168	Aurora Sinai Medical Center	Milwaukee
170	Libertas Center (OP Data Only)	Green Bay
172	Bellin Psychiatric Center	Green Bay
178	Froedtert Holy Family Memorial, Inc.	Manitowoc
179	Indianhead Medical Center / Shell Lake	Shell Lake
~~**181**~~	~~Post-Acute Medical Specialty Hospital of Milwaukee~~ Closed Q219	~~Greenfield~~
182	Aurora St Luke's Medical Center – South Shore	Cudahy
184	Lakeview Specialty Hospital & Rehab	Waterford
189	Aurora Medical Center in Kenosha	Kenosha
190	Select Specialty Hospital – Milwaukee	West Allis
192	Rogers Memorial Hospital – Milwaukee	West Allis
194	Children's Wisconsin – Fox Valley Hospital (NC 12/19)	Neenah
195	Orthopaedic Hospital of Wisconsin	Glendale
~~**196**~~	~~Columbia Center Birth Hospital~~ (Closed 7/1/2018)	~~Mequon~~
197	Aurora BayCare Medical Center in Green Bay	Green Bay
198	Oakleaf Surgical Hospital	Eau Claire
~~**203**~~	~~SurgiCenter of Racine Ltd~~ (Facility closed Q418)	~~Racine~~
~~**207**~~	~~Marshfield Clinic ASC~~ (Termed Q418 - Reporting as PBL under 069)	~~Marshfield~~
~~**208**~~	~~North Shore Surgical Center~~ (closed Q32020)	~~Milwaukee~~
209	SSM Health Surgery and Care Center	Madison
210	Wauwatosa Surgery Center	Wauwatosa
211	SSM Health Davis Duehr Surgery Center	Madison
212	SurgiCenter of Greater Milwaukee	Milwaukee
218	Northwest Surgery Center	Milwaukee
220	Wausau Surgery Center	Wausau

222	Menomonee Falls ASC	Menomonee Falls
225	Center for Digestive Health	Milwaukee
229	Niagara Health Center	Niagara
231	Madison Surgery Center, Inc.	Madison
233	West Bend Surgery Center	West Bend
234	Ambulatory Surgery Center LLC	Oshkosh
~~**235**~~	~~Marshfield Clinic – Minocqua ASC~~ (reporting as PBL 01/2021)	~~Minocqua~~
240	Wisconsin Laser and Surgery Center, LLC	Milwaukee
241	Woodland Surgery Center	Appleton
~~**242**~~	~~Marshfield Clinic – Eau Claire ASC~~ (Reporting as PBL Q12021)	~~Eau Claire~~
243	Arthroscopic Surgery Center LLC	Appleton
246	Center for Aesthetic and Plastic Surgery	Neenah
249	Marshfield Clinic – Wausau Center ASC	Wausau
250	Mayfair Digestive Health Center LLC	Wauwatosa
~~**251**~~	~~Wisconsin Health Center ASC~~ (APM site closed Q22020)	~~Greenfield~~
253	East Mequon Surgery Center LLC	Mequon
254	PMTC Surgery Center Inc.	Milwaukee
255	Bluemound Surgery Center	Waukesha
257	NovaMed Surgery Center of Madison LLP	Madison
258	Froedtert Surgery Center LLC	Milwaukee
259	Wisconsin Surgery Center LLC	Milwaukee
260	Pinnacle Cataract & Laser Institute LLC	Appleton
~~**261**~~	~~SurgiCenter of Greater Madison~~ (APM facility closed Q22020)	~~Middleton~~
262	Surgery Center of Wisconsin Rapids	Wisconsin Rapids
~~**263**~~	~~Sheboygan Medical Center LLC~~ (APM facility closed Q22020)	~~Sheboygan~~

264	Ambulatory Surgical Center of Stevens Point	Stevens Point
266	Orthopedic & Sports Surgery Center	Appleton
~~**269**~~	~~Aspirus Stevens Point Surgery Center~~	~~Stevens Point~~
270	Transformations Surgery Center, Inc. (Has not reported since Q22020)	Middleton
272	The Orthopaedic Surgery Center LLC	Pewaukee
~~**273**~~	~~Access Medical Center LLC~~ (APM site closed Q22020)	~~Racine~~
~~**274**~~	~~United Medical Center~~ (APM site closed Q22020)	~~Milwaukee~~
276	Lake Country Endoscopy Center LLC	Oconomowoc
277	GastroIntestinal Associates Endoscopy Center, LLC	Wausau
278	Northwoods Surgery Center	Woodruff
279	BJOSC, LLC	Wausau
280	The Surgery Center, LLC	Franklin
281	ProHealth Care Moreland Surgery Center	Waukesha
283	Metropolitan Medical Center	Shorewood
~~**285**~~	~~Pain Centers of Wisconsin – Green Bay, LLC~~	~~Green Bay~~
~~**286**~~	~~Pain Centers of Wisconsin – Franklin, LLC~~	~~Franklin~~
287	Pine Ridge Surgery Center	Wausau
288	Orthopedic Surgery Center of Green Bay (Q22021 No longer affiliated with Bellin)	Green Bay
289	Alexander Eye Surgery Center, LLC	Appleton
290	GI Specialists, LLC d/b/a Moreland Endoscopy Center	Waukesha
~~291~~	~~Southeast Wisconsin Ambulatory Surgical Center~~ Closed February 2019	~~Kenosha~~
~~**293**~~	~~Pain Centers of Wisconsin-Fox Point~~	~~Fox Point~~
294	Independent Surgery Center, LLC	Chippewa Falls
~~**295**~~	~~Pain Centers of Wisconsin - Kenosha~~	~~Pleasant Prairie~~
296	Pain Centers of Wisconsin – Fort Atkinson (reopened through new arrangement with Fort)	Fort Atkinson

297	EC Laser and Surgery Institute of WI, LLC	Wausau
298	Vascare Mayfair, LLC	Wauwatosa
299	Tower Clock Surgery Center	Green Bay
300	Select Specialty Hospital – Milwaukee – St. Francis (NC 04/18)	Milwaukee
302	Ascension All Saints, Inc. (NC: Q118)	Racine
303	Aurora Medical Center in Oshkosh	Oshkosh
305	Froedtert South (NC: from UHS 10/1/17)	Kenosha
306	Bellin Health Oconto Hospital	Oconto
~~**307**~~	~~LIFECARE Hospitals of Milwaukee~~ (closed June 2019)	~~Milwaukee~~
308	Marshfield Medical Center - Weston (NC 1/8/2020)	Weston
309	Mercyhealth Hospital & Medical Center – Walworth (NC 1/18/17)	Lake Geneva
310	Select Specialty Hospital - Madison	Madison
311	Ascension SE Wisconsin Hospital – Franklin (NC: Q118)	Franklin
312	ProHealth Rehabilitation Hospital of Wisconsin (NC Q218)	Waukesha
313	Midwest Orthopedic Specialty Hospital	Franklin
314	Aurora Medical Center in Summit	Summit
315	Aurora Medical Center in Grafton	Grafton
316	Columbia St. Mary’s Hospital Milwaukee	Milwaukee
317	St. Mary's Janesville Hospital	Janesville
319	Rogers Memorial Hospital	Brown Deer
320	UW Health Rehabilitation Hospital	Madison
321	Willow Creek Behavioral Health (New 01/2017)	Green Bay
322	Marshfield Medical Center - Eau Claire (New Q318)	Eau Claire
323	Marshfield Medical Center-Minocqua (New Q32020)	Minocqua
324	Aspirus Plover Hospital (NC from Stevens Point Hospital 11/2021)	Steven's Point

325	Froedtert Community Hospital (New Q4 2020)	New Berlin
326	Froedtert Community Hospital (New Q42020)	Pewaukee
327	Miramont Behavioral Health (New Q12022)	Madison
328	Ascension Wisconsin Hospital - Menomonee Falls - Micro Hospital (New Q12022)	Menomonee Falls
329	Ascension Wisconsin Hospital - Greenfield - Micro Hospital (New Q12022)	Greenfield
330	Ascension Wisconsin Hospital - Waukesha - Micro Hospital (New Q12022)	Waukesha
331	Aurora Medical Center Mount Pleasant	Mount Pleasant
332	Froedtert Community Hospital - Oak Creek	Oak Creek
333	Froedtert Community Hospital - Mequon	Mequon
334	ProHealth Care Waukesha Memorial Hospital - Muckwonago	Muckwonago
335	Marshfield Medical Center - River Region at Steven's Point	Steven's Point
336	Granite Hills Hospital	West Allis
337	Milwaukee Rehabilitation Hospital	Milwaukee
338	ThedaCare Medical Center Orthopedics - Spine and Pain	Appleton
339	Froedtert Bluemound Rehabilitation Hospital	Wauwatosa
340	Mental Health Emergency Center (estimated submission date Q123)	Milwaukee
~~**400**~~	~~Pain Center of Wisconsin – Wausau~~	~~Wausau~~
~~**401**~~	~~Pain Center of Wisconsin - Wauwatosa~~	~~Wauwatosa~~
~~**402**~~	~~Pain Center of Wisconsin – Beaver Dam~~	~~Beaver Dam~~
~~**403**~~	~~Pain Center of Wisconsin – West Bend~~	~~West Bend~~
~~**404**~~	~~Pain Center of Wisconsin – Appleton~~	~~Appleton~~
405	~~Pain Center of Wisconsin – Stevens Point~~ (Closed Q1 2020)	Stevens Point
~~**406**~~	~~Waukesha Pain Center, LLC~~	~~Waukesha~~
407	Wisconsin Digestive Health Center	West Allis

408	Wisconsin Specialty Surgery Center	Kenosha
409	Heart and Vascular Institute, LLC	Pewaukee
~~**410**~~	~~Pain Center of Wisconsin – Sauk Prairie~~	~~Prairie du Sac~~
~~**411**~~	~~Pain Center of Wisconsin – Oconto Falls~~	~~Oconto Falls~~
412	GLSD Medical LLC	Franklin
413	BJOSC at Plover (New Q319)	Plover
414	Aurora Surgery Center, LLC - Germantown	Germantown
~~**415**~~	~~Lake Country Surgery Center~~ (Closed Q418)	~~Pewaukee~~
416	Bellin Health Marinette Surgery Center (New Q118)	Marinette
417	Geneva Surgical Suites, LLC (New Q318)	Genoa City
418	Milwaukee Surgical Suites, LLC	Franklin
419	Midwest Nephrology Associates Surgery Center	Milwaukee
420	Wisconsin Institute of Surgical Excellence, LLC (New Q418)	Neenah
421	New Berlin Medical Services (New Q418)	New Berlin
422	Southern Lakes Endoscopy LLC (New Q119)	Mukwonago
423	Drexel Town Square Surgery Center (New Q119)	Oak Creek
424	Aurora Surgery Center - Greenfield (New Q32019)	Greenfield
425	Advanced Spine Center of Wisconsin, LLC	Neenah
426	Ascension Wisconsin Surgery Center - Mount Pleasant LLC (New Q22020)	Mount Pleasant
427	BayCare Aurora Kaukauna Surgery Center (New Q4 2020)	Kaukauna
428	Aurora Pleasant Prairie Ambulatory Surgery Center (New Q4 2020)	Pleasant Prairie
429	Kenosha Digestive Health Center (New Q12021)	Kenosha
430	Orthopedic Surgery Center of the Fox Valley (New Q22021)	Neenah
431	North Shore Surgical Suites (New Q32021)	Pleasant Prairie
432	Racine Digestive health Center (New Q32021)	Sturtevant

433	Eye Surgery Center of Wisconsin	Oak Creek
434	Spine Solutions of Green Bay	Green Bay
435	Spine Solutions of Sheboygan	Sheboygan
436	Spine Solutions of West Bend	West Bend
437	BJOSC LLC Westwood	Wausau

7.2 Race and Ethnicity Codes

Required for all data types – patients may choose more than one race code – See 837 Technical Specs - Section 5 for details. **Batch will be rejected if more than 25% of race and ethnicity codes are missing.**

1	American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3	Black or African American	A person having origins in any of the black racial groups of Africa.
4	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5	White	A person having origins in any of the peoples of North America, Europe, North Africa or the Middle East.
7	Declined	A person who refuses to answer this question.
9	Unavailable	A person unable to answer this question, or no available family member or caregiver to respond for the patient. May also be used by patients if their race is unknown.

Ethnicity

1	Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
2	Non-Hispanic or Latino	Person not of Hispanic or Latino ethnicity.
7	Declined	A person who refuses to answer this question or cannot identify him/herself ethnicity.
9	Unavailable/Unknown	A person unable to answer the question, or ethnicity is unknown to the patient.

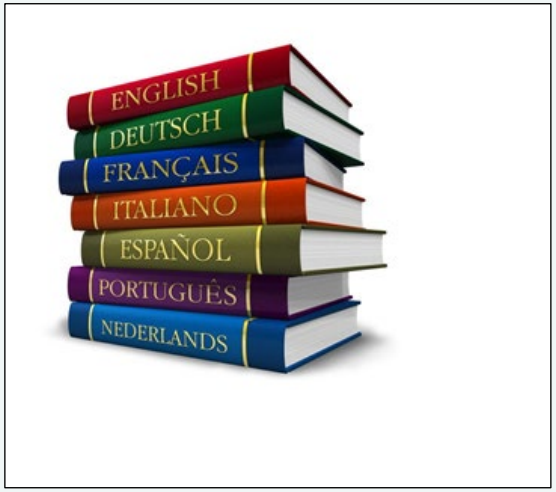
7.2.1 LANGUAGE CODES

Language is not on the claim form, but available in the EMR – much like Race/Ethnicity.

- Language: Loop 2010BA / 2010CA, DMG10 = ZZ (Mutually Defined), DMG11 = Language Code
- Maps to Language table in WHAIC database
- If the language name (comes through on the file, it will be cut off after three characters) In other words, we will take a full language name as most of them are the first three characters and disregard the rest.

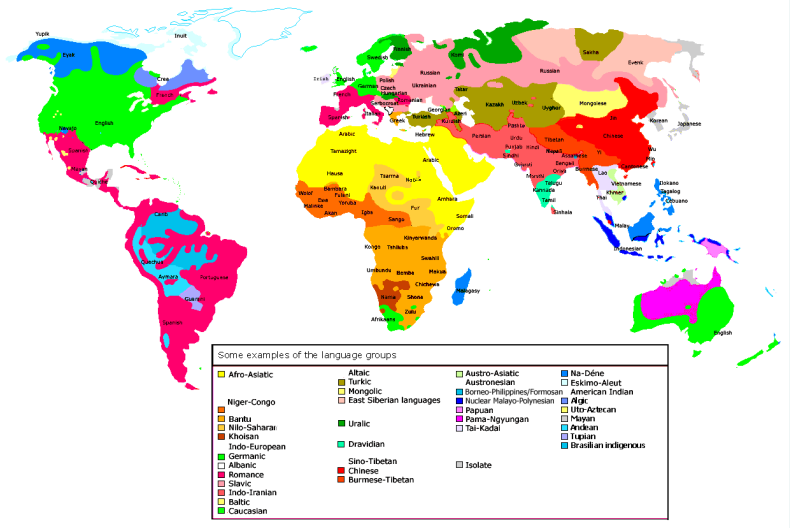
- Relevance: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf

WHAIC Language Codes 3/19 Last updated: 12/19	
Abrv	Primary Language
AFR	African Language(s)
ALB	Albanian
ARA	Arabic
ASL	American Sign Language
ASI	Asia (Other Asia)
BOS	Bosnian
Bur	Burmese
CHI	Chinese
ENG	English
FRC	French-Creole
FRE	French
GER	German/Deutsch



GRE	Greek
HAI	Haitian Creole
HEB	Hebrew
HIN	Hindi
HMO	Hmong
GUJ	India (Gujarati)
BEN	India-Bangladesh
ICE	Icelandic
IND	Indonesia
ITA	Italian
JPN	Japanese
KOR	Korean
LAO	Laos / Laotian
MAN	Mandarin
MON	Mongolian
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	Scandinavian
SCC	Serbo-Croatian (Cyrillic)
SER	Serbian
SPA	Spanish
SWE	Swedish
TAG	Tagalog
THA	Thai
VIE	Vietnamese
YAO	Yao (Hmong-Mien)



7.3 Expected Source of Payment and 837 Payer Mapping

Definition: *The source of payment that is expected to pay the greatest share of the encounter or claim should be listed as the primary payer.*

Throughout 2021 alerts will be set up to instruct submitters and editors to review the Appendix and adjust codes accordingly.

Types of Health Insurance Coverage - Most consumers have health insurance coverage from one of three sources:

- An individual health insurance policy
- A group health insurance policy (employer-sponsored coverage)
- A government-sponsored program (includes BadgerCare Plus, Medicaid, and Medicare).

For more information on these programs, including eligibility requirements, visit dhs.wisconsin.gov/badgercareplus/index.htm and cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol

Please see Section 5.A to reference the Mapping rules and Spec's to include the Payer ID off the claim in loop 2010BB REF02

Payer Table Mapping Details

01*/2023 Added 2 new A codes for commercial payers and 1 new Medicare Advantage code.

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
A10	09	Aetna (Aetna Healthcare Assurance Programs of Wisconsin, Inc.)	https://www.aetna.com/
A11	09	Ambetter (Managed Health Services Insurance Corp.)	Marketplace: https://www.ambetterhealth.com
A12	09	Blue Cross Blue Shield (aka Anthem, Anthem Blue, etc.)	www.anthem.com
A13	09	Aspirus Health Plan (formerly Aspirus Arise) *Updated Q12021* Aspirus Health Plan, Inc.	https://www.aspirushealthplan.com/landing/
A14	09	Celtic Insurance Company	https://www.healthplanone.com/ - domicile state IL
A15	09	Cigna Health and Life Insurance Company	Multiple plan types: https://www.cigna.com/

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
A16	09	Common Ground Healthcare Cooperative (Brookfield)	https://www.commongroundhealthcare.org/our-plans/individuals-families/
A17	09	Dean Health Plan, Inc. (Madison)	www.deancare.com
A18	09	Group Health Cooperative of South-Central Wisconsin (Madison)	ghcscw.com
A20	09	HealthPartners Insurance Company	https://www.healthpartners.com/hp/insurance/ domicile state MN
A21	09	Health Tradition Health Plan (Madison)	www.healthtradition.com
A22	09	Humana Insurance Company, Humana Wisconsin Health Ins. Corp.	www.humana.com
A24	09	Medica Community Health Plan Insurance Company	www.medica.com
A25	09	MercyCare HMO, Inc. - and MercyCare Insurance Company	www.mercycarehealthplans.com
A26	09	Molina Healthcare of Wisconsin, Inc.	https://www.molinahealthcare.com/
A27	09	Network Health Plan	https://networkhealth.com/
A29	09	Security Health Plan of Wisconsin, Inc. (Marshfield)	www.securityhealth.org
A30	09	UnitedHealthcare Insurance Company	www.uhc.com
A31	09	Quartz (Formerly Unity Health Plans Insurance Corporation) "Quartz Health Solutions, Inc. is co-owned by UW Health, Gundersen Health System and UnityPoint Health – Meriter.	Users can use this code or A43-09 01/2023 left in the table for 2023 reporting year.
A32	09	WPS Wisconsin Physicians Service Insurance Corp. (Madison, WI)	www.wpshealth.com
A33	09	Managed Health Services Insurance Corp.	https://www.mhswi.com/get-insured.html
A34	09	Aspirus Health Plan of Wisconsin	https://www.aspirus.org/aspirus-health-plan
A35	09	Health EOS / HealthEOS / MultiPlan	
A36	09	Children's Community Health Plan, Inc.	http://TogetherCCHP.org
A37	09	Community Care Health Plan Together with CCHP - partnered with Children's Hospital of WI	Marketplace Insurance health plan on exchange
A38	09	Compcare Health Services Insurance Corp. (Waukesha)	www.anthem.com
A39	09	Group Health Cooperative of Eau Claire (Eau Claire)	www.group-health.com
A40	09	The Medical Associates Clinic Health Plan of Wisconsin	www.mahealthcare.com
A41	09	My Choice Wisconsin Health Plan can: use MED or T19 or OTH 54 iCare is available to Medicare and Medicaid members *Formerly Trilogy Health Insurance - updated 01/2022*	https://mychoicewi.org/ Trilogy Health Insurance, Inc., merged into Care Wisconsin Health Plan, Inc., and at the time of the merger changed its name to: Care Wisconsin Health

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
			Plan - Trilogy Health Insurance, Inc., effective 1/1/2020.
A43	09	Quartz Health Benefit Plans Corporation (Sauk City, WI) GHP, Unity and PPIC:	https://quartzbenefits.com
A44	09	Choice Plus UHC / UMR (University Health Care)	
A45	09	WEA Trust	https://www.weatrust.com/#
A47	09	US Health and Life Insurance Company	www.ushealthandlife.com
A48	09	All Savers Insurance Company	www.myallsavers.com
A49	09	Care Improvement Plus Wisconsin Insurance Company	Parent company is UnitedHealth Group Inc.
A50	09	New 2023: Allstate Health Solutions	https://allstatehealth.com/
A51	09	New 2023: Robin with HealthPartners	Collaboration between Bellin, ThedaCare and HealthPartners for Northeast WI employers
A99	09	Other Commercial or nationwide out of state (not listed here) carriers. (Golden Rule Insurance, American National Life Insurance Co. of Texas)	
		NON-COMMERCIAL PLANS	
MED	09	Medicare Medicare is **federal health insurance for people 65 or older**, some younger people with disabilities, people with End-Stage Renal Disease. What is Medicare? *https://www.medicare.gov/Pubs/pdf/11306-Medicare-Medicaid.pdf*	Effective Q12021: To simplify mapping, we removed the requirement to identify PayType 01 & 02 - these paytypes are still available, but users may now report w/Paytype 09. This is intended to simply the processes of the hospital and ASC staff. We also recognize that some patients >65 may carry employer sponsored health coverage. https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
MPC	09	NEW Q422: Medicare Advantage Plans (Part C) *Medicare Advantage plans are offered by private companies approved by Medicare.* Medicare Advantage HMO/PPO (Eg. Medicare Advantage Plans) AARP, Senior insurance carriers, etc. all	Usually provided by a commercial plan.

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
		go in this bucket. If the patient has dual Medicare plans, list both primary and secondary as MED - 09	
T19	09	Medicaid, Fee for Service: Wisconsin Medical Assistance (Medicaid). According to DHS: Medicaid serves the elderly, blind and disabled = T19/09 Facilities may verify eligibility through the ForwardHealth Portal. Medicaid, HMO/PPO: Many people who receive Medicaid SSI or SSI-related Medicaid because of a disability determined by the Disability Determination Bureau must try Medicaid SSI HMO enrollment. Ex: Care Wisconsin.	Effective Q12021: To simplify mapping, we removed the requirement to identify PayType 01 - identifies straight Medicaid FFS Paytype 02 - identified Medicaid HMO/PPO PayType 09 - Universally accepted mapping Plan names: Community Care Health Plan, Inc.
BGR	09	BadgerCare, Fee for ServiceBadgerCare Plus, HMO/PPO: Families - parents, pregnant women, children, and childless adults. **Most BGR patients have HMO plans - BGR/02**. Independent Care Health Plan (iCare) Joint venture of Humana and Milwaukee Center for Independence that serves children and adults with disabilities/special needs. Added Family Care Partnership in 2010 Medicaid & Medicare managed care. Review payer of last resort guidelines and advice.	May include Trilogy Health, Community Care Health & Independent Health Care. BadgerCare (families, pregnant women, & childless adults) typically HMO – in WIpop/837 file = BGR/09 WI ForwardHealth has billing requirements that should be reviewed and adhered to. Online Handbook Display (wi.gov)
CHA	03	VA Health Care/ OPTUM VA / TRICARE (CHAMPUS) **supplement** (Military / Veteran) **CHAMPVA** Supplement Insurance Plan. The Civilian Health & Medical Program of The Department Of Veterans Affairs (Champva).	NEW: 1/1/21 CHA 03 now includes combined OTH 55 with because they both apply to veterans. About VA
C19	80	**COVID-19 HRSA Uninsured Program** NEW: Q120 Provider COVID-19 Vaccine Fact Sheet (hhs.gov) -COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured.	COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
			ForwardHealth Update 2021-01 - COVID-19 Vaccine Billing and Reimbursement (wi.gov)
OTH	21	Other Organization Self-Funded, Self-Insured, Fee for Service/HMO/PPO (Ex. ACA, Tribal Services, municipalities, school districts, ASR Health Benefits, Third Party Benefit Plan or Benefit Plan Admin/Other Plan Administrators, etc.) **Private employer insurance types get mapped from this code.** *A quick google search will help identify the plan name and type.*	NEW: 1/1/2021 combined OTH 21 and 31 to one option: Use OTH 21 to map all private payers, Alliance and Group / Benefit/Third Party Plan Administrators, Managers or other types of organizations that are self-funded or have plan managers.
OTH	41	Workers Compensation Insurance https://oci.wi.gov/Pages/Consumers/WorkersComp.aspx	If no insurance cert number - user can use the pcontol or year of birth.
OTH	51	**Medicaid, Out of State: Ex. Minnesota, Iowa, Illinois, Michigan Medicaid Patients.**	
OTH	52	Other Government: 51.42/51.437/46.23 County Board Ex. Mental/Behavioral Health and Department of Corrections, and other County Dept. for aging, chronically ill or chemically dependent.	For use with patients coming from a jail / mental health facility or other county departments where the patient is under the care of the state.
OTH	54	Wisconsin Family Care Program (WI – DHS Program): https://www.dhs.wisconsin.gov/publications/p0/p00570.pdf ; Ex. Care Wisconsin: https://www.dhs.wisconsin.gov/news/releases/070717.htm **Category includes reporting for the previous mapping of OTH 59 and 71** – all are used to report free and/or subsidized government programs, nonprofit organizations, local health departments, and grant/research funds. To simply reporting, hospitals and ASCs can use this to capture all categories contained in this section including subsidized health care through grants, research, and other charity care. Wisconsin Well Woman Program / Susan G. Komen Funding Community Care Health Plan, Inc. / Community Care, Inc. Community Care Health Plan, Inc., provides care under two government programs: Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership Program (Partnership) and Independent Care Health Plan	NEW: 1/1/2021 category now includes code 59 and 71. IRIS (Include, Respect, I Self-Direct) Information Family Care, Family Care Partnership, and PACE Information Birth to 3 Program Information Children's Long Term Support Waiver Program and Children's Community Options Program Information Eligible individuals choose from Care Wisconsin and My Choice Family Care, upon certification. Advocates4U, Connections, First Person Care

Payer ID	PayType	Payer Name (Expected Source of Payment): The payer refers to the primary entity that pays the claims or administers the insurance product, benefits, or both.	Other details: Website / comments / notes Medicare Advantage plans - use MPC 09
			Consultants, and TMG intend to support those choosing IRIS. *May also include Indian / Tribal Care or Children whose care is paid from funds granted to the office of Indian Affairs.
OTH	61	Self-Pay: Insurance Cert field may be left blank with self-pay (Cert Number field must be blank) This field also includes cost sharing plans - because no claim is created, and a statement is invoiced. For example, ALtrua HealthShare, and Liberty Share.	State statute requires facilities to report self-pay encounters along with all other encounters.
OTH	99	Other or Unknown Payer: 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. rom auto insurance to crime victim claims Unknown Type (Ex: crime victim funds and claims, disability determination, unidentified programs or WI SAFE Fund (sexual assault). Other or Unknown **TPL** (Auto - Accident - State Farm Auto, American Family auto). No Fault insurance is medical coverage for injuries that are related to motor vehicles. In states where car insurance is mandatory no fault is always primary, no matter what other insurance coverage a person may have.,	Do not use this code to report or map unknown commercial (A99) or private insurance companies (OTH 21). This is not a catch all code. Alerts will be set up as well as frequent audits to work with facilities to make necessary corrections.

State of Wisconsin, Office of the Commissioner of Insurance – Guide to Health Care Insurance: https://oci.wi.gov/Documents/Consumers/PI-225.pdf

2023 Updates:

Payer ID	Code	Termed Payer Name	
~~A19~~	~~09~~	Quartz ~~(formerly Gundersen Health Plan, Inc.)~~ Refer to A43	~~www.gundersenhealthplan.org~~

~~A31~~	~~09~~	~~Quartz (Formerly Unity Health Plans Insurance Corporation)~~ ~~*~~REFER to A43	
A28	09	Physicians Plus (combined with Quartz A43)	
~~A23~~	09	Independent Care Health Plan - can use MED or T19 or OTH 54 iCare is available to Medicare and Medicaid members	https://www.icarehealthplan.org/
~~A34~~	~~09~~	~~WPS (formerly Arise Health Plan) *Updated Q12021*~~	~~https://www.wpshealthsolutions.com/news/news-wps-arise-rebrand-09182020.shtml~~
A46	09	Federated Mutual Insurance Company	Offers Property, casualty and life. Does not offer health insurance.
A42	09	Wisconsin Collaborative, Ins. Co.-**WCIC** is a joint venture between Anthem Blue Cross and Aurora Health Care. Well Priority is a new POS product being offered by WCIS	
~~OTH~~	~~31~~	Self-funded Third Party, Benefit Plan Admin, etc. 2020: • OTH 21 and OTH 31 – combined to OTH-21 = self-insured/TPA and benefit plan administration (BPA) or private employer funded insurance.	Discontinued use OTH 21.
~~OTH~~	~~55~~	Veteran supplement coverage	Discontinued use CHA - 03
~~OTH~~	~~59~~		Discontinued use OTH - 54
~~OTH~~	~~71~~		Discontinued use OTH - 54
~~OTH~~	~~98~~		Discontinued use OTH - 99

1/1/2021	MED, T19, BGR	01 and 02	New: Users have the option to report only 09.

			This is intended to simply the processes of the hospital and ASC staff.
1/1/2021	T18	01/02/09	Combined to MED. Data shows only 25% of hospitals and ASCs use this code.

7.3.1 CLAIM FILING INDICATOR CODE

Definition: Code identifying type of claim or expected adjudication process. The first reported payer Claim Filing Indicator code must be associated with the primary payer.

When the patient has a Medicare Advantage plan, the claim should be billed to the secondary payer with a Medicare Part A or B indicator, not as commercial insurance.

Purpose: Collection of the Claims Filing Indicator code will provide WHAIC and facility an additional **internal cross check** to verify payers are reported as accurately as possible.

Data Element: 837I/R 837P: Loop 2000B / SBR09 **Field Details:** Situational (If collected, report code)

X12 Code	X12 Description
09	Self-pay
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization – Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross (Map to WHAIC A Code)
CH	CHAMPUS – Civilian Health and Medical Program of the Uniformed Services
CI	Commercial Insurance (Map to correct “A” Code to represent Commercial Payer) Non-Medicare payer
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization (HMO)
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V

VA	Veterans Administration / Affairs Plan
WC	Workers Compensation Health Plan
ZZ	Charity or Unknown

7.3.2 PAYER ID / NAIC

Data Element: 837I, 837R, 837P: Loop 2010BB / REF01 (NF (NAIC Code), REF02 = Value

Field Details: Situational (If collected, report code)

- **Definition:** Support the Exchange of EDI Claims Using a Payer List and Payer ID. This field will not have edits. When using the services of a clearinghouse, it is critical that the proper Payer ID is used so the EDI claims are sent to the right payer.
- **Purpose:** This field made available as an internal and external cross check if a Payer Identification or NAIC Code is reported on the EDI claims file. Based on WHAIC research most facilities use an EDI Claims Payer List to identify or map a Payer ID to support their electronic transactions **are routed to the right health plan**.

This field will not be released in the public data sets.

7.3.3 ALERTS

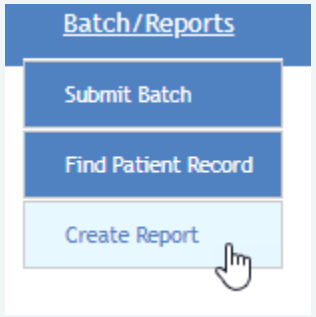
Alerts are not Edits or Errors. Alerts are intended to be an opportunity to review the data more closely and timely. Our intent is to allow ample time to make necessary changes before the end of the year. You are not required to work all alerts.

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

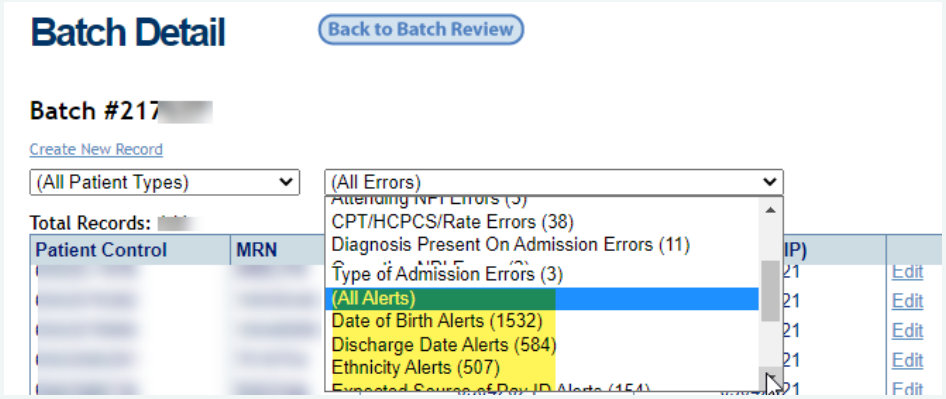
WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen.

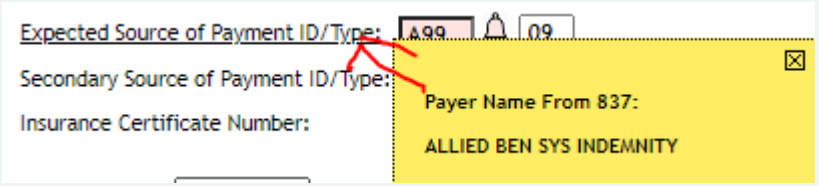
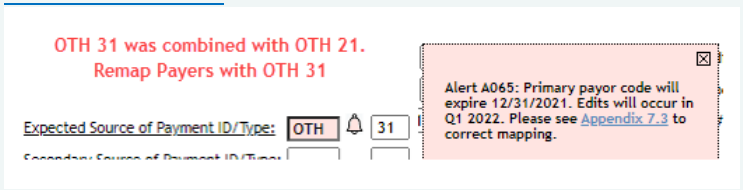
Alerts can be isolated and reviewed separately from other edits a couple of different ways

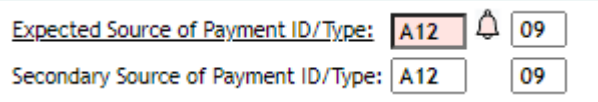
3. ***By running an inventory report from the Batch/Reports***



4. ***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 commercial, private, or other forms identified in the

Alert Codes	Alert Defined	Alert reconciliation how to handle
		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. • 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

Alert Codes	Alert Defined	Alert reconciliation how to handle
		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.
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. Alert is on hold.

Alert Codes	Alert Defined	Alert reconciliation how to handle
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.

2021 - Changes are intended to be made gradually. We do not expect hospitals and ASCs to reprogram all payers to the new payer fields / mapping scheme.

7.4 Type of Bill (TOB)

Definition: A code indicating the specific type of bill (inpatient, outpatient, etc.). The first digit is a leading zero. The second and third digits are the facility code. The fourth digit is a frequency code. *Leading zero is not applicable to the EDI files, only to the paper UB-04 claim form.

Although Type of Bill (TOB) is generally not provided on the 837P, WHAIC does require as per the State of Wisconsin statute all facilities to supply one.

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

DEFINITIONS FOR FREQUENCY CODES ACCEPTABLE FOR WHAIC

Non-Payment/Zero Claim (O) - applies to zero charge records- total charges = zero: Provider uses this code when it does not anticipate payment from the payer for the bill but is informing the payer about a period of non- payable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement, or termination of the plan of care.

Admit Through Discharge Claim (1) - applies to patients that are in and out of a facility in the same encounter of treatment.

Type of Bill Table

Type of Bill Code	Category of Service	Facility /Record Type
0999	Freestanding ambulatory surgery centers (FASC) may continue to use 0999 in the type of bill field.	
0830 0831	Special Facility-Ambulatory Surgery Center non-payment zero claim Special Facility-Ambulatory Surgery Center admit through discharge claim.	Outpatient Surgery performed in a Ambulatory Surgical Center.

7.5 Place of Service (POS) or Type of Encounter Hierarchy

Place of Service for the 837P is Assigned by WHAIC

WHAIC assigns POS to ASCs using the Facility ID range 200-400.

Although revenue codes are not required, they are accepted by ASCs.

7.6 WIPOP Coding Guidelines and Definitions for Data Submission

Data Submitters must follow current coding and claim submission guidelines. WHAIC assigns, to the best of our ability, the principal and additional procedure codes based on current coding guidelines and revenue line-item detail.

The **primary/principal diagnosis code** - ICD-10-CM diagnosis code describing the condition established **after study** to be chiefly responsible for occasioning the admission of the patient for care or for the outpatient services provided during the visit. This definition does not apply to the coding of all outpatient encounters. If the physician does not identify a definite condition or problem at the conclusion of an outpatient visit or encounter the coder should report the documented chief complaint as the reason for the encounter/visit.

Additional / Other reportable diagnoses - are defined as those conditions that coexist at the time of the admission/outpatient visit or develop subsequently and affect patient care for the current episode of care. Usually, reportable other diagnoses affect length of stay, total charges or accurate DRG classification.

The 'principal procedure code' - is the one procedure most related to the principal diagnosis. The 837 claims file should be properly coded using current coding guidelines for inpatient records. WHAIC will assign outpatient principal procedure codes based on surgical revenue codes in the revenue line-item detail and the current CPT and HCPCS surgical coding guidelines.

'**Additional procedures**' performed during the principal episode of care (or during the length of stay for inpatients) or that may include invasive or exploratory procedures (exploratory surgery is a surgery which is performed exclusively for diagnostic purposes, without the purpose of treating a disease). WHAIC will assign outpatient procedure codes based on the revenue line-item detail, CPT/HCPCS and costs (if duplicated.)

The **outcome of delivery,** category Z37, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record.

Note: This complies with Wisconsin Statute 69.14(1) (d) 1 stating the place of birth is the location where the placenta is delivered. Therefore, if a delivery occurs at home or en-route to the hospital, and the placenta is delivered at the hospital, the "place of birth" is the hospital.

Cancelled Outpatient Surgery - when a patient **presents for outpatient surgery** (same day surgery), the reason for the surgery is coded as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication. The principal diagnosis is the condition that occasioned the patient's admission for surgery.

Factors influencing health status and contact with health services (Z00-Z99) Chapter 21 of the ICD-10-CM Official Coding Guidelines provides the parameters for use of these codes. Please note there are some codes that can only be used as principal **or** additional diagnosis codes.

Z Codes That May Only be Principal/First-Listed Diagnosis is in Appendix B of the ICD-10 CM Coding Book.

The Z codes/categories identified in the coding guidelines may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.

Social determinants of health (SDoH) ICD-10 Codes Z55 - Z65. These codes were developed by the World Health Organization to allow better specificity to the circumstances of the patients served in your community.

WHAIC supports and encourages all facilities to collect and report these codes on their claims and encounters sent through WIpop.

Healthcare providers and data users will be able to use these codes to document when and where a patient would benefit from a certain social service, i.e transportation or access to nutritional food and other services.

Present on Admission (POA) Indicator

The POA Indicator applies to the diagnosis codes for records involving inpatient admission to general acute-care hospitals. The POA indicator is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.

Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the “Cooperating Parties”) publishes a list of ICD-10-CM codes for which the POA indicator does not apply. The indicator can be left unreported only for the codes on this list. This list is included in the POA guidelines published annually in October in the ICD-10-CM Official Guidelines for Coding and Reporting and will be updated in the WHAIC online manual annually:https://www.cdc.gov/nchs/icd/icd10cm.htm

The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes, diagnosis was present at time of inpatient admission.
N	No, diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
Blank	Exempt from POA reporting. **Do not use 1, or other value.**

7.6.2 REVENUE CODES

Revenue codes in medical billing are 4-digit numeric ids that are used in hospital bills to notify insurance companies what type of services wer4e provided to patients. These are 4-digit number always starting with **"0 (Zero)"**. We have updated the **list of Revenue Codes for Medical Billing** as per the latest information effective on 15 March 2020. The revenue codes in medical billing provide information to the insurance company on whether the services were performed like an emergency room service, operating room service, etc.

WHAIC uses revenue codes to direct the patient encounter / claim record to the correct place of service (

Revenue codes go along with procedure codes. When putting them in the chargemaster, add the correct revenue code to the CPT code you were going to use for a particular department. It is the use of revenue codes that allows hospitals to use the same CPT code in multiple departments because it will show which department the services were provided in.

A more complex example to use would be a simple laceration repair of a wound on the scalp, trunk of the body, or the extremities such as hands and feet CPT 12001, which is the procedure code could be done in multiple places of service.

- Service could be done in the OR; revenue code 360. WHAIC POS = 1
- Service could d be done in the emergency room; revenue code 450. WHAIC POS = 2
- It could be done in the Urgent Care; that would be revenue code 0361 WHAIC POS = 6
- It could be done in a clinic; that would be revenue code 510. WHAIC does not take professional claims unless it is billed on a 837i as a PBL. There are at least 3 other revenue codes where this procedure could be performed. All records containing Revenue Codes require the exact dates of service if they are span dates.

Edits will occur with Revenue Codes 096X through 099x – Professional Fees if submitted to WHAIC.

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
010X	**All-inclusive Rate** 0100 – All-inclusive room and board plus ancillary 0101 – All-inclusive room and board	NA	Inpatient
011X	**Room and Board Private (one bed)** • 0110 - General	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	• 0111 - Medical/Surgical/GYN • 0112 - OB • 0113 - Pediatric • 0114 - Psychiatric • 0115 - Hospice • 0116 - Detoxification • 0117 - Oncology • 0118 – Rehabilitation • 0119 - Other		
012X	**Room and Board Semiprivate (two beds**) • 0120 - General • 0121 - Medical/Surgical/GYN • 0122 - OB • 0123 - Pediatric • 0124 - Psychiatric • 0125 - Hospice • 0126 - Detoxification • 0127 - Oncology • 0128 – Rehabilitation • 0129 - Other	NA	Inpatient
013X	**Room and Board (3 and 4 beds)** • 0130 - General • 0131 - Medical/Surgical/GYN • 0132 - OB • 0133 - Pediatric • 0134 - Psychiatric • 0135 - Hospice • 0136 - Detoxification • 0137 - Oncology • 0138 – Rehabilitation	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	• 0139 - Other		
014X	**Room and Board Deluxe Private** • 0140 - General • 0141 - Medical/Surgical/GYN • 0142 - OB • 0143 - Pediatric • 0144 - Psychiatric • 0145 - Hospice • 0146 - Detoxification • 0147 - Oncology • 0148 – Rehabilitation • 0149 - Other	NA	Inpatient
015X	**Room and Board Ward** • 0150 - General • 0151 - Medical/Surgical/GYN • 0152 - OB • 0153 - Pediatric • 0154 - Psychiatric • 0155 - Hospice • 0156 - Detoxification • 0157 - Oncology • 0158 – Rehabilitation • 0159 - Other	NA	Inpatient
016X	**Other Room and Board** • 0160 - General • 0164 - Sterile • 0167 - Self-care • 0169 - Other	NA	Inpatient
017X	**Nursery**	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Accommodation charges for nursing care to newborns and premature infants in nurseries. The level of care should be clinically evaluated on a daily basis, typically based on the resources provided to the infant. The assigned revenue code corresponds to the level of care determined during the daily evaluation. The levels of care and resulting revenue codes may, and likely will, fluctuate during the infants stay in the facility. • 0170 - General • 0171 - Newborn Level I • 0172 - Newborn Level II • 0173 - Newborn Level III • 0174 - Newborn Level IV • 0179 - Other		
018X	**Leave of Absence** • 0180 - General • 0182 - Patience convenience - charges billable • 0183 - Therapeutic leave • 0185 - Nursing home (for hospitalization) • 0189 - Other	NA	Inpatient
019X	**Subacute Care** Accommodations charges for subacute care to inpatients or skilled nursing facilities. • 0190 - General • 0191 - Level I • 0192 - Level II • 0193 - Level III • 0194 - Level IV • 0199 – Other	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
020X	**Intensive Care Unit** Routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. (a) Includes hospital inpatient step-down units, Progressive Care Units and Definitive Observation Units. • 0200 - General • 0201 - Surgical • 0202 - Medical • 0203 - Pediatric • 0204 - Psychiatric • 0206 - Intermediate ICU[(a)] • 0207 - Burn Care • 0208 - Trauma • 0209 – Other	NA	Inpatient
021X	**Coronary Care Unit** Routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical or surgical unit. • 0210 – General classification: Coronary care (CCU) • 0211 – Myocardial Infarction: CCU/MYO INFARC • 0212 – Pulmonary Care: CCU/Pulmonary • 0213 – Heart Transplant: CCU/Transplant • 0214 – Intermediate CCU: CCU/Intermediate • 0215-8: Reserved • 0219 – Other coronary Care CCU: CCU/Other Report when a discrete coronary care unit exists for rendering such services.	NA	Inpatient

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
024x	**All inclusive ancillary, general**		
025X	**Pharmacy** Charges for medication produced, manufactured, packaged, controlled, assayed dispensed, and distributed under the direction of a licensed pharmacist. • 0250 - General Classification • 0255 - Drugs Incident to Radiology • 0258 - IV Solutions • 0259 - Other Pharmacy Note: Submission of a Healthcare Common Procedural Coding System (HCPCS) code with revenue code 0258 requires the appropriate National Drug Code (NDC).	No	6 - Other Outpatient Encounter
026X	**IV Therapy** Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. 0260 - General Classification 0261 - Infusion Pump 0262* Pharmacy Services 0264* Supplies 0269* Other IV Therapy	YES	6 - Other Outpatient Encounter
027X	**MEDICAL/SURGICAL SUPPLIES AND DEVICES** Charges for supply items required for patient care. 0270 - General Classification 0271 - Non-Sterile Supply 0272 - Sterile Supply 0273 - Take-home supplies 0274 – Medical / Surgical supplies and devices, prosthetic and orthotic 0275 - Pace Maker	Yes	6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0276 - Intraocular Lens 0278 - Other Implants [(a)] Note: This code can be used to bill the subdermal contraceptive implant, or any other medically necessary, non-experimental implant as described below. Cochlear implant handling can also be billed using code 0278. ***Other examples of implants***: Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds. [(a)] Implantable: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic or diagnostic purposes.		
0280	**Oncology**		
0290	**Durable Medical equipment (DME)** 0290 – Durable Medical Equipment, general 0291 – Durable Medical Equipment, rental 0292 – DME – purchase of new 0299 – DME		
030X	**Laboratory-Clinical Diagnostic** Charges for the performance of diagnostic and routine clinical laboratory tests. 0300 - General Classification 0301 - Chemistry 0302 - Immunology 0303 – renal patient 0304 - Non-Routine Dialysis 0305 - Hematology	Yes	5

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0306 - Bacteriology and Microbiology 0307 - Urology 0308 – Reserved Lab 0309 - Lab Note: Lab revenue codes require a HCPCS/CPT code.		
031X	**Laboratory – Pathological** Charges for diagnostic and routine laboratory tests in tissues and culture. 0310 - General Classification 0311 - Cytology 0312 - Histology 0313 – general class 0314 - Biopsy 0315 – Pathology 0316 – reserved pathology 0317 – Reserved pathology 0319 – Other Lab Path	Yes	5
032X	**Radiology – Diagnostic** Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorography. 0320 - General Classification 0321 - Angiocardiography 0322 - Arthrography 0323 - Arteriography 0324 - Chest X-Ray 0325 – Reserved, diagnostic 0326 – Reserved diagnostic 0327 – Reserved diagnostic 0328 – Reserved diagnostic 0329 - Other Radiology Diagnostic	Yes	6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
033X	**Radiology – Therapeutic and/or Chemotherapy administration** **C**harges for therapeutic radiology services and chemotherapy administration required for the care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs, which should be reported under the appropriate revenue code (025X/063X). 0330 - General Classification 0331 - Chemotherapy Administration-Injected 0332 - Chemotherapy Administration-Oral 0333 - Radiation Therapy 0335 - Chemotherapy Administration-IV 0339 - Other Radiology Therapeutic Note: When using 0331, 0332, or 0335 there must be RC 0636 on the record.	Yes	5 – OLR
034X	**Nuclear Medicine** Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. 0340 - General Classification 0341 - Diagnostic 0342 - Therapeutic 0343 - Diagnostic Radiopharmaceuticals 0344 - Therapeutic Radiopharmaceuticals 0349 - Other Nuclear Medicine	Yes	5 - OLR
035X	**Computer Tomographic (CT) Scan** Charges for Computerized axial tomography (CAT) CT scans of the head and other parts of the body. 0350 - General 0351 - Head 0352 - Body 0359 - Other	Yes	5

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
036X	**OPERATING ROOM SERVICES** Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment. 0360 - General 0361 - Minor surgery** 0362 - Organ transplant-other than kidney 0367 - Kidney transplant 0369 - Other operating room services	Yes	**POS 1 – OPS** ** except for 0361 – 0361 code is assigned to POS 6 according to WHAIC hierarchy.
037X	**ANESTHESIA** Charges for anesthesia services in the hospital. 0370 General 0371 Anesthesia incident to radiology 0372 Anesthesia incident to other diagnostic services 0374 Acupuncture 0379 Other anesthesia	NA	NA – not assigned based on stand- alone codes
038X	**Blood and Blood Components** 0380 - General 0381 - Packed red cells 0382 - Whole blood 0383 - Plasma 0384 - Platelets 0385 - Leucocytes 0386 - Other blood components 0387 - Other derivatives (Cryopricipitates) 0389 - Other Blood and blood components	Yes	6 - Other Outpatient Encounter
039X	**Blood and blood component admin, processing and storage** Charges for administration, processing, and storage of whole blood, red blood cells, platelets, and other blood components, such as plasma and plasma derivatives.	NA	As a general rule not a stand-alone code.

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0390 - General Classification 0391 - Administration (e.g., Transfusions) 0392 – Processing and Storage 0399 - Other Blood Handling / Admin		
040X	**Other Imaging Services** Charges for specialty imaging services for body structures 0400 - General Classification 0401 - Diagnostic Mammography 0402 - Ultrasound 0403 - Screening Mammography 0404 - Positron Emission Tomography (PET) Scan 0409 - Other Imaging Services	Yes	POS = 5 - OLR
041X	**RESPIRATORY SERVICES** Charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy. 0410 - General Classification 0412 - Inhalation Services 0413 - Hyperbaric Oxygen Therapy **0419 –** Other Respiratory Services	Yes	POS = 4 - Therapy
042X	**PHYSICAL THERAPY (All Ages)** Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities. 0420 - General Class Physical Therapy 0421 - Visit Charge 0422 – Hourly 0423 – Group	Yes	POS = 4 - Therapy

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0424 Evaluation or Re-Evaluation **0429 – Other PT**		
043X	**OCCUPATIONAL THERAPY (Limited to Age 21 Years and Under)** Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work. 0430 – General – occupational therapy 0431 – OT Visit Charge 0432 – OT hourly charge 0434 – OT Evaluation or reevaluation 0439 – OT	Yes	POS = 4 - Therapy
044X	**SPEECH-LANGUAGE PATHOLOGY (Limited to Age 21 Years and Under)** Charges for services provided to persons with impaired functional communications skills. 0440 – Speech therapy - general 0441 - Visit Charge 0442 – Hourly charge 0443 – group therapy 0444 - Evaluation or Re-Evaluation 0449 – Speech therapy	Yes	POS = 4 - Therapy
045X	**EMERGENCY ROOM** Charges for emergency treatment to those ill and injured recipients who require immediate unscheduled medical or surgical care. 0450 - General Classification 0451 – EMTALA Emergency Medical Screening Services 0452 – ER Beyond EMTALA 0456 – Urgent Care [(a)] 0459 – Other ER	Yes	POS = 2 – ER/ED (a) = OHO POS 6

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
046X	**PULMONARY FUNCTION** Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases. 0460 - General Classification 0469 - Other Pulmonary Function	Yes	POS = 6 - Other Outpatient Encounter
047X	**AUDIOLOGY** Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. 0470 - General 0471 - Diagnostic 0472 - Treatment 0479 - Audiology	Yes	POS = 6 - Other Outpatient Encounter
048X	**CARDIOLOGY** Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test. 0480 - General Classification **0481 - Cardiac Cath Laboratory** 0482 - Stress Test 0483 - Echocardiology 0489 - Other Cardiology	Yes	4 - Other Outpatient Encounter 0481 classified as OPS – POS 1 for WHAIC.
049X	**AMBULATORY SURGICAL CARE** Charges for ambulatory surgery that are not covered by any other category. 0490 – General Class Ambulatory Surgical Care 0499 – Other Ambulatory Surigical Care Note: Do not report *Observation with this code; report with revenue code 0760 or 0762*.	Yes	POS = 1 – OPS

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
051X	**CLINIC** Charges for scheduled non-emergency outpatient clinic visits for the purpose of providing diagnostic, preventative, curative, and rehabilitative services. 0510 - General Classification 0511 – Chronic Pain Center 0512 – Dental Clinic 0513 - Psychiatric Clinic ** 0514 – OB-GYN Clinic 0515 – Pediatric Clinic 0516 – Urgent Care Clinic 0517 – Family Practice Clinic 0519 – Other Clinic Note: ***Use code 0513 in conjunction with the following revenue codes:* *0914 - Psychiatric Clinic Visit/Individual Therapy* 0918 - Psychiatric Testing 0944 - Drug Rehabilitation 0945 - Alcohol Rehabilitation	Yes	POS = 6 - Other Outpatient Encounter
052X	**Freestanding Clinic RHC/FQHC** **Do not send this series of rev codes to WHAIC**	NA	NA – RHC/FQHC
053X	**Osteopathic Services** Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy (DO). 0530 – General classification 0531 – Osteopathic Therapy 0539 – Other *Generally, these services are unique to osteopathic hospitals and cannot be accommodated in any of the existing rev codes.*		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
054X	**Ambulance** 0540 – Ambulance, general 0541 – Ambulance, supplies 0542 – Ambulance, medical transport 0543 – Ambulance, heart mobile 0544 – Ambulance, oxygen 0545 – Ambulance, air 0546 – Ambulance, neonatal services 0547 – Ambulance, pharmacy 0548 – Ambulance, electrocardiogram (EKG) transmission 0549 – Ambulance *Do not send these to WHAIC as a stand alone service		
0550	**Skilled Nursing** 0550 – Skilled nursing 0551 – Skilled nursing visit		
0561	**Home health medical, social services, general**		
0571	**Aide/Home health visit**		
060X	**Home Health ((HH) – Oxygen** Home Health (HH) agency charges for oxygen equipment, supplies or contents, excluding purchased equipment. 0600 - General 0601 - Stat/Equip/Supply or contents 0602 - Stat/Equip/Supply Under 1 LPM 0603 - Stat/Equip Over 4 LPM 0604 - Portable Add-on 0609 - Other	Yes	POS = 5 OHO

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
061X	**MAGNETIC RESONANCE TECHNOLOGY (MRT)** Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body. 0610 - General Classification 0611 - MRI-Brain (including Brain Stem) 0612 - Spinal Cord (Including Spine) 0614 - MRI-Other 0615 - MRA-Head and Neck 0616 - MRA-Lower Extremities 0618 - MRA-Other 0619 - Other MRT	Yes	POS = 4 OLR
062X	**MEDICAL/SURGICAL SUPPLIES- EXTENSION OF 027X** Charges for supply items required for patient care. This category is an extension of 028X for reporting additional breakdown where needed. 0621 - Supplies Incident to Radiology 0622 - Supplies Incident to Other Diagnostic Services 0623 - Surgical Dressings 0624 – U.S. Food and Drug Administration (FDA) investigational devices	Yes	6 - Other Outpatient Encounter
063X	**PHARMACY- DRUGS REQUIRING SPECIFIC IDENTIFICATION** This category is an extension of 025X for reporting detailed coding where needed. 0631 – Drug, single 0632 – Drug, multi 0634 – Pharmacy, extension of 025X Erythropoietin (EPO) less than 10,000 units 0635 - Pharmacy, extension of 025X Erythropoietin (EPO) 10,000 or more units 0636 - Pharmacy, extension of 025X Pharmacy/Coded Drugs	Yes	6 - Other Outpatient Encounter
065X	**Hospice** 0650 – Hospice 0651 – Hospice, Routine home care 0652 – Hospice, continuous home care 0656 – Hospice, general inpatient care (non-respite)		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	WHAIC does not typically accept straight hospice patient care – distorts quality data.		
069X	**Pre-hospice/Palliative Care Services**	Yes	6 - Other Outpatient Encounter
070X	**CAST ROOM** Charges for services related to the application, maintenance, and removal of casts. 0700 - General Classification	No	6 - Other Outpatient Encounter
071X	**RECOVERY ROOM** 0710 - General Classification Note: Use code 0710 to bill routine post-operative monitoring during a normal recovery. Recovery room services must not be billed as observation services.	No	6 - Other Outpatient Encounter
072X	**LABOR ROOM/DELIVERY** Charges for labor and delivery room services provided by specially trained nursing personnel to patients. Includes: prenatal care during labor, delivery, postnatal care in recovery room, and minor gynecologic procedures performed in a delivery suite. 0721 - Labor 0722 - Delivery 0723 – Circumcision 0724 – labor room delivery birthing center 0729 – labor room delivery	No	
073X	**EKG – ECG (Electrocardiogram)** Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments. 0730 - General Classification 0731 - Holter Monitor 0732 - Telemetry 0739 - Other EKG - ECG	Yes	POS = 5 - OLR
074X	**EEG (Electroencephalogram)**	Yes	5 – OLR

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders. 0740 - EEG/General 0749 - Other EEG		
075X	**GASTRO-INTESTINAL SERVICES** Any service or procedure room charges for endoscopic procedures not performed in the operating room. 0750 - General Classification 0759 - Other Gastro-Intestinal	Yes	POS = 1 - OPS
076X	**TREATMENT/OBSERVATION ROOM** Charges for the use of a treatment room or for the room charge associated with outpatient observation services. 0760 – Specialty / Observation Room 0761 - Treatment Room 0762 - Observation Room	Yes	POS = 3 OBS
077X	**Preventative Care Services** 0770 – Preventative care services, general 0771 – vaccine administration		6 – Other outpatient
0780	**Telemedicine – Facility Charges related to telemedicine**	Yes	6 - Other Outpatient Encounter
0790	**LITHOTRIPSY** Charges for the use of lithotripsy in the treatment of kidney stones. Extra-corporeal shock wave therapy 0790 - General Classification	Yes	6 - Other Outpatient Encounter
081X	**Acquisition of body components** 0811 – Acquisition of body components, living donor 0812 – cadaver donor 0813 – unknown donor		

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0814 – Acquisition of body components, donor bank 0819 – donor		
082X	**HEMODIALYSIS – OUTPATIENT** 0820 - Hemodialysis Outpatient/General 0821 - Hemodialysis Outpatient/Composite 0824 - Hemodialysis Outpatient/Maintenance/100 percent 0829 - Other Outpatient Hemodialysis	Yes	6 - Other Outpatient Encounter
083X	**PERITONEAL DIALYSIS - Outpatient** 0830 - Peritoneal Dialysis/General 0831 - Peritoneal Dialysis Outpatient/Composite Rate 0834 - Peritoneal Dialysis/Maintenance/100 percent 0839 - Other outpatient peritoneal dialysis	Yes	6 - Other Outpatient Encounter
084X	**Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home** 0840 - General 0841 - Composite or other rate 0842 - Home supplies 0843 - Home equipment 0844 - Maintenance/100% 0845 - Support Services 0849 - Other	Yes	6 - Other Outpatient Encounter
085X	**Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home** 0850 - General 0851 - Composite or other rate 0852 - Home supplies 0853 - Home equipment 0854 - Maintenance/100% 0855 - Support Services 0859 - Other	Yes	6 - Other Outpatient Encounter

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
086X	**Magnetoencephalography** 0860 – General 0861 - MEG	Yes	6 - Other Outpatient Encounter
087X	**Cell/Gene Therapy** For claims submitted on or after April 1, 2019, hospitals may report the CAR T-cell-related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) established by the National Uniform Billing Committee (NUBC). When billing charges separately for tracking these services when furnished in the outpatient setting, providers must submit: 0871 – HCPCS 0537T with revenue code 0871 0872 – HCPCS 0538T with revenue code 0872 0873 – HCPCS 0539T with revenue code 0873 0874 – Remember that Medicare pays for the administration of CAR T-cells in the hospital outpatient setting separately under CPT code 0540T with Revenue Code 0874, which is assigned to status indicator “S”. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19009.pdf	Yes	6 – Other Outpatient Encounter
088X	MISCELLANEOUS DIALYSIS Charges for dialysis not identified elsewhere. 0880 - General Classification 0881 - Ultrafiltration	Yes	6 - Other Outpatient Encounter
090X	Behavioral Health Treatments/Services (also see 091X, and extension of 090X) 0900 - General 0901 - Electroshock 0902 - Milieu therapy 0903 - Play therapy	Yes	6 - Other Outpatient Encounter

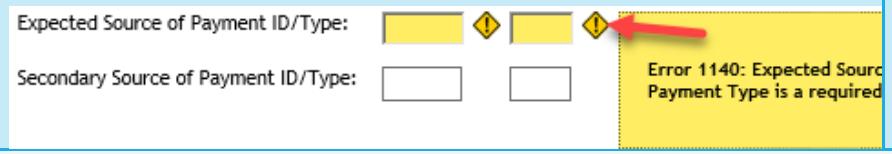
Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
	0904 - Activity therapy 0905 - Intensive outpatient services - psychiatric 0906 - Chemical dependency 0907 - Community behavioral health program - day treatment		
091X	**PSYCHIATRIC SERVICES** Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment. Behavioral Health Treatments/Services - Extension of 090X 0911 - Rehabilitation 0912 - Partial hospitalization - less intensive 0913 - Partial hospitalization - intensive 0914 - Individual therapy 0915 - Group therapy 0916 - Family therapy 0917 - Biofeedback 0918 – Testing 0919 - Behavioral health treatments	Yes	6 - Other Outpatient Encounter
092X	Other Diagnostic Services 0920 - General 0921 - Peripheral vascular lab 0922 - Electromyelogram 0923 - Pap smear 0924 - Allergy test 0925 - Pregnancy test 0929 - Other	Yes	4
093X	Medical Rehabilitation Day Program 0931 - Half day 0932 - Full day	Yes	4

Service Category	Description	Required Procedure Code for OP records	POS as assigned by WHAIC
094X	Other Therapeutic Services - See also 095X 0940 - General 0941 - Recreational 0942 - Education/training 0943 - Cardiac rehabilitation 0944 - Drug rehabilitation 0945 - Alcohol rehabilitation 0946 - Complex medical equipment - routine 0947 - Complex medical equipment - ancillary 0948 - Pulmonary rehabilitation 0949 – Other	Yes	5
095X	Other Therapeutic Services (Extension of 094X) 0951 - Athletic training 0952 - Kinesiotherapy	Yes	5
096x – 098X	Professional fees should not be submitted to WIpop	NA	NA

7.7 Edit Codes and Descriptions

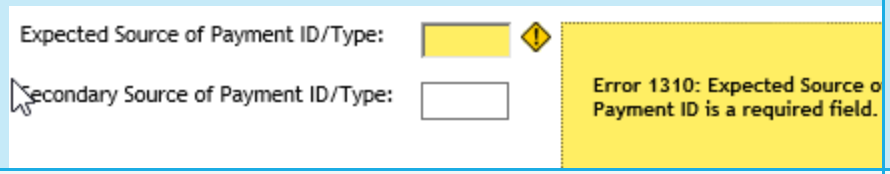
Notes are provided to help users work and/or clear edits.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1000	PTTYPE	The Patient Type supplied is invalid. Assigned by WHAIC unless DDE.	1=INP OR 2=OP
1005	SERVCODE	The Place of Service Code supplied does not match the revenue codes associated with this patient. See Appendix 7.5 - Place of Service Direct Data Entry users must consult manual and enter accordingly.	WHAIC assigns place of service using the revenue line item detail, based on the hierarchy of codes outlined in Appendix 7.5 with some exceptions.
1006	SERVCODE	This facility type "FASC" must use place of service 1 (OPS)	Applies to DDE users
1010	BDAT	Date of Birth is a required field. MMDDYYYY	Verify DOB in MR
1030	ZIP	Zip Code is a required field. Unless patient is homeless , in that case facility may use 5 zeroes, but must use condition code 17.	Condition Code 17 must be used for homeless or unknown.
1040	SEX	Gender is a required field. M, F or U – (transgender or baby born with both parts)	If U, Enter Condition Code 45 in any of the 4 condition codes.
1050	RACE	Race is a required field. If race is unknown = 9. This field is determined by the patient. Facility should not choose or map to specific races.	See Appendix 7.2 Race and Ethnicity Codes. Batches will be denied if >25% of records are supplied with denied or unavailable.
1060	ADMS	Point of Origin is a required field for this type of patient record.	See Appendix 7.7 or 7.7.1 in the case of newborns.
1065	RACE	Race 1 and Race 2 fields cannot contain the same value.	Delete race 2 and click update.
1070	ADMT	Type of Admission is a required field for this type of patient record. Required on INP records.	See NUBC / UB-04 Guidelines
1080	ADAT	Admission Date is a required field for this type of patient record. Applies to INP and ED records.	Applies to Inpatient and ED records.
1081	ADAT	Admission Date is a required since Discharge date is provided.	One without the other will create an edit.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1090	DXP_REQ	Principal Diagnosis is a required field.	Check claim or EMR for diagnosis ode.
1091	DXP_POA	Principal Diagnosis Present on Admission is a required field. Applies to INP records. Acceptable values are Y, N, U, W and Blank for exempt.	See Coding Guidelines Appendix 7.6.
1092	DXP_POA	Principal Diagnosis Present on Admission does not correspond to accepted values. Acceptable values are Y, N, U, W and blank for exempt.	If you have a 1, E or a value other than what is acceptable, delete the value and click update.
1093	DXP_POA	Principal Diagnosis Present on Admission is exempt from the reported Principal Diagnosis and cannot be submitted. Refer to the current ICD-10 Coding Guidelines https://www.cdc.gov/nchs/icd/icd10cm.htm	If exempt from reporting, field must be blank. Remove the Y, N, U, W or other value. *Most Status Codes "Z" range are exempt*
1094	DXP_POA	Principal Diagnosis Present on Admission is not allowed on this patient type.	PoA only allowed on inpatient records. Delete the value and update record.
1100	DXA	Admitting Diagnosis is a required field. Applies to INP records.	Edit will occur if provided on OP records. Delete if the code exist on an outpatient record.
1110	PINA	Attending NPI is a required field. Applies to INP and ED records.	Edit will occur if missing, review record and add NPI.
1120	DDAT	Discharge Date is a required field for this type of patient record.	Applies to INP and ED records/encounters.
1121	DDAT	Discharge Date is a required since Admission date is provided.	Cannot have one without the other.
1130	PTSTATUS	Discharge Status is a required field for this type of patient record.	See Appendix 7.8 – according to the NUBC it's a required field on all institutional claims.
1140	SOPTYPE	Expected Source of Payment Type is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1150	TC	Total Charges is a required field. *Must match total charges in revenue detail.	Exclude professional services if on the record.
1160	BILLTYPE	Type of Bill is a required field. See Appendix 7.4 Type of Bill.	See UB-04 Data Specification Manual (NUBC)
1170	SERVCODE (Aka POS)	The SEVECODE is the same as Place of Service (POS) supplied is invalid. See Appendix 7.5 Place of Service for correct Mapping requirements.	WHAIC will assign based on revenue code detail or type of facility.
1180	MRN	Medical Records Number is a required field.	Special characters are not acceptable, example: <1231>
1190	STPERIODF	Statement Covers Period From is a required field for this patient record. From means the date the service started.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data.
1200	STPERIODT	Statement Covers Period 'Through 'To' is a required field for this patient record. 'To' means the date the service ended.	Required on OBS, Therapies, Lab/Rad and other hospital outpatient data
1220	REVCODE	Revenue Code is a required field for this type of patient record.	All outpatient records require revenue codes except for FASC.
1240	UNITSERV	Units of Service is a required field.	Positive whole numbers only.
1245	UNITSERV	Units of Service must be greater than zero when Revenue Charge is greater than or equal to zero.	Units are required – must be 1 or greater.
1250	REVCHG	Revenue Charge is a required field. Cannot be left blank.	$0 is acceptable
1260	DX	Additional Diagnosis is a required field when an injury code exists in the S and some T ranges.	Add an external cause code from the V00 – Y99 ICD-10 coding book range to explain – how, what, and/or where accident occurred.
1261	DXRV1	Reason for Visit 1 is required for this type of patient record. One code required for RHC 013x and 085x, and 078x with Revenue Codes 045x, 0516, 0526, or 0762. Up to 3 codes allowed for any outpatient record.	This definition is provided according to the NUBC coding guidelines.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1262	DXRV2	Reason for Visit 2 cannot be submitted without Reason for Visit 1.	Adjust record according to edit.
1263	DXRV3	Reason for Visit 3 cannot be submitted without Reason for Visit 1 & Reason for Visit 2.	Adjust record accordingly.
1265	DXRV1	Reason for visit 1 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct and you want an over-ride.
1266	DXRV2	Reason for visit 2 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.
1267	DXRV3	Reason for visit 3 does not correspond to accepted values.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct
1269	DX	Additional Diagnosis not allowed if Principal Diagnosis not submitted.	Reference code in ICD-10 CM, remove decimals, contact WHAIC if correct.
1270	PR	Additional Procedure is a required field. Valid when facility creates an additional procedure.	WHAIC adds from the 837 claim file, applies to DDE users only.
1271	DXRV1	Reason for visit 1 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	Review NUBC billing guidelines.
1272	DXRV2	Reason for visit 2 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
		045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	
1273	DXRV3	Reason for visit 3 is not allowed for this patient type and cannot be submitted. The Patient's Reason (FL 70a-c) is a "Situational" reported field. It is required for Medicare institutional claims processing on Type of Bill 013x and 085x when: a) Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and b) Revenue Codes 045x, 0516, or 0762 are reported. The requirement for reporting Patient's Reason for Visit is restricted to the outpatient bill types above.	
1274	DXRV1	Reason for Visit 1 is a duplicate of another Reason for Visit diagnosis	Delete duplicate
1275	DXRV2	Reason for Visit 2 is a duplicate of another Reason for Visit diagnosis	Update accordingly
1280	PRDATE	Additional Procedure Date is a required field when additional procedure is supplied. Effective 01/18	WHAIC assigns based on revenue code details. But, DDE users should verify EMR for details.
1310	SOPID	Expected Source of Payment ID is a required field. 	Appendix 7.3 Expected Source of Payment for correct mapping. Commercial payer codes start with 'A' - example: Aetna is A10 – 09. The A10 is the Payment ID and the 09 is the Payment Type code.
1340	PINB	Operating Provider NPI 1 is required on outpatient surgery records.	Must identify the physician/other qualified health care provider who performed surgery.
1350	ETHN	Ethnicity is a required field. See Appendix 7.2	See Appendix 7.2 for list of acceptable codes.
1360	ECID	Encrypted Case ID is a required field.	See details in section 5.2 837 File Handler/Black Box
1365	PRP	Principal Procedure must be specified for this type of patient record.	Applies to direct data entry facility. Required for outpatient surgery records

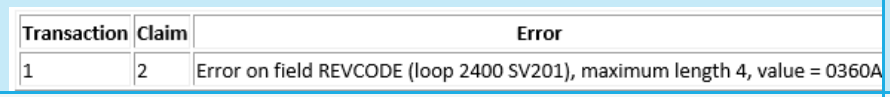
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1370	PRP	Evaluation & Management codes are not an acceptable Principal Procedure.	Use appropriate procedural CPT/HCPCS code. Applies to DDE. WHAIC populates all 837 files.
1375	PRP	Principal Procedure required if Operating Provider NPI 1 is reported.	Required on OPS records.
1380	PRP	Principal Procedure required when Procedure Date is reported.	WHAIC populates the principal and procedure date.
1385	PRP	Principal Procedure must be specified if Other Provider NPI 2 is reported.	WHAIC assigns procedure codes – contact WHAIC for review.
1390	PRP	Principal Procedure must be specified when Additional Procedures are reported.	Applies to DDE – WHAIC populated procedure codes based on revenue line item detail.
1395	ADPRPD	Principal Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure".	Typically applies to direct data entry of records. This means you can't populate the principal without repeating it along with the cost of the procedure in the rev line detail.
1396	ADPRPD	Additional Procedure code does not appear in the revenue lines. All CPT/HCPCS codes must be identified in the revenue lines below. *This section is intended to identify services that meet the definition of "procedure".	Typically applies to direct data entry of records. This means you can't populate the additional procedure code(s) without repeating it along with the cost of the procedure in the rev line detail.
1400	PRPD	Principal Procedure Date required if Principal Procedure is reported.	WHAIC assisgns to all 837 claim files.
1410	SOPTYPE2	Secondary Source of Payment Type is required when Secondary Source of Payment ID is specified.	
1420	SOPID2	Secondary Source of Payment ID is required when Secondary Source of Payment Type is specified.	
1430	MISSINGMO		
1555	CERTNUM	Insurance Certificate Number is a required field unless self-pay.	For self-pay use NULL or Blank

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
1590	LVDAYS	Leave Days cannot be a value greater than zero for this type of patient record.	Delete value and click update.
1600	PINB	Operating Provider NPI 1 cannot be specified if Principal Procedure is not reported.	Delete Operating NPI or add Principal Procedure
1605	PINC	Other Provider NPI 2 cannot be specified if Principal Procedure is not reported.	Delete NPI 2.
1610	PINC	Other Provider NPI 2 cannot be specified if Operating Provider NPI 1 is not reported.	Delete NPI 2 or add operating NPI.
2010	BDAT	Date of Birth does not correspond to a valid date (mmddyyyy).	Review record and update accordingly.
2015	BDAT	Date of Birth cannot be after Admit, Principal Procedure or Statement Covers From date.	
2020	ADAT	Admission Date does not correspond to a valid date (mmddyyyy).	
2021	ATIME	Admission Time does not correspond to a valid time (hhmm)	
2022	ATIME	Admission Time must be blank when Admission Date is blank	
2030	PRPD	Principal Procedure Date does not correspond to a valid date (mmddyyyy).	
2040	DDAT	Discharge Date does not correspond to a valid date (mmddyyyy).	
2041	DTIME	Discharge Time does not correspond to a valid time (hhmm)	
2042	DTIME	Discharge Time must be blank when Discharge Date is blank	
2050	STPERIODF	Statement Covers Period From does not correspond to a valid date.	Format date: mmddyyyy
2060	STPERIODT	Statement Covers Period To does not correspond to a valid date.	Format date: mmddyyyy

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
2065	STPERIODT	The date specified does not fall within the boundary of the working quarter. 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. *This does not apply to outpatient surgery records.*	This record should be pulled into the following quarter if it crosses a quarter (*This does not apply to outpatient surgery records*.) This applies to both inpatient and most outpatient. Inpatient is based on discharge date and outpatient data like OBS, Therapies and lab/radiology are based on statement through date.
2066	STPERIODF	Statement Covers Period From must match the minimum service date in submitted revenue records.	Verify the statement from and through match the revenue record dates of service.
2067	STPERIODT	Statement Covers Period To must be no more than one day greater than the maximum service date in submitted revenue records.	
2070	SERVDATE	Service Date does not correspond to a valid date (mmddyyyy).	Review file: DTP*434 Loop
2075	SERVDATE	Service Date is a required field for this type of patient record.	Review file: DTP*434 Loop
2080	PRDATE	Additional Procedure Date does not correspond to a valid date	The date must be formatted: mmddyyyy
2090	TC	Total Charges cannot be less than zero	Value must equal the value in revenue sect.
2100	UNITSERV	Units of Service do not correspond to a valid non-zero data format (nnnnnnn).	A value of 1 must be used – whole numbers only.
2310	LVDAYS	Leave Days must be a non-negative integer value (nnn).	Calculated by WHAIC
2311	LVDAYS	Leave Days should be less than Length of Stay.	Calculated by WHAIC
2320	ECID	Encrypted Case ID is not a properly formatted value (letter-number-number-number-letter).	AKA – ECID See details in section 5.1.1
2325	ECID	Encrypted Case ID cannot have numeric digits greater than '6'.	See details in section 5.1.1
2330	ECID	Encrypted Case ID cannot have non-zeros following a zero.	See details in section 5.1.1
2335	ECID	Encrypted Case ID cannot have consecutive identical non-zeros.	See details in section 5.1.1

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
2340	UCID	Unique Case ID is not properly formatted. The value must contain 64 characters. See Appendix 7.11	AKA – UCID. See Black Box details.
2345	UCID	Unique Case ID is a required field. Please see Appendix 7.11.	See 837 File handler requirements in section 5.2 or 7.11 Black Box details.
2350	DDAT	LOS cannot be greater than 2 days for ER (Discharge Date minus Admit Date).	Contact WHAIC to do an over-ride after the information is verified.
3020	ZIP	ZIP Code does not correspond to accepted values.	Verify in the patient record and update. For out of country patients, use 00000
3030	SEX	Gender does not correspond to accepted values. Value of U or O requires Condition Code 45 if transgender or ambiguous gender.	If U, Condition Code 45 must be used accordingly.
3040	RACE	Race does not correspond to accepted values.	See Appendix 7.2
3045	RACE2	Race 2 must be valid if specified.	See Appendix 7.2
3046	RACE	Declined race cannot be combined with another race	Delete declined and hit update.
3050	ADMS	Point of Origin does not correspond to accepted values.	Consult Claim or NUBC for correct Point of Origin or (AKA Source of Admission)
3060	ADMT	Type of Admission does not correspond to accepted values. See Official NUBC UB-04 Manual for values.	Refer to Appendix 7.7.1 for Admit Type listing.
3070	DXP	Principal Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3080	DXA	Admitting Diagnosis does not correspond to accepted values, or code was deleted.	Verify accuracy of code choice. Refer to the current ICD-10 Manual.
3110	PINA	Attending Provider NPI does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3120	PINB	Operating Provider NPI 1 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3130	PINC	Other Provider NPI 2 does not correspond to accepted values.	Verify NPI before contacting WHAIC. Verify NPI Number in the NPPES NPI Registry https://npiregistry.cms.hhs.gov/
3136	PIND	Rendering Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Often in the ASC file, the rendering provider is the same as the operating NPI.
3137	PINF	Referring Provider does not correspond to accepted values.	Verify NPI before contacting WHAIC. Referring NPI is not the same as the billing NPI. Verify the NPI number for the Referring Provider is a human and not a facility.
3140	PRP	Principal Procedure does not correspond to accepted values, or code was deleted. Verify code in CPT or HCPCS if OP.	If outpatient record, verify code is a valid CPT or HCPCS. INP record – verify code with ICD-10 PCS
3145	PRP	Principal Procedure contains a valid procedure code, but not a valid principal procedure code. May be an add-on code or non-procedure code like a DME or Supply code.	If outpatient record, verify code in CPT or HCPCS. INP record – verify code with ICD-10 PCS
3150	PTSTATUS	Discharge Status does not correspond to accepted values. See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specifications.	See Appendix 7.8 - Discharge status or Official NUBC UB-04 Specification
3180	BILLTYPE	Type of Bill does not correspond to accepted values.	See Appendix 7.4 – some TOBs are not acceptable
3181	BILLTYPE	Type of Bill 0999 is not allowed for hospitals.	Hospitals must use the TOB that's on the claim form
3185	BILLTYPE	Zero charge records require Nonpayment/Zero charge Bill Type. See Appendix 7.4 - Type of Bill	As per NUBC guidance, type of bill must end in zero for total charges to be equal to zero.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3186	BILLTYPE	Type of bill (TOB)must match the record type. Edit 3186 will apply when either of these states is true: • The record is inpatient and TOB is NOT in the 110 – 121 range • The record is outpatient and TOB is in the 110-121 range	This is a new 2020 edit to avoid hospitals and ASCs pre-mapping or assigning records to a specific TOB without regard to what's on the claim.
3210	REVCODE	Revenue Code does not correspond to accepted values. The whole file will reject if revenue code is longer than 4 digits.  Transaction | Claim | Error 1 | 2 | Error on field REVCODE (loop 2400 SV201), maximum length 4, value = 0360A	Revenue codes are 4 digits and the leading zero, if applicable, must be present. Verify in UB-04.
3211	LVDAYS	At least one revenue record WITH a valid 018x revenue code must exist WHEN Leave Days is NOT 0 OR empty.	WHAIC assigns based on rev record detail.
3214	REVCODE	This revenue code cannot be submitted as a standalone record. 01/2018 **edit updated to avoid over-reporting of stand-alone ambulance claims.	Records that contain revenue codes 054X, 037X and 062X that are not accompanied by other revenue codes indicating a face-to-face encounter on the record will receive an edit.
3215	REVCODE	Revenue code cannot include professional charges. Professional Rev codes 096X - 098X excluded.	Delete line item, adjust the total charges if necessary.
3216	REVCODE	FASCs are not required to use revenue codes, if one is provided the acceptable range is: 0250, 0278, 0279, 0329, 036+, 0400, 0481, 049+, 0636, or 0750	Most FASC should be submitting data using the 837P which does not have a space for the revenue codes.
3220	HCPCSRATE	HCPCS/Rate Code must be accepted value or valid rate.	If code is valid, contact WHAIC and we will update table.
3225	HCPCSMOD1	HCPCS Modifier 1 does not correspond to accepted values.	Exclude Vendor, Internal or Payer Modifiers.
3226	HCPCSMOD2	HCPCS Modifier 2 does not correspond to accepted values.	Exclude Vendor, Internal or Payer Modifiers.
3227	HCPCSMOD3	HCPCS Modifier 3 does not correspond to accepted values.	Exclude Vendor, Internal or Payer Modifiers.
3228	HCPCSMOD4	HCPCS Modifier 4 does not correspond to accepted values.	Exclude Vendor, Internal or Payer Modifiers.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3230	DX	Additional Diagnosis does not correspond to accepted values, or code was deleted. Verify code in the ICD-10 CM	Verify code in the ICD-10 CM and adjust accordingly.
3235	HCPCSMOD1	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3236	HCPCSMOD2	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3237	HCPCSMOD3	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3238	HCPCSMOD4	Records for professional services are not acceptable.	Delete line item, adjust the total charges if necessary.
3240	PR	Additional Procedure does not correspond to accepted values, or code was deleted.	WHAIC assigns procedure codes based on revenue line item detail and the CPT/HCPCS surgery guidelines. If the code is valid, contact whaicinfocenter@wha.org to request a code review.
3245	PRMOD1	Additional Procedure Modifier 1 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3246	PRMOD2	Additional Procedure Modifier 2 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3247	PRMOD3	Additional Procedure Modifier 3 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3248	PRMOD4	Additional Procedure Modifier 4 does not correspond to accepted values.	Consult with current CPT or HCPCS Manual
3250	ETHN	Ethnicity does not correspond to accepted values.	See Appendix 7.1.2 Race and Ethnicity.
3340	CCODE1	Condition Code 1 does not correspond to accepted values	See NUBC Specifications

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3341	CCODE2	Condition Code 2 does not correspond to accepted values	See NUBC Specifications
3342	CCODE3	Condition Code 3 does not correspond to accepted values	See NUBC Specifications
3343	CCODE4	Condition Code 4 does not correspond to accepted values	See NUBC Specifications
3350	CCODE1	Condition Code 1 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3351	CCODE2	Condition Code 2 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3352	CCODE3	Condition Code 3 is a duplicate of another Condition Code	Delete one of the other duplicate CC
3360	CCODE1	Condition Code 1 must be populated first if other Condition Code exist	If Condition Code 1 is blank, but condition code 2 is populated, move Condition Code 2 value to Condition Code 1.
3361	CCODE2	Condition Code 2 cannot be blank if other Condition Code is not blank	
3362	CCODE3	Condition Code 3 cannot be blank if other Condition Code is not blank	
3775	SOPID	Must be accepted Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3785	SOPID2	Must be accepted Secondary Source of Payment ID and Type combination. See Appendix 7.3 Expected Source of Payment Mapping.	See Appendix 7.3 Expected Source of Payment Mapping.
3805	PRPMOD1	Principal Procedure Modifier 1 does not meet accepted values.	Verify modifier is CPT or HCPCS Manual
3806	PRPMOD2	Principal Procedure Modifier 2 does not meet accepted values.	Verify modifier is CPT or HCPCS Manual
3807	PRPMOD3	Principal Procedure Modifier 3 does not meet accepted values.	Verify modifier is CPT or HCPCS Manual
3808	PRPMOD4	Principal Procedure Modifier 4 does not correspond to accepted values.	Verify modifier is CPT or HCPCS Manual
3810	PRPMOD1	Principal Procedure Modifier 1 is a duplicate of another Principal Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.
3811	PRPMOD2	Principal Procedure Modifier 2 is a duplicate of another Principal Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3812	PRPMOD3	Principal Procedure Modifier 3 is a duplicate of another Principal Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.
3815	PRPMOD1	Principal Procedure Modifier 1 cannot be blank when a later Principal Procedure Modifier is not blank	Review records in revenue line item detail and move modifier to correct position.
3816	PRPMOD2	Principal Procedure Modifier 2 cannot be blank if other Modifier exist	Review records in revenue line item detail and move modifier to correct position.
3817	PRPMOD3	Principal Procedure Modifier 3 cannot be blank if other Modifier exist	Review records in revenue line item detail and move modifier to correct position.
3820	PRMOD1	Additional Procedure Modifier 1 is a duplicate of another Additional Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.
3821	PRMOD2	Additional Procedure Modifier 2 is a duplicate of another Additional Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.
3822	PRMOD3	Additional Procedure Modifier 3 is a duplicate of another Additional Procedure Modifier	Review records in revenue detail and refine modifiers to remove duplicate, if applicable.
3825	PRMOD1	Additional Procedure Modifier 1 cannot be blank when a later Additional Procedure Modifier is not blank	Review records in revenue line item detail and move modifier to correct position.
3826	PRMOD2	Additional Procedure Modifier 2 cannot be blank when a later Additional Procedure Modifier is not blank	Review records in revenue line item detail and move modifier to correct position.
3827	PRMOD1	Additional Procedure Modifier 3 cannot be blank when a later Additional Procedure Modifier is not blank	Review records in revenue line item detail and move modifier to correct position.
3830	HCPCSMOD1	HCPCS/CPT Modifier 1 is a duplicate of another Modifier	Delete duplicate or request over-ride.
3831	HCPCSMOD2	HCPCS/CPT Modifier 2 is a duplicate of another Modifier	Delete duplicate or request over-ride.
3832	HCPCSMOD3	HCPCS/CPT Modifier 3 is a duplicate of another Modifier	Delete duplicate or request over-ride.
3835	HCPCSMOD1	HCPCS/CPT Modifier 1 cannot be blank when other Modifier exist.	Move modifier to correct position.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
3836	HCPCSMOD2	HCPCS/CPT Modifier 2 cannot be blank when other Modifier exist.	Move modifier to correct position.
3837	HCPCSMOD3	HCPCS/CPT Modifier 3 cannot be blank when other Modifier exist	Move modifier to correct position.
3900	MARITALS	Marital Status does not correspond to accepted values. See Appendix 7.11 for acceptable codes or contact WHAIC to update our table.	This is not a required field, but if collected must match table in Appendix 7.11
3930	AUTOACD	Auto Accident State does not correspond to accepted values	This is a 2-digit value based on National State Abbreviations. http://www.50states.com/abbreviations.htm
3950	BLKGRP	Census Block Group - a 12-digit number. Field is created based on address and specification in 837 Companion Guide.	Value created by WHAIC after the file is submitted with the patient address.
4010	DDAT	Discharge Date outside boundaries for selected quarter. Delete the record and resubmit with the next quarter or request a caveat.	Applies to IP and ED only. It verifies the discharge date is within the correct quarter.
4020	SERVDATE	Service Date outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed). **For Emergency Department (ED) records:** Place of service (POS) assignment is based on the established hierarchy and use of revenue codes as defined in Appendix 7.5. In order to accommodate services that occur in the emergency department (ED) and the uniform billing rules, two new bypass edits for services rendered in the ED have been created. See explanation below. a. For hospitals that provide recurring specialty type services such as infusions or dialysis in the ED and the patient is also treated for a minor procedure or service during the course of the recurring visits in the ED: • WHAIC will bypass edits for recurring outpatient hospital records with multiple revenue line items for outpatient lab/radiology or other outpatient services and also has an ED	4020 applies to IP and ED only. It applies if any of these are true: • Revenue service date is after the discharge date • IP, and Revcode 030+, and servdate is more than 10 days prior to admit date • IP, and Revcode NOT 030+, and servdate is more than 3 days prior to admit date • ED, and servdate is more than 3 days prior to admit date

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
		visit that occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 rev code, a statement 'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. To clarify: 1. If the encounter/record has less than seven (7) days of service line items, the record is ED. 2. If the encounter/record has more than seven (7) days, the place of service will be determined by the OHO revenue codes. b. For hospitals that perform a minor outpatient surgery procedures such as a suture in the ED, the record will be counted and included in the ED record volume: • WHAIC will overlook revenue code 0361 (minor surgery) on an ED record as long as there is at least one revenue code of 0450, 0451, 0452, or 0459. This bypass edit allows the ED record take precedence over the outpatient surgery revenue code. **c. OHO DATA:** For all other hospital outpatient (OHO) data, the 0361 revenue line will not be used to set the place of service, unless it's the only revenue line on the record. *Defined in 12/2017 Newsletter*	
4025	SERVDATE	Service Date outside boundaries of Statement Period. Dates in revenue line item must match the statement from/through dates.	Applies to OHO only. It applies if the revenue service date is before the statement period from date, or after the statement period through date.
4030	PRPD	Principal Procedure Date occurs outside boundaries of the admission and discharge dates (72 hours prior to admission date is allowed).	Applies to inpatient, outpatient surgery or any other data type that has a principal procedure.
4035	SERVDATE	Service Date outside accepted date range. For outpatient surgery (OPS) records: 01/2018	4035 applies to OPS only. It applies if any of these are true:

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
		WHAIC cannot accommodate every scenario that might occur on any given claim or circumstance, however; in an effort 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. If there is an LT or RT modifier on any revenue line, then all revenue lines are allowed to have a service date up to 90 days after the principal procedure date. We 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. *Defined in 12/2017 Newsletter* New 2/18: PRE-OP visits that occur ***within 7 days*** of the outpatient surgery will not receive an edit.	• Revenue service date is more than seven (7) days before the principal procedure date • Revenue service date is more than ten days after the principal procedure date To correct the edit, adjust the date to meet the criteria. WHAIC does not include DOS in the data sets we release, so it's acceptable for the facility to adjust the dates on the record to accommodate the record and clear the edit.
4040	BDAT	Date of Birth exceeds human lifespan of 124 years.	Review MR, EMR or claim for accurate DOB.
4060	DXP	Principal Diagnosis contains a valid diagnosis code, but not a valid Principal diagnosis code.	Verify the ICD-10 CM dx code and make a swap of another code on the record according to the appropriate coding guidelines.
4070	DXA	Admitting Diagnosis contains a valid diagnosis code, but not a valid admitting diagnosis code.	Review the medical record/documentation for a new code.
4071	DXA	Admitting Diagnosis is not allowed for this patient type and cannot be submitted. Do not include admitting diagnosis on outpatient records.	Admitting diagnosis code is not allowed on outpatient records. Delete the code.
4400	PRPD	Principal Procedure Date outside boundaries for selected quarter.	Verify the date. If the DOS is for previous quarter, delete the record. If deleting more than 5 records, email WHAIC to caveat.
4405	PRPD	Principal Procedure date does not fall in Statement Period.	OPS records are defined by surgery date.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click “Update” in WIpop to clear edit
4410	PRPD	Principal Procedure Date cannot be before Birth Date.	
4480	DDAT	Discharge Date cannot be before Birth Date.	
4500	VALCODE1	Value Code 1 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4501	VALCODE2	Value Code 2 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4502	VALCODE3	Value Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4503	VALCODE4	Value Code 4 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4504	VALCODE1	Value Code 1 is a duplicate of another Value Code	
4505	VALCODE2	Value Code 2 is a duplicate of another Value Code	Review claim, EMR or consult NUBC.
4506	VALCODE3	Value Code 3 is a duplicate of another Value Code	Review claim, EMR or consult NUBC.
4507	VALCODE1	Value Code 1 cannot be blank when a later Value Code is not blank	Review claim, EMR or consult NUBC.
4508	VALCODE2	Value Code 2 cannot be blank when a later Value Code is not blank	Review claim, EMR or consult NUBC.
4509	VALCODE3	Value Code 3 cannot be blank when a later Value Code is not blank	Review claim, EMR or consult NUBC.
4510	VALAMT1	Value Code 1 Amount cannot be blank when Value Code 1 is not blank	Review claim, EMR or consult NUBC.
4511	VALAMT2	Value Code 2 Amount cannot be blank when Value Code 2 is not blank	Review claim, EMR or consult NUBC.
4512	VALAMT3	Value Code 3 Amount cannot be blank when Value Code 3 is not blank	Review claim, EMR or consult NUBC.
4513	VALAMT4	Value Code 4 Amount cannot be blank when Value Code 4 is not blank	Review claim, EMR or consult NUBC.
4514	VALAMT1	Value Code 1 Amount must be blank when Value Code 1 is blank	Review claim, EMR or consult NUBC.
4515	VALAMT2	Value Code 2 Amount must be blank when Value Code 2 is blank	Review claim, EMR or consult NUBC.
4516	VALAMT3	Value Code 3 Amount must be blank when Value Code 3 is blank	Review claim, EMR or consult NUBC.
4517	VALAMT4	Value Code 4 Amount must be blank when Value Code 4 is blank	Review claim, EMR or consult NUBC.
4600	OCC1	Occurrence Code 1 does not correspond to accepted values	Review claim, EMR or consult NUBC.

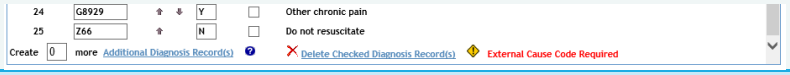
Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click “Update” in WIpop to clear edit
4601	OCC2	Occurrence Code 2 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4602	OCC3	Occurrence Code 3 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4603	OCC4	Occurrence Code 4 does not correspond to accepted values	Review claim, EMR or consult NUBC.
4604	OCC1	Occurrence Code 1 is a duplicate of another Occurrence Code	Review claim, EMR or consult NUBC.
4605	OCC2	Occurrence Code 2 is a duplicate of another Occurrence Code	Review claim, EMR or consult NUBC.
4606	OCC3	Occurrence Code 3 is a duplicate of another Occurrence Code	Review claim, EMR or consult NUBC.
4607	OCC1	Occurrence Code 1 cannot be blank when a later Occurrence Code is not blank	Review claim, EMR or consult NUBC.
4608	OCC2	Occurrence Code 2 cannot be blank when a later Occurrence Code is not blank	Review claim, EMR or consult NUBC.
4609	OCC3	Occurrence Code 3 cannot be blank when a later Occurrence Code is not blank	Review claim, EMR or consult NUBC.
4610	OCCSTART1	Occurrence Code 1 Start cannot be blank when Occurrence Code 1 is not blank	Review claim, EMR or consult NUBC.
4611	OCCSTART2	Occurrence Code 2 Start cannot be blank when Occurrence Code 2 is not blank	Review claim, EMR or consult NUBC.
4612	OCCSTART3	Occurrence Code 3 Start cannot be blank when Occurrence Code 3 is not blank	Review claim, EMR or consult NUBC.
4613	OCCSTART4	Occurrence Code 4 Start cannot be blank when Occurrence Code 4 is not blank	Review claim, EMR or consult NUBC.
4614	OCCSTART1	Occurrence Code 1 Start must be blank when Occurrence Code 1 is blank	Review claim, EMR or consult NUBC.
4615	OCCSTART2	Occurrence Code 2 Start must be blank when Occurrence Code 2 is blank	Review claim, EMR or consult NUBC.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
4616	OCCSTART3	Occurrence Code 3 Start must be blank when Occurrence Code 3 is blank	Review claim, EMR or consult NUBC.
4617	OCCSTART4	Occurrence Code 4 Start must be blank when Occurrence Code 4 is blank	Review claim, EMR or consult NUBC.
4618	OCCEND1	Occurrence Code 1 End must be blank when Occurrence Code 1 Start is blank	Review claim, EMR or consult NUBC.
4619	OCCEND2	Occurrence Code 2 End must be blank when Occurrence Code 2 Start is blank	
4620	OCCEND3	Occurrence Code 3 End must be blank when Occurrence Code 3 Start is blank	
4621	OCCEND4	Occurrence Code 4 End must be blank when Occurrence Code 4 Start is blank	
4650	OCCSTART1	Occurrence Code 1 Start does not correspond to a valid date (mmddyyyy)	
4651	OCCSTART2	Occurrence Code 2 Start does not correspond to a valid date (mmddyyyy)	
4652	OCCSTART3	Occurrence Code 3 Start does not correspond to a valid date (mmddyyyy)	
4653	OCCSTART4	Occurrence Code 4 Start does not correspond to a valid date (mmddyyyy)	
4654	OCCEND1	Occurrence Code 1 End does not correspond to a valid date (mmddyyyy)	
4655	OCCEND2	Occurrence Code 2 End does not correspond to a valid date (mmddyyyy)	

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click “Update” in WIpop to clear edit
4656	OCCEND3	Occurrence Code 3 End does not correspond to a valid date (mmddyyyy)	
4657	OCCEND4	Occurrence Code 4 End does not correspond to a valid date (mmddyyyy)	
4658	OCCEND1	Occurrence Code 1 End cannot be before Occurrence Code 1 Start	
4659	OCCEND2	Occurrence Code 2 End cannot be before Occurrence Code 2 Start	
4660	OCCEND3	Occurrence Code 3 End cannot be before Occurrence Code 3 Start	
4661	OCCEND4	Occurrence Code 4 End cannot be before Occurrence Code 4 Start	
5010	ADAT	Admission Date must be equal to Birth Date when Principal Diagnosis is 'Z38' with a fourth digit of 0, 3 or 6.	Newborn baby born inside a hospital
5020	ADAT	Admission Date can be no more than two days after Birth Date when Principal Diagnosis is 'Z38' with the fourth digit NOT 0, 3 or 6..	Means baby was born outside of hospital and was later admitted.
5030	PRP	Principal Procedure is gender specific and does not match Gender specified. This requires a 45 in Condition Code field or contact WHAIC to do a manual override.	Add condition code 45 to one of the four condition code fields to bypass the edit.
5050	DDAT	Discharge Date cannot occur before Admission Date.	Verify Dates of Service
5070	BDAT	Date of Birth must be less than or equal to the Admission Date.	
5120	DX	Additional Diagnosis is a duplicate of Principal Diagnosis. Verify if the procedure was performed twice.	Verify procedure performed twice. Review revenue code details and the additional procedures. Delete extra code.
5151	DXP	Code first rule specifies that diagnosis xxx must be sequenced before diagnosis yyy	Review coding guidelines and/or EMR.
5166	DX	Additional Diagnosis requires a corresponding Primary or Additional Diagnosis which was not found	Review medical record to determine all codes submitted are on record.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click “Update” in WIpop to clear edit
5167	DXP	Principal Diagnosis requires a corresponding Additional Diagnosis which was not found	
5180	TC	The sum of all Revenue Charges must equal the Total Charge.	The totals in the revenue line item detail must match the totals in Section 2. Total Charges.
5191	ADMS	Source of Admission must be '5', or '6' if the Type of Admission equals '4' (newborn).	
5210	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '1' and Point of Origin equals 6.	
5240	DXP	Principal Diagnosis is gender specific and does not match the Gender specified.	Contact WHAIC to do an over-ride if needed.
5250	DXA	Admitting Diagnosis is gender specific and does not match the Gender specified.	Review Medical Record.
5255	ADMT	Admit Type must equal '4' when Age Days is calculated as less than one day.	
5256	ADMT	Admit Type cannot equal '4' (newborn) for this type of patient record.	
5257	ADMT	Admit Type cannot equal '4' (newborn) if Age in Days is calculated as greater than '0' and Point of Origin equals 5.	
5258	ADMT	Admit Type must be 5 when 068x revenue code in on the record.	
5260	DX	Additional Diagnosis is gender specific and does not match the Gender specified.	Add Condition Code 45 to over-ride edit.
5270	DXRV1	Reason for Visit 1 is gender specific and does not match the Gender specified.	Add Condition Code 45 to over-ride edit.
5271	DXRV2	Reason for Visit 2 is gender specific and does not match the Gender specified.	Add Condition Code 45 to over-ride edit.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click "Update" in WIpop to clear edit
5272	DXRV3	Reason for Visit 3 is gender specific and does not match the Gender specified.	Add Condition Code 45 to over-ride edit.
5305	REVRECORD	At least one revenue record is required.	Review claim and add details to record.
5310	DX	Duplicate Additional Diagnosis codes are not allowed.	
5312	DX_POA	Diagnosis Present on Admission is exempt from the reported Diagnosis and cannot be submitted.	See WHAIC website – coding guidelines
5313	DX_POA	Diagnosis Present on Admission is not allowed on this patient type.	Only allowed on inpatient records.
5314	DX_POA	Diagnosis Present on Admission does not correspond to accepted values.	Only values are Y, N, W, U and blank if exempt from reporting.
5315	DX_POA	Diagnosis Present on Admission is a required field. Correct values are Y, N, W, U and blank if not required.	Review MR
5330	PRP	Principal Procedure is age specific and does not match Date of Birth specified.	Review medical record to verify codes
5340	PR	Additional Procedure is age specific and does not match Date of Birth.	Review MR and code and update record accordingly.
5355	PR	This code does not meet the WHAIC definition of supplemental, invasive or exploratory procedure. This edit fires when the code starts with A, B, E, J or 8, or if the code is in the 992 range, or if the code is in the 00 – 01 range and does not end with a letter.	Do not use Evaluation and Management Codes, pathology, simple blood draws 36415, supply codes, DME codes, etc.
5360	PR	Additional Procedure is gender specific and does not match the Gender specified.	Verify in medical record or contact WHAIC to over-ride edit.
5370	DX	Diagnosis codes in the S-T range, w/some exceptions require an external cause dx code in the V through Y range.	At least one external cause code must be specified when a diagnosis exists between S00-T14, T20-T35 or T69.

Edit Number ID	Edit Code	Record Edit/Validation Code Description Click on Diamond to see edit	Notes and fixing edits Click “Update” in WIpop to clear edit
			
5390	HCPCSRATE	This revenue code requires a HCPCS or CPT code. See Appendix 7.6 - Coding Guidelines for more information or the UB-04 Manual.	Most outpatient revenue codes require a corresponding CPT/HCPCS code defining what was performed or provided.
5400	PBLID	Provider-based Location ID does not correspond to accepted values.	Contact WHAIC to update the PBL Table
6040	SERVCODE	Place of Service cannot be specified for this type of patient record.	INP records do not require a place of service.
8500	PROVID	Provider NPI is a required field and must be valid.	Contact `WHA with any questions.

7.8 WIpop Roles and Registration

To use the secured WHAIC portal to submit, correct or complete discharge data, **all users must register with their own Username and Password.** WHAIC will de-activate all unused accounts after a specific period. Contact **whainfocenter@wha.org** to reactivate an account.

WIpop Roles – are designations assigned by the facility to manage and oversee the statutorily required and timely data submissions and corrections to the quarterly inpatient and outpatient data.

- *Users that need to **add newly acquired sites to perform edits or submit data** to their account once registered and approved must contact WHAIC to add or update facility listing.*

To register, open site **https://portal.whainfocenter.com** in your web browser and **click "Register"**. Keep reading for more information on roles and details on "how to register".

Once user registers, WHAIC will receive an email to review and approve for specific access requested. If a specific role of primary or secondary is not defined, user will be given the most basic user access. Primary contact will be notified of new users.

WIpop Primary contacts will receive notification of all newly registered WIpop users. The WIpop site is for authorized users only. Registered users agree use of WIpop and Secure Portal system without authority, or in excess of your authority, is strictly prohibited.

The Primary Contact will:

- Oversee and monitor access requirements in WIpop and contact WHAIC with changes.
- Serve as primary contact to address issues with the data or timely submission/training.
- Receive confirmation emails of:
  - data submissions,
  - notice of affirmation, and
  - newly registered WIpop Users
- Have access to the data deliverables site to download/share the facility data.
- Receive all profile and validation reports for review, distribution, and accuracy.
- Have access to the Provider Based Location (PBL) table *if applicable.
- Receive/review the Present on Admission (POA) report *if applicable.
- Authority (granted / delegated) to electronically sign and submit affirmation statement.

Secondary Contact will:

- Oversee and monitor access requirements in WIpop and contact WHAIC with changes
- Receive all profile and validation reports for review, distribution, and accuracy.
- Have access to the data deliverables site to validate/download the facility data; and
- Serve as back up contact when there are issues with the data.

WIpop Only Role will:

- Have authority to upload data.
- Run reports out of WIpop; and
- Clear/fix edits.

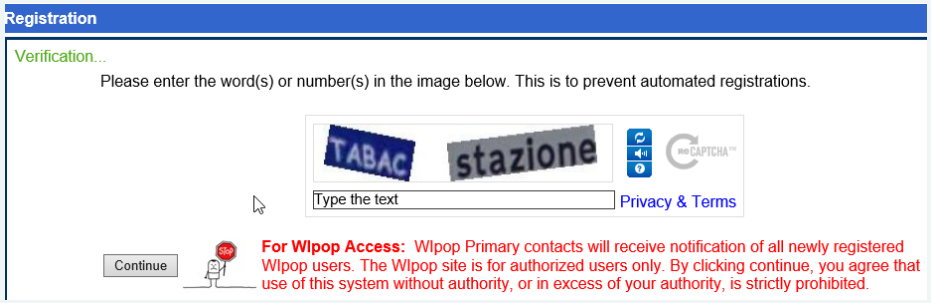
To Register to WIpop

*WHAIC **cannot add users** to WIpop. All users must register through the secured WIpop portal site.

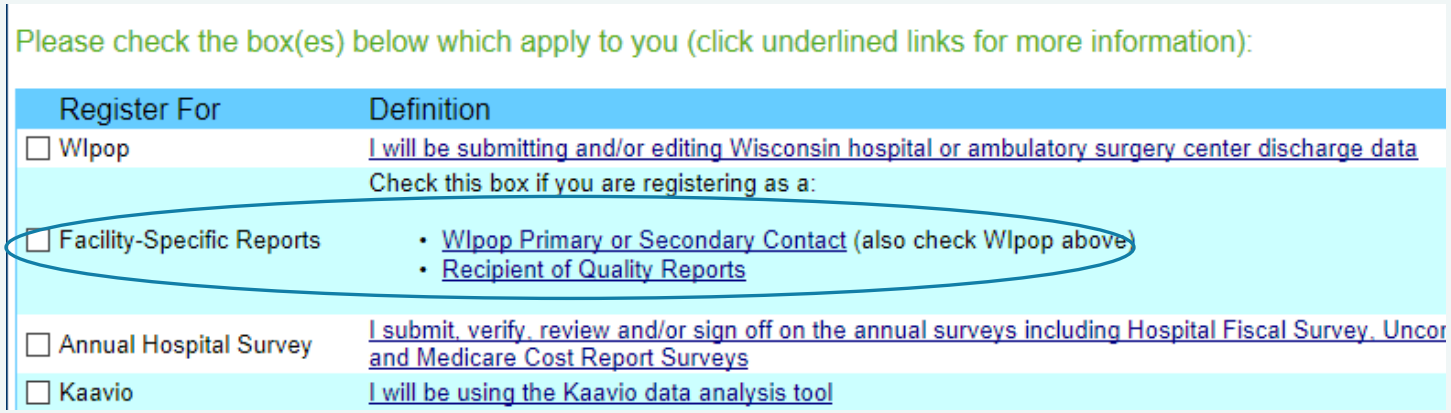
To register, open site **https://portal.whainfocenter.com** in your web browser and click "Register":

Contact whainfocenter@wha.org to reactivate an account.

A prompted phrase will display on the screen to defeat automated registrations.

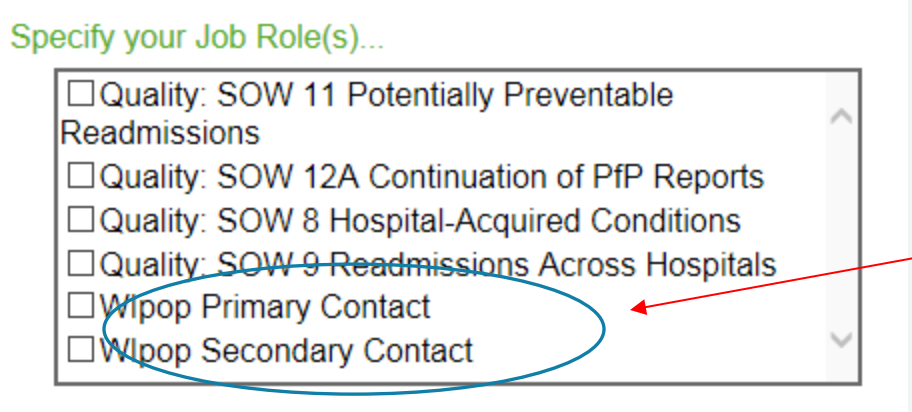


Register for WIpop: Choose either "WIpop" or select "Facility-Specific Reports" for a Primary or Secondary User Role. Primary or secondary contacts must select both the WIpop and Facility-Specific boxes.



*User access can be upgraded / downgraded anytime, primary contact emails WHAIC whainfocenter@wha.org with instructions.

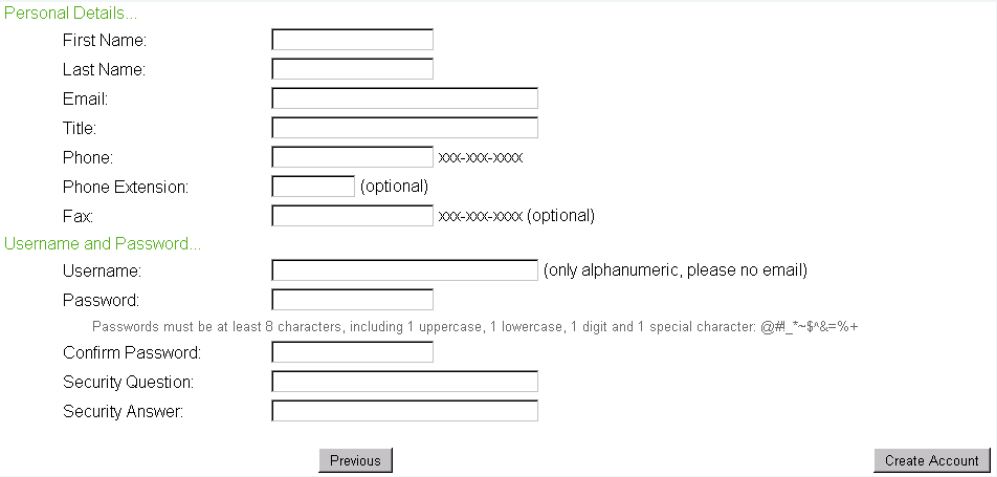
4) If you **checked "Facility – Specific Reports" this applies to you.** Scroll through the list of job roles and pick the most appropriate role for your access. A list of facilities will be presented. Check the facility(s) for which you submit or correct data and click Next:



Choose either Primary or Secondary Contact

Click **Description of Job Roles** for more information.

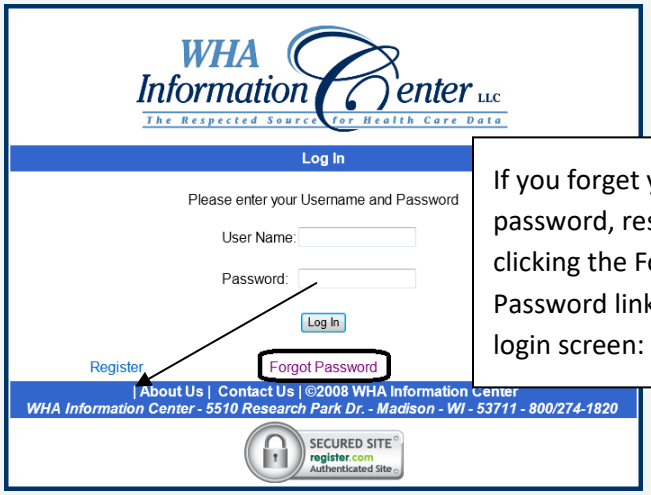
5) Finally, you will be asked to complete the Registration Details and then press Create Account:



Once the account has been activated an auto-generated email is sent with the permissions assigned to the user and the primary contact. If you do not receive a response from WHAIC within 5 days, contact us for further follow up.

WHAIC will de-activate Primary and Secondary accounts after a specific period. Contact **whainfocenter@wha.org** to reactivate an account.

Forgotten Passwords



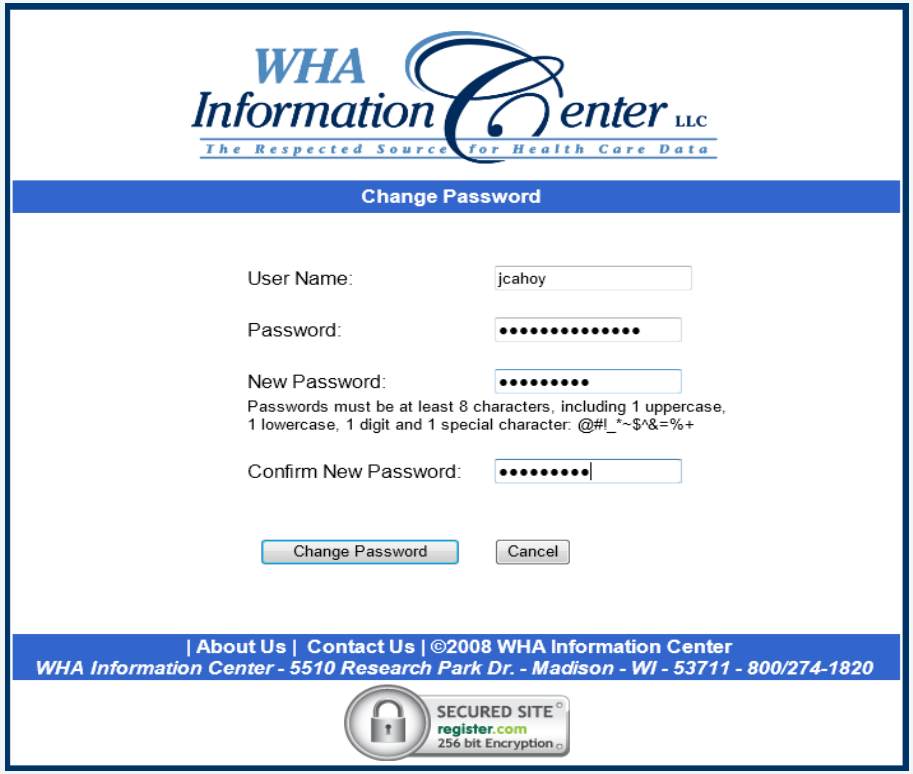
If you forget your password, reset it by clicking the Forgot Password link on the login screen:

You will be asked to enter your User Name:

You will then be prompted to answer the security question you specified when you first registered. Enter this value and click Submit:

The system will change your password and then email your new password to you.

You will probably want to change this system-generated password, which is done on the Change Password screen.



Enter your current password and specify a new password. The new password must conform to the rules indicated on the page.

All Passwords expire annually. Users will be prompted to change it at that time.

Contact **whainfocenter@wha.org** to reactivate an account.

7.9 837 Interface/Black Box UCID/ECID - De-identification of Name

WHAIC does not have the authority to collect patient name, social security number or any other patient related identifier. Data submitted with these patient identifiers will be rejected. Facilities are required to map the patient's name to an encrypted source code and remove the SSN from the 837 file. Since patient names are not accepted the 837 file spec should be followed accordingly:

Send "NULL". NM104 – NM107 must be blank.

For facilities using the WHAIC 837 Interface/black box.

C. 837 File Handler/Black Box
- ECID and UCID Options
- 837 File Handler program, also known as the **"black box**"

Black box program and instructions from http://www.whainfocenter.com/WHAInfoCenter/media/DataSubmitters/WHAIC_837_Handler.zip

- Create your own program to generate the ECID and UCID. The UCID employs a name standardization algorithm (New York State Identification and Intelligence System) and then hashes the result to produce a 64-character ID.

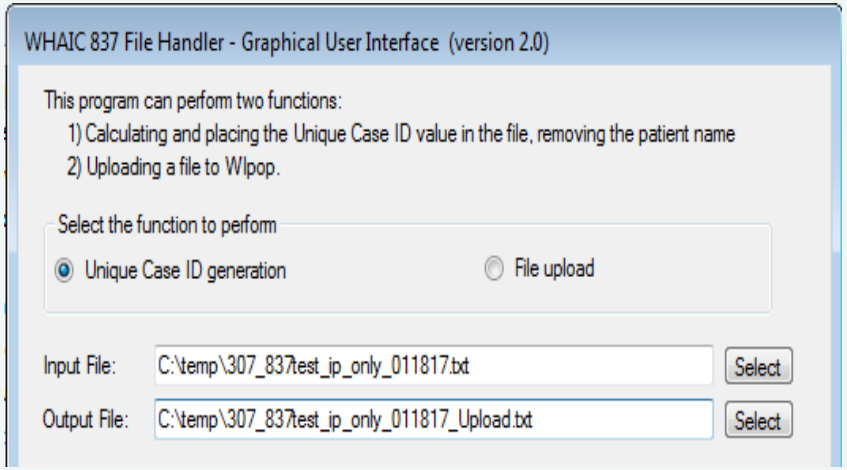
Either method requires compliance with the specifications as defined by WHAIC

D. 837 File Handler / Black Box Functions

Function 1: Using the patient's name, birth date and sex, the program will calculate and add the ECID and UCID to the 837 and remove the patient name.

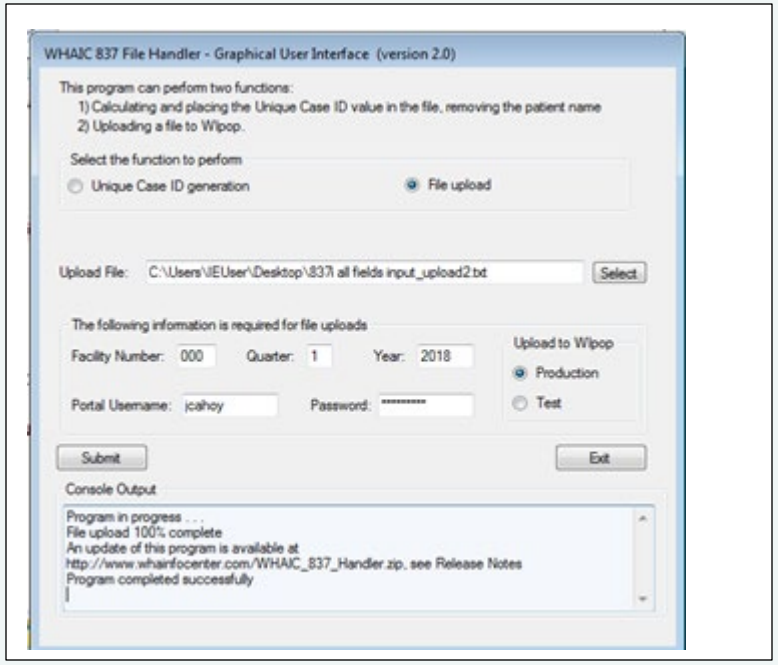
Function 2: Transfer a file directly to WIpop, bypassing the need to upload the file using a browser.

- The program has a Windows installer and a graphical user interface end for ease of use. The GUI calls and passes parameters to a Windows console program, which performs the processing.
- The console program can be executed directly from automated batch processes.



Create the UCID / ECID

User may then submit file directly from the 837 File Handler



E. Black Box UCID Generation

Here is a sample 2010BA subscriber loop in the input file:

Name replaced with NULL, UCID plus ECID replaces member ID in NM109

SY = Social Security Number, also set to NULL

NM1*IL*1*SMITH*JANE****MI*4444444~

N3*236 N MAIN ST~

N4*MADISON*WI*53717~

DMG*D8*19600501*F*M*5:2~

REF*SY*123445678

The output file will instead contain:

NM1*IL*1*NULL*****MI*732A00AAA61B62DECB3133CA33DA93C2FFF123A1D7F77FEB2935B789D72D3F24-S530J~

N3*236 N MAIN ST~

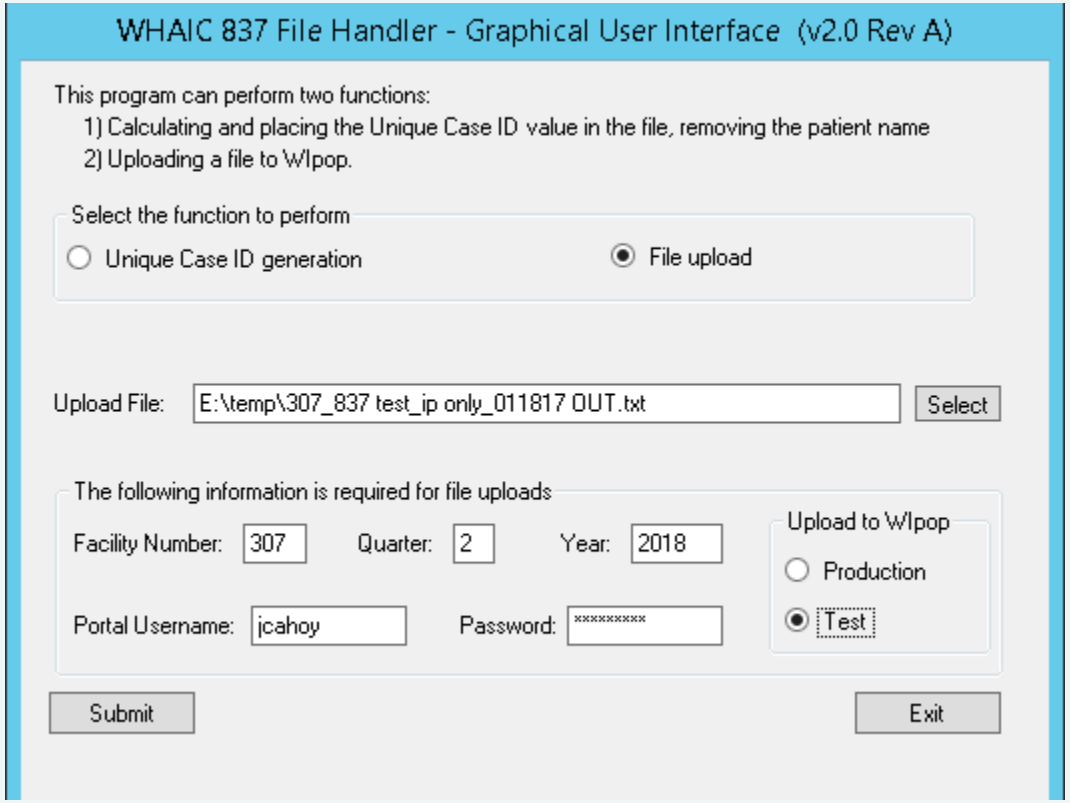
N4*MADISON*WI*53717~

DMG*D8*19600501*F*M*5:2~

REF*SY*NULL~

F. Black Box File Transfer

RECAP: Once you have your output file, you can submit it directly to WIpop using this same program. You just need to submit your WIpop login credentials, as well as the facility and quarter to which this file applies. As with current WIpop batches, an 837 upload must contain data for only one facility and quarter.



Many ASCs prefer to upload their batch from the 837 File Handler to save on a few steps.

7.10 Data Dictionary (see main hospital manual)

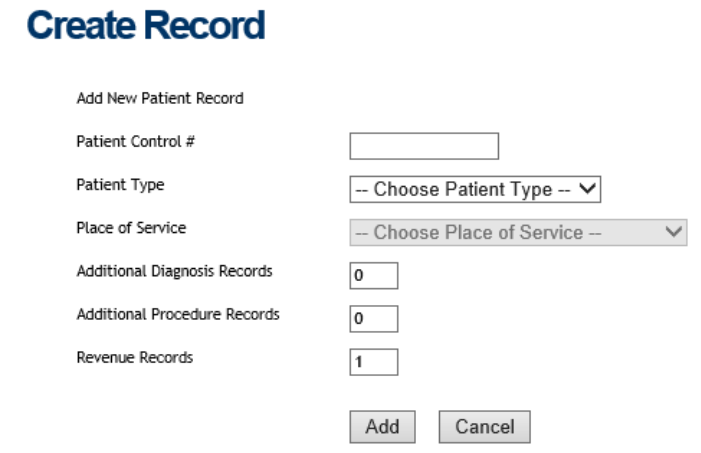
Reference the Main Hospital Manual for more information on the fields and definitions. The 837 Data Dictionary is intended to provide an explanation/description for each of the fields located in WIpop and applies to both hospitals and ASCs.

7.11 Manual Data Entry Instructions

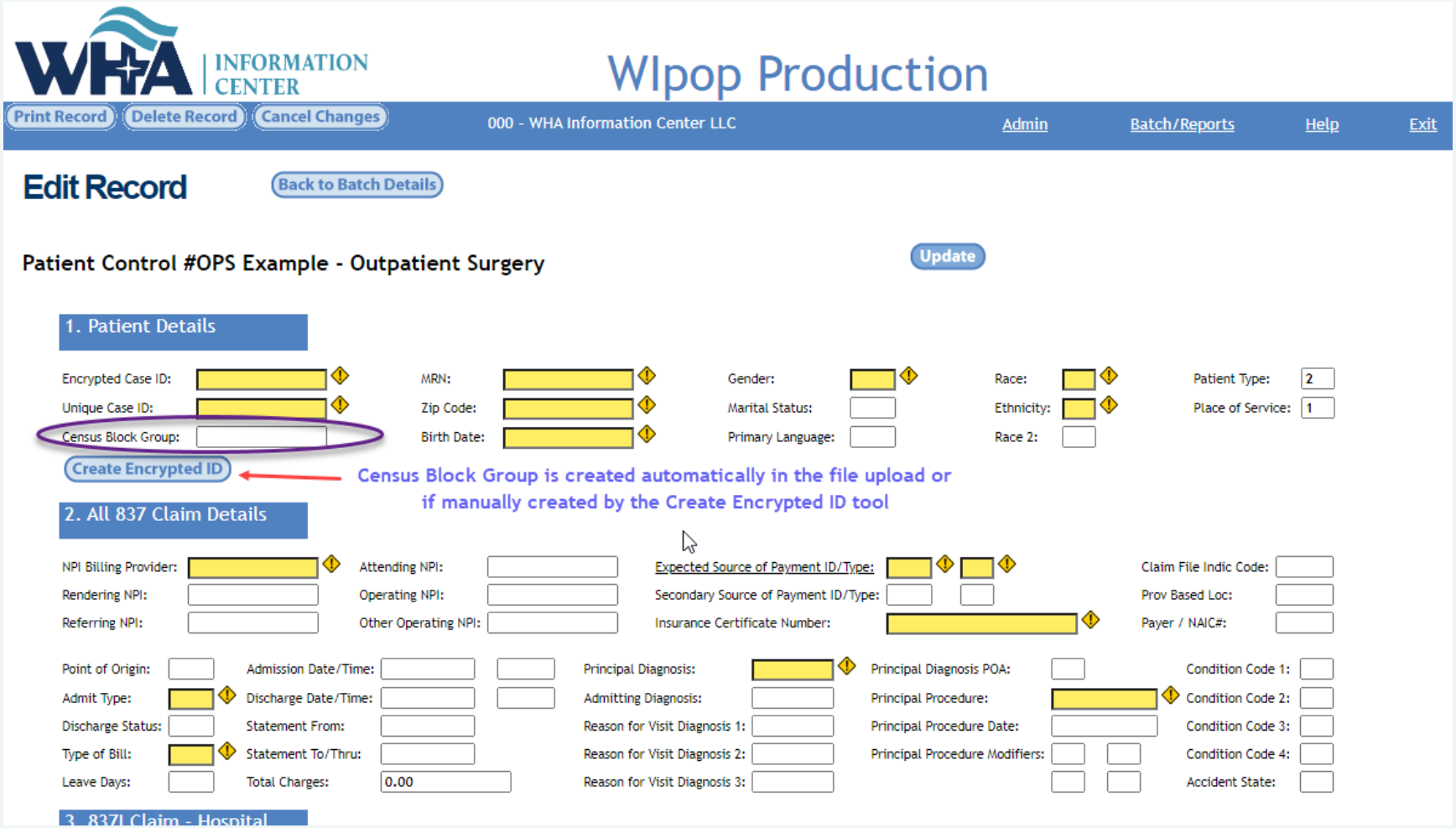
Click update in the record to begin, this highlights MOST of the required fields

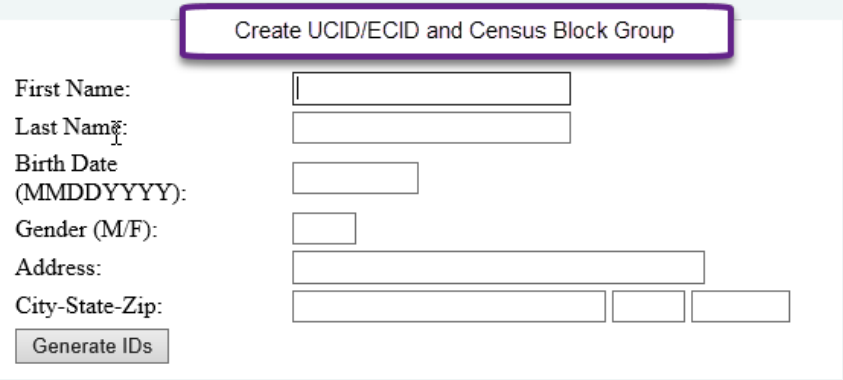
See Data Dictionary for field information and details

Data Element	Instructions to create a record and do manual data entry in WIpop
Patient Control Number	Patient's unique alphanumeric number assigned by the facility to facilitate retrieval of individual financial records and posting of the payment. Up to 24 digits allowed.
Type of Encounter	Identifies the status of the patient (inpatient or outpatient) at the time of discharge. **FASCs will always choose 'outpatient'.**
Place of Service	FASCs will always enter '1'.
Number of Additional Diagnoses Records	Number of diagnosis codes to be entered in the revenue record. Unlimited number allowed.
Number of Additional Procedure Records	Number of procedure codes to be entered in the procedure record. Unlimited number allowed.
Number of Additional Revenue Records	Number of revenue codes to be entered in the revenue record. Unlimited number allowed.



Click update in the record to begin, this highlights MOST of the required fields


INFORMATION CENTER
WIpop Production
Print Record
Delete Record
Cancel Changes
000 - WHA Information Center LLC
Admin
Batch/Reports
Help
Exit
Edit Record
Back to Batch Details
Patient Control #OPS Example - Outpatient Surgery
Update
1. Patient Details
Encrypted Case ID:
Unique Case ID:
Census Block Group:
MRN:
Zip Code:
Birth Date:
Gender:
Marital Status:
Primary Language:
Race:
Ethnicity:
Race 2:
Patient Type: 2
Place of Service: 1
Create Encrypted ID
Census Block Group is created automatically in the file upload or if manually created by the Create Encrypted ID tool
2. All 837 Claim Details
NPI Billing Provider:
Rendering NPI:
Referring NPI:
Attending NPI:
Operating NPI:
Other Operating NPI:
Expected Source of Payment ID/Type:
Secondary Source of Payment ID/Type:
Insurance Certificate Number:
Claim File Indic Code:
Prov Based Loc:
Payer / NAIC#:
Point of Origin:
Admit Type:
Discharge Status:
Type of Bill:
Leave Days:
Admission Date/Time:
Discharge Date/Time:
Statement From:
Statement To/Thru:
Total Charges: 0.00
Principal Diagnosis:
Admitting Diagnosis:
Reason for Visit Diagnosis 1:
Reason for Visit Diagnosis 2:
Reason for Visit Diagnosis 3:
Principal Diagnosis POA:
Principal Procedure:
Principal Procedure Date:
Principal Procedure Modifiers:
Condition Code 1:
Condition Code 2:
Condition Code 3:
Condition Code 4:
Accident State:
3. 837I Claim - Hospital



Patient Detail and Claim Information	
MRN: Medical Record Number	The unique number assigned to each patient by the facility that distinguishes the patient and their medical record from all other patients.
Insurance Cert #	Patient insurance number assigned by the payer organization. The primary payer insurance ID / Member number or group policy number is recorded. Leave blank for self-pay.
Birth Date	The patient's month, day, and year of birth (mmddyyyy).
Gender	F = Female M = Male *Gender may be U if patient has an ambiguous gender or is transgender. Condition Code 45 must be used in any Condition Code field to override edit in WIpop.*
Marital Status	Optional – populate if collected – see Appendix 7.14 for codes.
Race	See **7.2** for the appropriate one-digit code.

Patient Detail and Claim Information	
Race 2 (optional)	If patient identified two races, enter the first chosen in race 1, followed by race 2 code.
Ethnicity	See 7.2 for the appropriate one-digit code.
ZIP Code	The five-digit code assigned by the US Postal Service. The field should be zero-filled ('00000') for a person with an address that does not include a valid US ZIP code. If the ZIP code is unknown, such as for homeless patients, this field should be left blank and populate a Condition Code with '17'.
Encrypted Case ID	An encrypted code based on the patient's last name and initial of first name. The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient. Once you click the generate ECID the data of birth and the gender of the patient automatically populates in the HTML page.
Unique Case ID	The case ID generator automatically assigns the code. It is designed to help protect the confidentiality of the patient. Once you click the generate ECID the data of birth and the gender of the patient automatically populates in the HTML page.
Admit Date/Time	Not required for FASCs.
Point of Origin	Not required for FASCs.
Admit Type	Not required for FASCs.
Principal Diagnosis	The ICD-10-CM diagnosis code describing the condition established after study to be chiefly responsible for the services provided during the visit. *Do not enter decimals.*

Patient Detail and Claim Information	
Present on Admission (POA) Indicator	Not applicable for FASCs.
Discharge Status	Not required for FASCs.
Admitting Diagnosis	Not required for FASCs.
Reason for Visit 1	Not required for FASCs.
Reason for Visit 2	Not required for FASCs.
Reason for Visit 3	Not required for FASCs.
Leave Days	Not applicable for FASCs.
Discharge Date / Time	Not required for FASCs.
Attending Provider NPI	Not required for FASCs.
Rendering NPI	Provide if available
Referring NPI	Provide if available
Operating Provider NPI 1	The NPI number of the operating provider who performed the principal procedure.
Other provider NPI 2	The NPI number of the second procedure provider that participated in procedure.

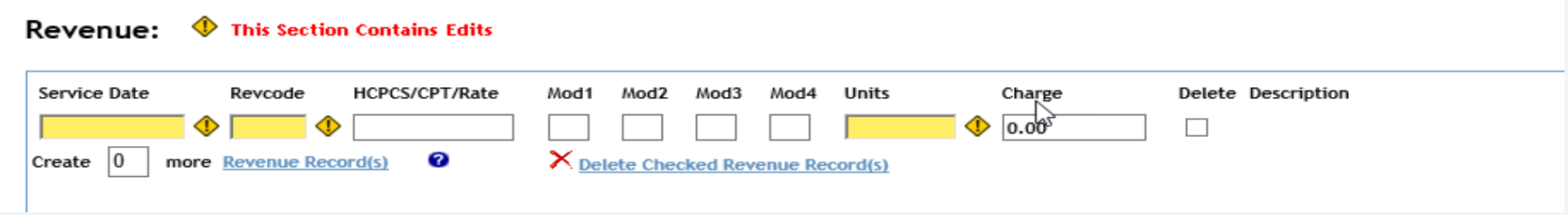
Patient Detail and Claim Information	
Principal Procedure Date	Record the month, day and year the principal procedure was performed. (mmddyyyy).
Principal Procedure	The CPT procedure most related to the principal diagnosis performed during the episode of care.
Modifier 1 -4	CPT or HCPCS Level II modifiers. Enter if available in the 4 modifier fields as appropriate. The modifier that has the most impact on payment should be entered in the Modifier 1 field.
Expected Source of Payment (SOP) ID	The first three characters from the primary payer code. See Appendix 7.3 for appropriate codes. Example MED or T19 for Medicare.
Expected Source of Payment (SOP) Type	The fourth and fifth characters of the payer code. See Appendix 7.3 for appropriate codes. Example a 2 digit code **'01'** if Medicaid fee for service or non HMO or '41' for Work comp.
Secondary SOP ID	The first three characters from the secondary payer code when there is a secondary payer. See above.
Secondary SOP Type	The fourth and fifth characters of the secondary payer code. See above.
NPI Billing Provider	National Provider ID (NPI) number of billing provider – Facility Billing NPI number.
Type of Bill	A code indicating the specific type of bill. Please see Appendix 7.4 for appropriate codes. Typically FASCs use Code '999' because the type of bill code is not supplied on the HCFA 1500.
Total Charges	Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. Assumed to be positive. Field = ('0.00') if no charges.

Patient Detail and Claim Information	
Statement Covers From	Not required for FASCs.
Statement Covers Through	Not required for FASCs.
Condition Code 1 - 4	**Code '17'** should be entered for all inpatient and outpatient cases where a patient is homeless at the date of service when there is an unknown ZIP code. Remaining condition codes apply to hospitals. **Condition Code 45** should be used for gender unknown.

Additional Diagnosis (Dx) Record and External Cause Codes	
ICD-10 Code	The ICD-10-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis (include External Cause Codes). Add line items as appropriate.
POA - Additional Dx	Only applies to Inpatient Records - Not applicable for FASCs.

Additional Procedure Record	
Additional Procedure Code	The CPT or HCPCS codes corresponding to additional procedures in addition to the principal procedure listed on the Primary Record, that were performed during the episode of care. Unlimited number allowed.
Modifier 1 - 4	CPT or HCPCS Level II modifiers recorded on claim/record. The modifier that has the most impact on payment should be entered in the Modifier 1 field.

Additional Procedure Record	
Procedure Date	Date the secondary or additional procedure was performed.



Revenue Record detail required	
Service Date	Record the month, day, and year that the outpatient service was provided. Format = (mmddyyyy).
Revenue Code	Not required for FASCs if using the 837P or direct data entry.
CPT/HCPCS/Rate	HCPCS/CPT Level I and II codes applicable to the service provided.
Modifier 1 - 4	CPT or HCPCS modifiers that affect payment most should be entered in the Modifier 1 field.
Units	The value defined as a positive number '**a minimum of '1'** regardless if the charge is zero or greater than zero.
Charge	Total charges related to the HCPCS/CPT code or rate recorded on a specific line.

7.12 Marital Status Codes

Collection of Marital Status is SITUATIONAL or Optional to provide support for facilities that collect this information. WHAIC will collect this field but we do not have plans at this time to include it in any of our publications.

2010BA	DMG04	Subscriber Marital Status Code	O	Loop 2010BA, NM101 = IL Loop 2010BA, NM102 = 1	Marital Status optional field, supply if collected.
2010CA	DMG04	Patient Marital Status Code	O	Loop 2010CA, NM101 = QC Loop 2010CA, NM102 = 1	Marital Status optional field, supply if collected.

Situational/*Optional field in the 837 file, submit if collected. See Section 5.4 and 5.5 of Companion Guide*

Code	Display	Definition
A	Common Law	
B	Domestic Partner	Person declares that a domestic partner relationship exists.
C	Not Applicable	Child
D	Divorced	Marriage contract has been declared dissolved and inactive.
I	Single	Currently not in a marriage contract.
K	Unknown	Details cannot be obtained.
M	Married	A current marriage contract is active.
R	Unreported	Question not answered.
S	Separated	Separated
U	Unmarried	Single, Divorced or Widowed
W	Widowed	Spouse has died.
X	Legally Separated	Legally Separated

*Details and values in table are taken from ASC X12N - Insurance Subcommittee and AHRQ – Agency for Healthcare Research and Quality

7.13 Terms, Acronyms, and Definitions

Affirmation Statement	A document that when electronically signed and submitted by an authorized representative of the facility, it affirms, to the best of the signer's knowledge, all data submitted are complete and accurate. The primary contact must access the Affirmations Statement from the Data Deliverables / Affirmations tab through the Portal.
Caveat	If data errors are discovered after the validation period closes or WHAIC releases the data the facility may notify WHAIC of data errors to be documented in future datasets.
Data Profile	A summary of all submitted data and a summary of the number of records received by WHAIC from a facility.
Data Type	Inpatient, Outpatient, Outpatient Surgery, Observation, Emergency Room.
Enhanced Ambulatory Patient Groupings (EAPG)	Enhanced Ambulatory Patient Groups (EAPGs) is a visit- based patient classification system used to organize and pay services with similar resource consumption across multiple settings.
Emergency Department (ED)	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such cardiac arrests. The emergency department is also called the emergency room or ER.
Inpatient	A patient is admitted to a room for an overnight stay or for numerous days with continuous general nursing services in an area of an acute care facility. Examples of treatment areas for admission: ICU, Labor and Delivery, Cardiology Units or General Medicine Units.
Medicare Advantage	The definition by Medicare.Gov is that it's a plan that beneficiaries can collect Medicare benefits through private insurance companies approved by and under contract with Medicare

Non-OHO	A term used by WHAIC to represent data types for patients in the hospital setting: Inpatient, Emergency Room, Outpatient Surgery and Observation encounters.
Observation	*Observation status* is an administrative classification of patients seen and/or treated in a hospital setting who have unstable or uncertain conditions potentially serious enough to warrant close observation, but usually not so serious to warrant admission to the hospital. These patients may be placed in beds usually for less than 24 hours without formal admission to the hospital. These hospital patients are neither inpatient nor outpatient. Patients are placed in a hospital bed (often in an inpatient unit) after displaying signs or symptoms that require additional medical work up or evaluation in order to provide a more definitive diagnosis—but do not need the level of services provided in an inpatient setting. Observation stays are usually limited to 24 hours then the physician must determine whether patients' condition warrants an inpatient admission or discharge.
Ordering Physician	A physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service. The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. • Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.
Other Hospital Outpatient Data (OHO)	Also known as OHO. Records that do not fall in the category of inpatient, outpatient surgery, observation or ER. These records have associated revenue codes and distinct place of services based on the location or service.

Outpatient	A patient that receives a diagnosis and/or treatment at a hospital but does not stay overnight. Examples of treatment in this environment: observation care, emergency department, clinic, radiology or laboratory service.
Outpatient Surgery	This term is also referred to as ambulatory surgery, same-day surgery or day surgery in which patients have a surgical procedure that does not require an overnight hospital stay. Outpatient surgery can be a distinct unit within a hospital or a freestanding ambulatory surgery facility.
Patient	The person is receiving health care services. The term patient in this guide is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In Loop ID-2000C, the patient is not the same person as the subscriber, and the patient is a person (for example, spouse, children, others) who is covered by the subscriber's insurance plan and does not have a unique member identification number. However, the patient receiving services can be the same person as the subscriber. In that case, all information about that person is carried in the Subscriber loop (Loop ID-2000B).
POS (Place of Service)	The location of where a service is rendered to a patient. Patients can be inpatient or outpatient and based on revenue code and the hierarchy in the WIpop manual, WHAIC will assign the location.
Primary Record	Demographic and patient claim details of services rendered and by whom.
Rendering Provider	If the practitioner **rendering** the service is part of a billing group (even two people), report the individual practitioner's National **Provider** Identifier (NPI) in the **Rendering Physician** # area (2310B loop, segments NM108 [XX] and NM109 [NPI], of the 837P electronic claim or Item 24J of the CMS-1500 paper claim form).
Reference Lab	Any lab performing clinical laboratory diagnostic tests (or the interpretation /report of such tests, or both) without a face-to-face encounter between the individual and the lab billing for the test and/or interpretation/report.

Referring physician	A **referring physician** is a **physician** who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering physicians is defined as a **physician** or when appropriate a non-**physician** practitioner who orders services for the patient.
Revenue Record	This is unique to the WIpop system. Revenue Center codes, HCPCS/CPT/HIPPS Rates, number of units and total charges.
Service Provider	In many instances the Service Provider is an organization; therefore, the Service Provider NPI reported would belong to an organization health care provider. The Service Provider may be an individual only when the services were performed by, and will be paid to, an independent, non-incorporated individual. When an organization health care provider has determined that it has subparts requiring enumeration, that organization health care provider will report the NPI of the subpart as the Service Provider. The subpart reported as the Service Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner.
Summary Profile	A summary of the number of records submitted to WHAIC, broken down by quarter, year to quarter and month. Also includes tables, graphs and a 12 month overview of total records.
Student	An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or resident.
Validation	The action taken by the facility to check or prove the validity or accuracy of the data submitted.
Value Code	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. It has two pieces - a code and an amount. Examples include: Units of Blood furnished; Patient Liability Amount; Professional Component Charges which are combined billed; etc.

AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
ASC	Ambulatory Surgery Center
CAH	Critical Access Hospital
CDC	Center for Disease Control
CM	Clinical Modification (i.e. diagnosis codes)
CMS	Center for Medicaid and Medicare Services
CPT	Current Procedural Terminology
CRM	Contact Relationship Management
DHS	Wisconsin Department of Health Services
EAPG	Enhanced Ambulatory Payment Group
EDAS	Electronic Data Affirmation Statement
FASC	Free Standing Ambulatory Surgery Center

FAQ	Frequently asked questions
FL	Field Length
FY	Fiscal year
HCPCS	Health Care Procedural Coding Set
HIPAA	Health Insurance Portability and Accountability Act
IC	Information Center
ICD-10	International Classification of Disease tenth revision
INP	Inpatient
IPPS	Inpatient Prospective Payment System
IT	Information Technology
NCCI	National Correct Coding Initiative
NCHS	National Center for Health Statistics
NPI	National Provider Identifier
NUBC	National Uniform Billing Committee (UB-04)

OBS	Observation Records
OHO	Other Hospital Outpatient data
OIG	Office of Inspector General
OP	Outpatient
OPPS	Outpatient Prospective Payment System
OPS	Outpatient Surgery
PBL	Provider Based Location
PCS	Procedural Coding System
PHI	Protected Health Information
PII	Patient identifiable information
POA	Present on Admission
PoO	Point of Origin
SPR	Summary Profile Report
TOB	Type of Bill

UCID	Unique Case Identifier (64 Character – WHAIC Specific)
WHA	Wisconsin Hospital Association
WHAIC	Wisconsin Hospital Association Information Center
WIpop	Wisconsin inpatient and outpatient (data submission system)

7.14 Frequently Asked Questions (FAQ)

How to search a PDF?

By default, if you open Adobe Reader and press CTRL + F, you'll get the normal **search** box. It is located at the top right. To use the advanced **PDF search** option, you can choose Advanced **Search** from the Edit drop down menu or press SHIFT + CTRL + F. Enter the phrase you are searching for in the **search** box.

Topic	Question	Answer	Content added / last updated
A - F			
Additional Procedure	How will WHAIC add additional procedures to my data?	Outpatient surgery Procedures are based on the revenue codes 036X, 0481, 049X and/or 750. The principal procedure will be assigned first and then any additional procedures located within the revenue line-item detail coded in addition to one of the revenue codes described above will be assigned to the additional procedure section along with any modifier(s) and date of service in the revenue line-item detail. Errors may occur if we inadvertently pull out an "add-on" code and populate it in the principal. If this occurs, the data submitter/editor may have to manually swap out the codes	12/1/17
Added Facility	I was assigned a new facility in the system to work edits. How do I get access?	*Users that need to add newly acquired sites to perform edits or submit data to their account once registered and approved must contact WHAIC to add or update facility listing and access rights.*	01/2020
Access	I no longer have access to the WIpop site to submit or correct edits, what happened.	For security purposes, WIpop Users automatically deactivate after 8 months of inactivity in the system and Primary and Secondary users automatically deactivate after 15 months. To reactivate an account, email us at whainfocenter@wha.org. Once account is reactivated, user must log in to the portal before COB of Friday of the week in which it was reactivated.	01/2020
Address	Why was my file rejected for missing a few addresses?	**File rejected if:** Our system is set-up to reject files if Greater than 10% of records missing address that allows us to create census block group detail.	07/2019

		File will also reject if the race and ethnicity is not collected, or file is submitted with greater than 25% missing or listed as unknown / unavailable.	
Alerts	What is an Alert and do I have to correct them?	Alerts are not Edits or Errors. Click here for more information. 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. * The alert bell may draw your attention to specific areas of race, ethnicity, payer and 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. WIpop Batch files will contain an Alert Records section for each Patient Type on the far right of the screen. **You are not required to work all alerts.** Click here for more information.	03/2020
Assign Principal Procedure	How will WHAIC assign the principal procedure to my outpatient records?	Outpatient surgery Procedures are based on the revenue codes 036X, 0481, 049X and/or 750. Assignment of principal procedure code to OUTPATIENT Surgery records is based on the revenue line item detail and the corresponding CPT code.	12/1/17
Birth Date	How do I handle an unknown birth date?	If the patient's age is unknown, use January 1 (0101) as the birth date and the four-digit year based on the age or the best information available.	11/30/17
Census Block Group	We had a problem populating the Census Block Group – what would cause that?	The Census Block group is based on the US Census, so generally it only works on residential addresses. It will not work with PO Boxes or industrial districts.	12/1/17
Charity care	Should we report charity care?	Yes, you are required to report and include all services rendered to patients regardless of payment method.	12/1/17
Charity Care	*How should we report Charity Care?*	If you submit data electronically, use the 837I, 837R or 837P to create a record (fake claim) and submit the patient details along with the rest of the data. Or, add patient records via direct data entry.	12/1/17
Data Submission	When trying to upload files, I received a rejection of file error that the files contain too many claims - over the 5000 limit. Is there a	Yes, split the file or submit based on INP vs. OP data. An 837 file can contain any number of transaction envelopes, but each transaction is limited to 5,000 claims. This is noted in section 3.4 of our spec (http://whainfocenter.com/uploads/PDFs/WIpop837_Manual/Section3.pdf) The software that creates your 837 should be able to handle this rule, as it's a common restriction, not unique to us. The rule applies to production files too.	02/18

	way for me to split them so they will upload, or will I need to go back and ask them to create a smaller file? Will this also be an issue in Production?		
Datatype	What place of service / data type does revenue code 0361 – minor surgery fall into?	For hospitals that perform minor outpatient surgery procedures using rev code 0361 such as a suture in the ED or during any outpatient visit, the record will be counted and included an outpatient visit according to the place of service hierarchy. For example, a 0361 in the ER/ED data would remain in the ED records. **To clarify:** After considerable review and consultation with several hospitals and professional coders, WHAIC made the decision to exclude revenue code 0361 (minor surgery) from the outpatient surgery data type. Our research showed this revenue code to be used most frequently with services related to infusions, injections, sutures, etc. that did not require a surgeon.	12/2018
Date of Service	*What is the logic or definition of how discharge data should be pulled on, i.e. what date is used?*	To be completely literal, we assign the quarter as such: For IP and ED, use discharge date For OPS, use the principal procedure date For all other outpatient services (OBS, Therapy, Lab/Rad and other OP hospital services use the statement through date.	03/18
Discharge Date and Time	The Discharge date is required on Inpatient and Emergency claims. The Discharge hour is required only on inpatient claims. What should we use for time on ER claims?	We would like the discharge time even on ER claims. But if the time just isn't available, you can report it as 0000 (i.e. 201709060000) using DTP02 = DT, or you can use DTP02 = D8 and only report the date.	12/1/17
Discharge Status	Can we use discharge status 30?	Yes, in the 837 claims files discharge status 30 is acceptable on interim type of bills. The intent of the 837 claim file to gain access to more information and make it less difficult for users.	01/18

Discharge Status	Why do we get an edit on Discharge status codes 40, 41 or 42 – expired Hospice?	We don't accept those values because they are indicative of a hospice patient expiring during a hospital stay. Having those codes skews quality data in the publications.	12/17
Discharge Status Codes	I saw that it is required for INP/ER claims? Will the file reject if the Patient Status is present on OP claims as well?	CMS requires patient discharge status codes for hospital inpatient claims, skilled nursing claims, outpatient hospital services, and all hospice and home health claims. The WI Statute has patient discharge status required on INP and ED claims. WHAIC encourages hospitals to provide discharge data according to the CMS guidelines and include on all OP records. The two-digit discharge status codes identify where the patient is going upon transfer from the acute inpatient setting. The most common discharge status codes are: Inpatient hospital (02), Nursing home that accepts Medicare and/or Medicaid (03, 61 or 64), Home Health Agency (06), Rehabilitation facility (62), Long-term care hospital (63)	12/17
Duplicates in the file	How do I correct duplicate records in my file?	**Resubmit the batch with the phrase "exclude_duplicates" somewhere within the file name.** (minus the quotation marks) Example file name: Q218 IN OP exclude_duplicates.txt	12/2019
Edits	What is Code-First Rules?	ICD-10 has a coding convention that requires the underlying or causal condition be sequenced first followed by the manifested condition, which is referred to as the "code first" guideline. For example, if a patient is on the antidepressant drug Tryptanol (amitriptyline), and this drug is what caused the patient's weight gain, it is considered an adverse effect and is the underlying or causal condition of the patient's obesity. Therefore, diagnosis code T43.015 (adverse effect of tricyclic antidepressants) must be coded first.	
Edits	How will WHAIC account for the wide variety of services that occur in the emergency department (ED), that are allowed based on CMS and the uniform billing guidelines?	For hospitals that provide recurring specialty type services such as infusions or dialysis in the ED and the patient is also treated for a minor procedure or service during the course treatment or recurring visits in the ED: • WHAIC will bypass edits for recurring outpatient hospital records with multiple revenue line items for outpatient lab/radiology, therapy or other outpatient hospital services and the record also includes an ED revenue code for a visit that occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 revenue code, a statement	12/2017

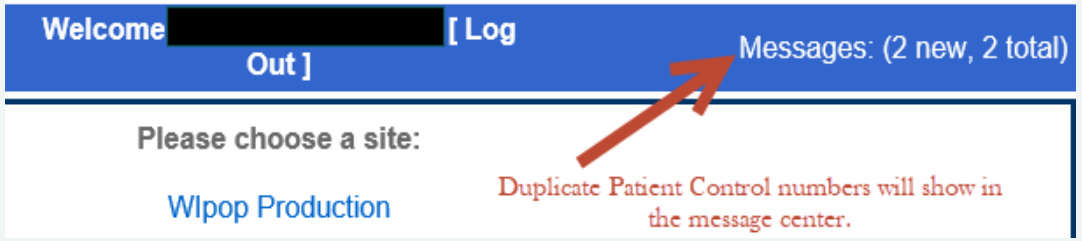
		'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. **To clarify:** 1. If the encounter/record has less than seven (7) days of service line items, the record is ED. 2. If the encounter/record has more than seven (7) days, the place of service will be determined by the OHO (OP HOSPITAL) revenue codes.	
Edits	Why are edits occurring for referring provider and billing provider?	You cannot use a facility NPI as the referring provider. The referring provider either needs to be the NPI of a person or left blank. *Referring NPI is not a required field.	4/2018
File	Our hospitals bill approx. 600 837Ps monthly, these are not FASC. Do you only accept 837P format for FASC?	Yes, WHAIC will only accept the 837P from a FASC. The 837P would represent the professional piece of the billing from a hospital, WHAIC only collects the facility portion and would need to have revenue codes included with the hospital 837 file, which the 837P does not support.	
File name Convention	For production, what are the file name parameters? Does the Facility ID# need to be part of the file name? Is there are valid file extension (.DAT,.TXT,etc)	There are no file name convention requirements or extension requirements to upload data to WIpop/WHAIC.	07/2019
How data collected	How are data collected?	Data is collected from acute care facilities, including Psych, Rehab and State Mental Health facilities. WHAIC does not collect discharge data from federally regulated facilities such as the Veterans Hospitals. Data must be submitted to WHAIC using an EDI claims file format and our secured web / portal. Only the items necessary to create and store the nonidentifiable data are stored in the WHAIC database.	
G-R			

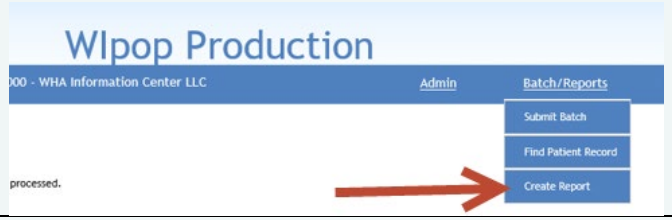
Gender/Sex	*What should I do with an **unknown gender or Other**?*	Gender/Sex may be U or O if the patient has an ambiguous gender or is transgender. Condition Code 45 must be used in any of the 4 Condition Code options in order to bypass the edits.	11/30/17
Language	The specs state that you are looking for the "Primary method of communication, either spoken or written". In Epic there are two different language fields collected. The first is "Caregivers Language" further defined as "Preferred language of the patient" and then Patient Language further defined as "Patients spoken language". Can you confirm which field you are looking for us to include?	WHAIC preference is to document the natural language spoken by the patient. "Patients spoken language" See Appendix 7.2.1 for the Mapping of Language codes	7/2019
NPI	*What about NPI numbers of residents? How about students?*	**Yes**, NPIs will be accepted for **residents.** NPIs will be accepted of the physician or qualified practitioner who was primarily and largely responsible for the patient's medical care and treatment. **Medical students do not have a license number or NPI number.**	11/30/17
NPI number	*For outpatient data, how is WHAIC defining "attending NPI?"*	According to the state statute, the ER/ED data is the only type of outpatient encounter/record where the attending NPI field must be populated. Edits will not occur if the attending is populated on other records.	11/30/17
Obtaining access to WIpop	How do I obtain access to the WIpop system?	To get access to WIpop all users must register first: http://www.whainfocenter.com/uploads/PDFs/WIpop837_Manual/Appendix_710.pdf Approval may take 24-48 business hours if all relevant information is present. WHAIC staff will not automatically approve anyone that has a different email address than that of the hospital staff.	10/30/17 Updated: 8/18

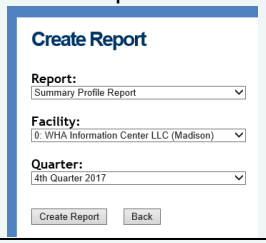
		Primary contacts are copied on all newly registered individuals requesting access to a facility. It is the primary contacts to notify WHAIC if the user should not be approved.	
Outpatient Surgery	*Are FASCs required to report type of admission?*	No, as per the 837P technical spec, type of admission is not a required data element for FASCs.	11/28/17
Payer	*Self-Pay*	Reporting Self-pay is required. See the 837 technical file specification for details. The field appears as OTH – 61 in WIpop.	
Payer	*What if my Payer is not listed on your Payer table?*	Contact WHAIC with the payer name and we will investigate if it's a commercial or private payer plan. If we plan to add the commercial payer, it will be added at the first of the year. Before contacting WHAIC, please do a quick google search to verify if the payer is actually a third-party benefit administrators	12/1/17
Payer	*NAIC#* We have a small number of claims that are sent paper and not electronically. We don't print these claims in-house but instead place a payor ID of PSCXX in our electronic claim form. When our clearinghouse sees the PSCXX they know not to electronically send the claim and instead print the claim for us and mail this to the payor.	Now that you are asking for the Payor ID, you will get the PSCXX, unless I do something to exclude them. Are you fine seeing the PSCXX or do you want these to instead be blank, to signify they were not sent electronically? There's no edit on the field, so it's fine to leave it blank or include whatever you have on the claim. It really is an audit tool to help ID other/unknown records that come in and work with facilities to ID correct mapping.	
Place of Service Edits	*I want to change the place of service, but it won't change.*	If after correcting edits for all the other data types and you mark each of them complete as you fix edits, you can't move a record into that closed/completed data type. You must open the entire batch and leave them open until all edits are completed.	
Payer Data	*We used to be able to use **OTH for commercial plans***	Effective with 1/1/18 all commercial plans are either reassigned a specific "A" code to identify the actual payer, or the use of A99 may be used for unknown commercial payer types.	12/1/17

	/ payers. How come I'm getting edits now?	WHAIC will update the Commercial payer table annually in January if new payers are on the OCI website. Users will be notified during the annual training.	
Provider-Based Locations	I just want to confirm that the PBL segment should go in Loop 2300 NTE02. Is there anything else that is needed for the PBL segment?	If you are using the Epic software, you are correct, just set NTE01 = UPI and NTE02 to the PBL ID number. It's our understanding that the Epic 837R software was not built with the PBL or "service facility" look in mind, so accommodations as above was designed.	
Provider-Based Locations	When do we have to report our Provider-based location data?	PBLs are outpatient departments of the hospital and as such we are required by statute to collect the facility component of all services and claims billed as an outpatient hospital claim. If a hospital has a shared Medicare number with facilities at different locations and claims are submitted to Medicare using the hospitals billing system then it's a provider-based location. Splitting a hospital outpatient charge into professional and facility components is called "provider-based billing." Records from a hospital outpatient department (AKA Provider Based Location (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. 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. WHAIC only wants the facility component of all services provided at the PBL regardless of whether the payer accepts provider-based billing or not. Hospitals that acquire or intend to submit claims using provider- based billing or in the event that a PBL closes, or the facility no longer bills as PB, contact WHAIC to terminate the PBL ID. PBL FAQ LINK	12/1/17
Race/Ethnicity	Does WHAIC have information on how to collect race and ethnicity?	WHAIC follows the minimum standards defined by the OMB. Facilities may collect as many races as it so chooses. All races collected must map to the ones defined in Appendix 7.2. We have posted additional information in terms of how to answer questions from patients. click on the link: http://www.whainfocenter.com/uploads/PDFs/Updates/Race_and_Ethnicity.pdf	11/30/17

Race/Ethnicity	Which race response option is appropriate when a patient is Hispanic or Latino?	According to the OMB, the most common response options for race in this situation is 'white'. Patients should always be self-reporting their race and ethnicity.	11/30/17
Race/Ethnicity	Who should select the race and ethnicity response options for newborns?	The mother should select the response options for the newborn.	11/30/17
Race/Ethnicity	*Which response option* should be selected if the patient is multiracial?	Multiracial is no longer be an option (effective 1/1/14). WHAIC collects up to 2 race choices. The OMB states "respondents who wish to identify their multi-racial heritage may choose more than one race; there is no "multi-racial" category". Since we follow the same language as the OMB, sites may collect and report more than one race for patients that choose to pick more than one race. See the technical specification to report in the correct field.	11/30/17
Race/Ethnicity	*Why was my file rejected?*	**File rejected if:** Greater than 10% of records missing address for census block group detail Greater than 25% of records with a race or ethnicity of unavailable / denied	
Record Submission	Sometimes we do not have accurate and complete records available to meet the data submission deadlines.	Facilities must adhere to the standard deadlines as outlined by the statute. We would want the data as accurate and complete as possible, so with that, submit as much as is available. This allows WHAIC the opportunity to produce the data sets in a timely manner. The submission deadline for first quarter IP, ED, OBS, OPS and OHO records is May 15 with edits due May 25. An extension request may be submitted through WIpop if necessary. Additional time is available to upload more data if necessary during the validation process.	10/30/17
Record Use	Is our data ever sold? (If so, to whom)?	Yes. Data is publicly available to purchase, provided the purchaser follows the data use agreement. The majority of sales are to the hospitals and surgery centers.	10/30/17
Record Submission	*Why didn't I get* confirmation of my record submission?	If the batch fails, a transaction email will be sent with the batch number and error report. On the bottom of this email, a comment: The file submitter will receive this message, with applicable patient control numbers added, in his/her WHAIC portal messages at https://portal.whainfocenter.com	12/1/17

		The portal message will have pcontrols for invalid records. 	
Record Submission	Should we submit charges from our clinic?	WHAIC **does not** collect professional charges. We do however collect Provider-Based Clinic data, also referred to as other outpatient hospital data such as diagnostic, laboratory, radiologic and other repetitive services as well as any other facility-based charges if the same Medicare provider number is shared with the submitting hospital and the same financial system is used. WHAIC will assign the place of service of 4,5 or 6 depending on the revenue codes in the OHO hierarchy table.	12/1/17
Record Submission	Adjusted and Interim Bills/Records	We can accept records with a Type of bill that ends in 1 – Admit through Discharge, 2 – Interim First Claim, 3 – Interim Continuing Claim and 4 – last claim. Note however that we do not accept duplicate records. WHAIC does not operate in the same manner as a claims processing or clearing house site in that we cannot detect duplicate records and do a search and replace for records on the same patient nor can we do any other modifications to the records. Each record that comes in is treated independent of the other.	12/1/17
Record Submission	Should facilities submit records for services provided at no charge? Drug screens, or free clinic service like blood pressure clinic?	Services provided at no charge **should not be** submitted to WHA Information Center. An example of this would be a reference lab, or 'free blood pressure clinic.' Services that are provided and charged based on ability to pay should be submitted. For example, if the patient is not billed because of inability to pay, we would expect to see the record with the charge, and a TOB that ends in zero – Non-payment / Zero Claim like 0850.	12/1/17

Record Submission	Should we submit records for rebills or late charges?	No, we allow non-payment/zero records, admit through discharge records, and records based on interim claims. No rebills, voids or corrected claims are allowed. We have no means to search and replace records that have already been submitted. And, the data users rely on the data to be accurate at the time it's released, therefore we do not release the data sets once it's been produced.	12/1/17
Record Submission	Should we continue to exclude swing bed/nursing home and hospice records from our data submission?	Yes, you must exclude those record types because they do not meet the definition of "hospital". The statute did not change regarding the definition of inpatient services; therefore, we cannot collect swing bed services in a nursing home or straight hospice records. However, this has been a tricky question – especially for CAH. Based on my research CAH use the 0181 to report patients that are in recovery from a hip or total knee and moved to a different location of the same hospital where they are still cared for on a daily basis and in the same hospital. In other words, it's okay to submit them provided the patient is in your facility as part of a transfer. We cannot accept patients in a SNF/nursing home patients, hospice or other type of terminally ill / elderly in a Nursing home / Hospice environment.	12/1/17
Record Use	What does WHA do with our data?	The data collected from all WI hospital and surgery centers is available for public use data sets (record-level), we provide discharge data to the Consumer PricePoint website (facility charges) we support four annually released publications using the data from WIpop (Health Care Data Report and Quality Indicators Report). And, we partnered with WHA's Quality Department to assist with reporting various quality initiatives.	10/30/17
Reports	*How do I run a report?*	Log into WIpop, choose which facility you wish to run a report for and click Batch Review. On top right side in WIpop Production, click Batch/Reports. In that dropdown, you will see Create Report. 	11/30/17

		You will then be able to select the type of report, facility, quarter, and batch. Then click create report.  Descriptions of the reports will be listed on the right side on the	
Required vs Situational	If the data element is marked as Situational, do I have to send it?	**Situational does not mean optional.** If an inpatient claim has an inpatient procedure on the claim, the inpatient procedure is required to be reported.	12/1/17
Roles	Where can I find more information about the roles in WIpop?	A description of the roles and responsibilities for WIpop are listed on our website and in WIpop above your listed of users. In short, the primary contact is responsible for over-seeing the quarterly data submission process to WIpop. A secondary contact gets most, but not all, of the data reports and serves as a back-up contact to the Primary. The WIpop user role is typically a vendor or individual that submits data or works edits.	10/30/17
S-Z			
Self-pay	Why do we have to report self-pay records?	WHAIC is contracted by the State of Wisconsin to collect all discharge data from hospitals and FASC. We want a complete representation of all patient data regardless of payer that provides greater value to the data users.	12/1/17
Self-pay	We are looking at the Pay Type/Pay ID errors and see that some of our accounts are self-pay. Are we supposed to be mapping the self-pay patient to a specific Plan ID/Type?	The code for self-pay is OTH-61. See Appendix 7.2 For self-pay, the Insurance Cert #: field may be left blank	
Self-pay	How should we report self-pay?	If you submit data electronically, use the 837I, 837R or 837P to create a record (fake claim) and submit the patient details along. You can specify "NULL" or just leave it blank.	12/1/17

Service Dates	Why am I getting an edit on the service dates if the revenue line items match what's in the statement from / to?	Typically, service date edits occur in the OPS data when the DOS falls outside of what WHAIC has deemed acceptable either before or after the principal procedure DOS. Service date more than 30 days before principal procedure date OR Service date more than 10 days after principal procedure date, AND no LT or RT modifier OR Service date more than 90 days after principal procedure date, AND has LT or RT modifier	08/18
Short Stay Edits	*Is there a reason we get edits on inpatient records that do not have inpatient revenue codes? We consider these short stays. We are billing part b for this claim – and the rev codes required in the INP billing edit are not something we can bill part b for an inpatient claim.*	WHAIC assigns the place of service for 837I and 837R files using the revenue codes on the claim. Inpatient revenue codes allowed are 0100-0189 or 0200 -0219. Part B is outpatient in a hospital like OBS care. Since WHAIC only uses the revenue codes and **not the TOB** to assign the POS, we can't determine what should be INP or OP based on this information. The facility must either correct the records manually by updating the POS, Patient Type field, etc. Or, map those Part B records to an OBS rev code such as 0760 or 0762 to allow WHAIC to properly assign them POS to OP.	08/2018 12/1/17
Source of Payment	*What pay ID and payer type number should I use for the Medicare Advantage?*	Medicare Advantage Plans are usually managed by a commercial or private insurance plan like an HMO. Since it is a contracted Medicare benefit, please code the record as: MED-02	12/1/17
Source of Payment	*Is all Medicaid the same as BadgerCare?*	No, there is a distinct difference. Although they share the same ID Card and some benefits are the same, Medicaid has stricter poverty levels and an asset test to determine one's qualifications. Source: WISCONSIN COALITION FOR ADVOCACY Source: Secs. 49.45-.47, Wis. Stats. Sec. 49.665, Wis. Stats. According to DHS:	12/1/17

		Medicaid = Elderly, Blind or Disabled BadgerCare = Families (parents, pregnant women, and children) Childless adults.	
Terminology	*I'm confused on the terminology; can you explain what an EDI file is?*	This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. For purposes of the 837R reporting standard, providers of health care services may include entities such as physicians, hospitals and other medical facilities, etc. required to provide claims information to meet regulatory requirements. **Sources** Accredited Standards Committee X12. ASC X12 Standard [Table Data] Data Interchange Standards Association, Inc., Falls Church, VA. http://www.x12.org/	12/1/17
Training	How do I receive training?	WHAIC offers annual face-to-face training in the fall, usually September. We also offer periodic WIpop 101 training that is a condensed version, but not a substitute for the in-person training. A bi-monthly newsletter is created when there is pertinent or necessary information to share with individuals involved in the data submission process.	10/30/17
Type of Bill	*Currently, our claims display the type of bill in CLM05-1 through 3. Will the WHA requirements expect the A to be absent, so that it just reads "131", or is it fine as shown:* *131 TOB Definition* *13 = means Hospital Outpatient*	Certain bill types are designated for inpatient use while others are designated for outpatient reporting. The A is valid and need not be removed. In fact nothing needs to be removed from the 837 except patient names and Social Security numbers, as we cannot accept those. Our document is not a complete 837 spec, rather it is intended to point out the specific segments and elements that will be used for the WIpop data extraction. Everything else in the file will be ignored. **For the 837I and R** the Facility Code Qualifier is an A – Uniform Billing Claim Form Bill Type. **For the 837P** the Facility Code Qualifier is a B – Place of Service Codes for Professional or Dental services.	12/1/17

	1 = an admit through discharge claim	CLM05 – 1 Facility Type Code Used by WHAIC CLM05 – 2 Facility Code Qualifier WHAIC Ignores Value CLM05 – 3 Claim Frequency Code Used by WHAIC	
Type of Bill	The Type of Bill spec seems to reference a leading zero. This is not 5010 compliant.	The leading zero is not to be included on electronic transactions, but it is acceptable on the paper UB-04. There are some hospitals and ASCs that do direct data entry and for that reason it's fine to include it.	12/1/17
Type of Bill	Please clarify for ASCs – how does TOB work?	To clarify type of bill, on an 837P, the type of bill is set to 083 plus the value in CLM0503. In most cases that will be 1, so bill type will be 0831. ASCs can still use 0999 as a valid code in WIpop if doing direct data entry, but it wouldn't be assigned from an 837 file.	
Type of Bill	In the 837 claim file - if we submit the last claim submitted in our datal, (which would be the most complete, correct claim) & the file comes to you with a TOB that ends in '7' like a 137 TOB, will the file be rejected, or will it be accepted with an edit?	If the patient control number is not a duplicate, the result would simply be an edit on the TOB field. We would not reject a file solely because of an invalid type of bill. Keep in mind we expect verification that the record would not be a duplicate of another record previously submitted and the TOB must be changed to a 131 in the WIpop file.	12/1/17
Type of Bill	*Are FASCs required to report type of bill?*	Yes, but the HCFA 1500 claim form does not require type of bill. See spec in section 5.5 for details.	11/28/17
Type of Bill	We are an ASC what TOB should we use?	You can use either 0831 or 0999 - the statute requires a TOB to be used and the UB-04 manual has 083x (x= 0 for zero charge claim, 1 = service dates from / to, 7 = voided claim, etc.) as a code that is specific to ASC sites. Typically, it's not included on the 837P, but several of our hospitals own ASCs and use this. SO, you can either use this code or the default of 999. See the technical specification for programming this into the file.	
Validation	What am I supposed to do during the validation period?	Download the data from the Portal / Data Deliverables: 1) Review your summary profile report and validation reports; 2) Any data inconsistencies ± 25% should be investigated. 3) Run/request a census report or some type of report from internal departments to verify the total number of patients seen matches the number of records submitted. 4) If total records don't match, submit missing data, correct edits & request new reports.	10/30/17

		5) To correct issues such as a duplicate procedure or inappropriate POA, open the batch, locate the record using the patient control number and update accordingly. 6) Verify batch has been marked complete and submit on-line affirmation statement.	
Validation Reports	One of our validation team members asked if there were plans to get an account level report of what was being reported in each Patient Type (Inpatient, Outpatient Surgery, Emergency Department Visit, etc). I didn't see a current validation report that had this detail, do you know if this would be something that could be added as a reporting option?	We provide a summary profile report and a full profile report with the validation reports at the close of the quarter. The profile reports have detailed counts and charges for each data type. As for a validation report, that shows all data for all records would be to large and cumbersome for the average data user. If you're looking for patient control numbers, with a few other key fields, we refined the current inventory report such that the place of service and payer code appears on every line. In general, we take suggestions and report ideas under consideration. However, our goal is to remove and/ condense validation reports, so that they provide maximum info with minimum clutter.	
When WHAIC created	When was WHAIC and WIpop created?	WHA Information Center (WHAIC) is a wholly owned subsidiary of the **Wisconsin Hospital Association**. WHAIC was incorporated on October 1, 2003, and began collecting data in January 2004 under a contract with the Wisconsin Department of Administration.	
Zip-Code	What Zip Code should I use for a patient out of the country?	The field should be zero-filled ('00000') for persons with an address that does not include a valid United States ZIP code	
Zip-Code	Do I zero fill or leave the field blank when a ZIP code is unknown?	If the ZIP code is unknown, such as for homeless patients, this field should be left blank and Condition Code '17' should be used for inpatient and outpatient records.	
Technical Questions for those Creating 837 File			
837 Specification, Creating file	Your 837 Companion Guide & Technical Spec Manual is not a complete	Our Manual is not intended to be a full 837 spec. Much like other state hospital associations or other data collection organization that collects discharge data, our documentation specifies only the 837 components that our parser will use for reference or have dedicated data fields	12/1/17

	837 file spec. It seems to be missing some of the data elements. Where we can get a complete 837 spec requirements for WIPOP.	in WIpop. The 837 file **needs to be a structurally correct 837, but the data not referenced in our guide will be ignored if supplied.** Since unused segments will be ignored, there is no need to strip all non-used components or populate with NULL. In short, you can submit all the data in the file, but unless it has a spot to populate in WIpop, or is necessary to process the file, the material will be discarded. You can purchase a full spec by going to the https://www.wedi.org/	
Address	The 2010BA loop address line 1 & 2 in the specs appear to pull on the same line. Is that correct or will address line 2 pull under address line 1?	We will only use N301 for our address. Technically you can provide a second address line in N302, but we will ignore that. Do not send two consecutive N3 segments.	
Case Sensitive	Does the data need to be programmed in upper or lower case?	No, the data is not case sensitive.	12/1/17
Creating File	How should we go about building or creating our 837 file?	Each facility should determine how to best supply your state data to WHAIC so that it matches your internal processes. Options might include: • Build the extract internally from mainframe system. • Build extract internally from claim (if this is the one used, the additional fields need to come from mainframe still) • Work with an EDI or Billing vendor or third party claims processor to build extract. Typically, a vendor will be used to create the 837 file.	12/1/17
Discharge Date Requirements	The WHAIC Discharge date requirements are a little different than what hospitals would submit on a	Yes, there are modifications required in the spec out of necessity to meet the state statute requirements, historical data trending and the 837 requirements. We understand the 837 does not have a field specifically designated for Discharge Date.	12/1/17

	regular 837I file. Are we expected to do modifications to what is originally submitted on the claim to a payer? .	*In the HIPPA 837I Standard the field is Discharge HOUR (not Discharge DATE) where only the time of discharge is submitted in format HHMM and a qualifier in DTP02=TM.* To satisfy the WHAIC requirements, hospitals will have to modify this field to include the discharge date before the discharge hour in format CCYYMMDDHHMM. In general, we assume the Statement Through Date (loop 2300 DTP03) is also Discharge Date. M*odify the qualifier from TM to DT.*	
File Translator, Software, Program	We are looking for a flat file conversion program to get to the 837 format. What are organizations with no programming resources doing to move forward with this change?	Each facility is responsible for determining the most cost effective, efficient way to deliver their data to us. We would encourage you to look for possible solutions from your billing provider or EMR vendor that are available for leverage to create your 837 file.	12/1/17
FTP	Are you allowing an FTP file delivery? It appears you want us to use a manual web app to upload files. That would be our very last choice (we don't do that with anyone for financial/claim data).	We are a data collection entity our data base structure is much different than that of a payer. WIpop data is uploaded through a browser and has been for many years. We do not use an FTP site because of the difficulty in cloning and maintaining our WIpop user security to an FTP server equivalent, as well as collecting the file metadata for each upload. We do offer an alternative to uploading the 837 file through a browser. The 837 File Handler (aka black box) program will upload a file	12/1/17
HI and SV Segment	Should HCPCS pull to both the HI segment and the SV segment or should they only pull to the HI segment?	The coding guidelines require inpatient codes to be populated on a claim; accordingly, so that is what is referred to in the HI segments. The SV segments are the revenue line item details and those would always be populated for any OP record and include the revenue code and HCPCS/CPT codes.	
NPI	On pulling an Operating physician will you be looking to the HI segment or the SV segment for the surgical procedures?	We will be populating those fields based on the revenue codes in the SV segment. If a 0360 exist, then we will look for a procedure code to populate the principal and additional accordingly.	

NULL fields	There are several locations in the file that state to pull "NULL" but also mention blank. Should we pull the value NULL or can it pull blank in those fields?	It can be either. We put NULL because it's a required field and confused some folks.	
Patient Relationships	Do we have to report the patient relationship to insured?	No, we do not require relationship identifiers in the data. If it's not in the spec, you don't have to report it.	
Payer	We are building our Claims File, should we be using A99-09 or A99-9 when populating the payer mapping information?	The fields are set up to be three alpha/numeric fields for Payer ID and two-digit field for the Payer Type. The correct mapping is to use A99 – 09.	12/1/17
Payer	For Loop 2000b SBR-03 it is built that if the payer is self- pay it is to produce a NULL, however the Policy or group number is not always collected, so when I load my file I have many edits because the Policy /Group number is blank.	That value can only be NULL on self-pays. For all other payers, we need something in that field. Preferably some ID that links the patient to their insurance, so policy, group, subscriber number, etc. But if nothing like that is available, technically all we validate for is that the field is not blank.	
Payer Codes	How often will WHAIC be adding new codes? How will we know when a new code is added?	New Commercial Payer Codes "A" codes will be added annually. WHAIC staff will obtain documentation from OCI to verify new commercial payers in the marketplace. WIpop users will be alerted of new payers added through the WHAIC Newsletter at least twice and then once again after they are effective. New and existing Commercial Payers will be reviewed during the annual training and "New" codes will be highlighted with a distinct color and effective date. Effective date for new codes will be the first quarter of the new year following notification. In the meantime, before the code is "ACTIVE" use A99-09 to report new payers.	

<table>
<tr>
<td>Physician Names</td>
<td>NM103, NM104 are the Physicians names in the 837 claim file however you do not have those fields listed and in the sample file you have ATTENDING listed, do you want the word ATTENDING in the file?</td>
<td>The specification we have outlined on our website only contains the loops and elements required to complete the WIpop data submission and file upload. Populate the field with whatever value you choose or leave it blank, we will ignore it all together during the processing of the file. As stated in the spec, what's important is the NPI numbers, code and qualifiers. The words ATTENDING, OPERATING, etc. are simply there as illustrations to see how the field is laid out.
<table>
<tr><th colspan="5">LOOP ID 2310 (A – F) PROVIDER Information</th></tr>
<tr><td>2310A</td><td>NM101</td><td>Attending ID Code</td><td>S</td><td>71 =</td></tr>
<tr><td>2310A</td><td>NM108</td><td>Attending Provider ID Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310A</td><td>NM109</td><td>Attending Provider ID NPI</td><td>S</td><td>Use</td></tr>
<tr><td>2310B</td><td>NM101</td><td>Operating Entity ID Code</td><td>S</td><td>72 =</td></tr>
<tr><td>2310B</td><td>NM108</td><td>Operating ID Code Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310B</td><td>NM109</td><td>Operating Provider NPI Number</td><td>S</td><td>Use</td></tr>
<tr><td>2310C</td><td>NM101</td><td>Other Operating Code Qualifier</td><td>S</td><td>ZZ =</td></tr>
<tr><td>2310C</td><td>NM108</td><td>Other Operating ID Qualifier</td><td>S</td><td>XX =</td></tr>
<tr><td>2310C</td><td>NM109</td><td>Other Operating Provider NPI nbr</td><td>S</td><td>Use</td></tr>
</table>
</td>
<td>12/1/17</td>
</tr>
<tr>
<td>Recurring accounts</td>
<td>For Recurring accounts can those pull as one account once they are discharged or will they need to pull before being discharged? If they need to pull before discharged what Discharge Status code should pull?</td>
<td>You can pull those either way. Populate the discharge status code with whatever is on the claim. We do not reject any of those anymore.</td>
<td></td>
</tr>
<tr>
<td>Reporting Guide and Question</td>
<td>How closely aligned to the HIPAA Institutional Claim 837 implementation guide 837I is the Health Care</td>
<td>Very Close, especially the 5010 Versions of each guide. For the most part the Health Care Service Data Reporting (HCDR) Guide is a subset of the HIPAA Institutional implementation guide. The notable exception is the collection of some additional demographic data, such as the patient marital status, race and ethnicity. It should also be noted that there is no business</td>
<td></td>
</tr>
</table>

	Service Data Reporting Guide 837R?	case for the collection of any coordination of benefits (COB) information in the HCDR, so that information is not supported in that guide.	
Testing			
Data Submission	If our new upload capability is completed by April 2018, is that adequate?	No, Q1 data is due May 15. All hospitals and ASC sites are required to send in test files during the 4th quarter to allow for time to work with your vendor or IT support to refine edits and issues as needed in a timely fashion prior to the Q1 due date.	12/1/17
Vendor Access	Can my vendor have access to WIpop to test the file?	Yes, you can authorize access to WIpop for your vendor to test your data on behalf of the facility. We may verify access with the primary contact to assure legitimacy.	12/1/17
Testing	If I pass testing, can I begin using the 837 file and format right way?	Testing is required prior to access to production. We evaluate the file as a whole, if it contains self-pay, value codes, occurrence codes and PBL data, if applicable.	12/1/17
Direct Data Entry	Do I have to test if we do direct data entry?	Yes, all facilities, regardless of mode of submission must submit files to the 837 test site in order to get access to the 837 production site. See the testing resource on our website.	12/1/17
Retesting/Software Updates or Program Changes	Do I have to retest after making software, system or mapping changes?	Yes, any software, system or mapping changes can affect the data submission file or output of the data. To ensure successful data processing and minimal edits, we encourage all changes be tested using the 837 Test site and not the Production site.	12/1/17