7.12 Data Dictionary

The 837 Data Dictionary is intended to provide an explanation/description for the fields located in WIpop

Field Name and Description
Facility Number: The unique 3-digit identification number assigned to each facility by WHAIC. This number must be used to upload your files and correspond with WHAIC. Appendix 7.1 has a list of all hospitals and ASCs three (3) digit facility ID numbers.
Patient Control Number (PCN) or Pcontrol: The unique alpha or numeric number assigned to the record by the facility. This code is used for reference in correspondence, problem solving, edit corrections and return of grouped data. The PCN is different from the medical record number, which identifies an individual patient and remains constant through multiple facility visits. The patient control number provides linkage of all record types containing patient-related data for a specific discharge. Must be numeric (0-9) and/or alphabetic (A-Z). UB-04 NUBC Definition: Patients' unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payment.
Patient Type: One-digit entry identifies the status of the patient at the time of discharge. WHAIC Required - Use the following codes: 1 = Inpatient 2 = Outpatient
Place of Service (POS): assigned to Outpatient Records Only. One-digit entry identifies the location / type of unit or area where the patient received outpatient services. WHAIC assigns POS by this hierarchy and codes below (See Appendix 7.5 for further information): **Outpatient** 3 = Observation Care (OBS) 1 = Outpatient Surgery (OPS) 2 = Emergency Department (ED) 4 = Therapy (PT/OT/ST) 5 = Outpatient (Lab/Radiology excluding referenced diagnostic services) 6 = Other Outpatient Hospital data
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.
Date of Birth: The patient's month, day, and complete year of birth. This date should be recorded in numeric form with a two-digit entry for the month/day and a four-digit entry for the year (mmddyyyy). For example, if the birth date is July 10, 1950, record 07101950. The entire birth date should be provided.
Census Block Group -Address, City, State and Zip is used to create the patient's census block group. The census block group, not the address, will be stored in the WIpop database and used in the discharge data. SECTION 8. 153.50 (6) (am) of the statutes is created to read:153.50 (6) (am) Hospitals or ambulatory surgery centers shall submit the patient's street address to the entity under contract under s. 153.05 (2m) (a) as directed by the entity. The entity may only use the street address to create a calculated variable that does not identify a patient's address or to convert the data element to the corresponding U.S. bureau of the census track and block group. The entity shall destroy the street address information upon the creation of the variable or upon the conversion to the census tract and block group.

Sex/Gender: F = Female; M = Male; O= Other, U = Transgender or Ambiguous gender - Condition Code 1: 45 Condition Code 2: Condition Code 3: Condition Code 4: ***Use condition code 45 in any of the Condition Code fields* to override the edit**.
Marital Status: a person's state of being single, married, separated, divorced, or widowed. If collected and stored in the EMR, WHAIC expects it to be sent in the data files.
ZIP Code: The five-digit code assigned by the U.S. Postal Service. Valid ZIP codes should be provided whenever possible. *Use five zeroes ('00000') for persons with an address that does not include a valid U.S. ZIP code.* If the ZIP code is unknown, such as for homeless patients, this field should be left blank and populate Condition Code 1 with '17'.
***Race 1**:* This information is based on self-identification and is to be obtained from the patient, relative, or responsible party. If a patient chooses not to answer the facility should enter the code for declined. In the most basic sense, race is defined as populations or groups of people divided based on various sets of physical characteristics from genetic ancestry. Do not default race categories to declined or duplicate field as this will cause the file to be rejected.
Ethnicity: This information is based on self-identification as is to be obtained from the patient, relative, or responsible party. If a patient chooses not to answer, the code for declined may be used. An ethnicity is a population of human beings whose members identify with each other, based on a real or presumed common genealogy or cultural traits. Mexican or Latino is not a race, according to the OMB they usually identify as Caucasian based on color of skin or region.
Race 2 (optional): An additional Race 2 element may be collected and reported. This information is based on self-identification and is to be obtained from the patient, relative, or responsible party.
Language: A **language** is a system of communication which consists of a set of sounds and written symbols which are used by the people of a particular country or region for talking or writing. ...the English **language**. If collected by the facility, the data is expected to be sent with the file.
UCID: WHAIC cannot accept PHI i.e., Patient Names or SSN in the data. Therefore, hospitals and freestanding ambulatory surgery centers are required to include a 64-character Unique Case Identifier (UCID) in the claims file. This data element has been collected by the WHAIC since 2013. Its primary purpose is to assist hospitals and ambulatory surgery centers in identifying when a readmission occurs at a facility other than where the original admission or ambulatory surgery occurred. There are two approaches to developing the 64-character UCID. One is to use the WHAIC 837 File Handler program, also known as the "black box". This program will accept your 837 file as input, creating an output file with patient names removed and add the UCID. The other approach is to create your own program to generate the UCID. The formula first applies a name standardization algorithm (New York State Identification and Intelligence System). The standardized name, combined with date of birth and gender, is then hashed using the SHA 256 hash function to produce the 64 - character UCID. As of Q42023 the WHAIC 837 File Handler program is embedded in the WIpop site. The facility no longer needs to download a program nor instructions from WHAIC. The UCID is unique to the patient; however, there are times such as with twins where we can get the same value if they have similar names. As a means to further protect patient data, the UCID is not included in the public dataset .

All 837 Claim Details Section 2

Insurance Certificate #: Insured's insurance identification number assigned by the payer organization. Term sometimes referred to member ID, Group number, plan number, insurance number, etc. If the record is for a self-pay case (OTH/61) the field may be zero-filled or left blank. (UB-04 FL 60) (CMS-1500 Form Locator 1A). An edit will occur when Expected Source of Payment field is filled in and there is no insurance number identified. *unless self-pay

NPI Billing Provider: The unique national provider identifier (NPI) number assigned to the facility submitting the bill. When the billing provider is an organization's health care provider, the organization's health care provider's NPI or its subpart's NPI is reported in this field. When a health care provider organization has determined that it needs to enumerate its subparts, it should report the NPI of a subpart as the billing provider. The subpart reported as the billing 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 WHAIC. Report all subpart NPIs to WHAIC.

Referring Provider - The referring **provider** is the provider who sends the patient to another provider for services. For example - patient's primary care **provider** referring his/her patient to a specialist.

Attending NPI: Required on Inpatient and Emergency dept. records – All National Provider Identifier (NPI) numbers *"a physician or other qualified health care professional"* are acceptable as of January 1, 2017, Dates of Service (DOS) even if the primary responsibility for a patient is a non-physician caregiver for example, dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor.

Not required for any other data type

Operating NPI: Required For outpatient surgery records. All National Provider Identifier (NPI) numbers are acceptable as of January 1, 2017, DOS even if the primary responsibility for a patient is a non-physician caregiver (e.g. dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor).

Acceptable for all other data types like Inpatient and Emergency Department if a procedure were performed and a qualifying CPT code and procedure date is provided, an NPI number would be expected.

Other Operating NPI: NPI numbers for *"a physician or other qualified health care professional"* are acceptable even if the primary responsibility for a patient is a non-physician caregiver (e.g., dentist, psychologist, podiatrist, nurse midwife, physician assistant, nurse practitioner, or chiropractor). Cannot provide this without the operating NPI1.

Rendering Provider - rendering provider is the healthcare provider who performed (or rendered) the services. For a solo practice, usually the billing provider and the rendering provider are the same entity. However, the two providers are still treated separately by the insurance companies when processing your claims.

Expected Source of Payment ID: The first three characters from the primary payer code (expected to pay the greater share) from the UB-04 form. For example, Wisconsin Medical Assistance (Medicaid) patients must be coded as "T19," with payer type of fee-for-service or 01 and workers comp is recorded as OTH/41. See Appendix 7.3 for appropriate codes.

Expected Source of Payment Type: The fourth and fifth characters of the payer code from the UB-04 form. This field identifies the payer group, for example FFS, HMO, Workers Compensation, Self-pay, other, etc.

Payer ID Number: 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**.

Secondary Source of Payment ID: The first three characters from the secondary payer as defined by Appendix 7.3.

*Situational does not mean optional.

Secondary Source of Payment Type: The fourth and fifth characters of the secondary payer code as defined by Appendix 7.3.

Accident State – The accident state field contains the two-digit state abbreviation where the accident occurred.

Hospital and Provider-based location / facility ID (PB): Splitting hospital services and outpatient charges into professional and facility components is called "provider-based billing" and patients receive two charges on the bill for services provided. One charge represents the facility or hospital charge, and one charge represents the professional or physician fee.

Hospital Services:

Hospitals that own and submit claims for ALL hospital services in off-campus (sister/parent) hospitals that are not separately licensed and share the same Medicare number as the main hospital as WHAIC does not collect the physical location of services from the claim at this time.

WHAIC established a NEW Policy Statement: Identification of ALL Hospital Services in ON and OFF-campus facilities.

Purpose: This policy has been established to ensure accuracy and consistency of reporting for all discharge data collected from off-campus hospitals and outpatient facilities that share the same Medicare number as the main hospital. Inpatient and outpatient data are available for a wide range of uses including, but not limited to, research, publications, commercial health care operations, understanding market trends/market share analysis, policy decision making, and other consumer care purposes.

Policy Statement: WHAIC requires all hospitals to report inpatient and outpatient hospital services, performed in off-campus locations from the main hospital, **with an assigned location identifier / provider-based identifier**. This policy applies to all hospitals performing billing services regardless of if the encounters are provider-based billing or affiliated location outside of the four walls of the main hospital that share the same Medicare number.

The value of the data increases when the user understands the type of services rendered ***and the location*** *in which those services were obtained*.

Leave Days: The total number of days a room was held for an inpatient while away from a facility. Consists of all 018X revenue codes (charges for holding a room while the patient is temporarily away from the hospital - applies to inpatient stays). WHAIC will calculate & populate based on admit / discharge, revenue code 018X and number of units.

Point of Origin: A code indicating where the patient (literally) came from before presenting to the facility for this admission or outpatient visit. For example, an auto accident patient was taken to the ER of Hospital A by ambulance, stabilized, then transferred to a Level I Trauma Center - Hospital B where he/she received additional treatment in the ED, and then is admitted as an inpatient to Hospital B. The Point of Origin on claim 1 is where the patient came from before presenting to the health care facility.

Admit Type: A code indicating the priority of this admission/visit.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trauma

Discharge (Patient) Status: A code indicating patient discharge status as of the ending service date of the period covered in the record. For example, a patient discharged to home or self-care would be recorded as '01'. See for appropriate codes.

NUBC: Required on all institutional claims

Type of Bill: A code indicating the specific type of bill (inpatient, outpatient, interim claims, etc.). The first digit is an optional leading zero. The second and third digits combined are a facility code. The fourth digit defines the frequency.

FASCs may routinely use '0999' since type of bill is not a standard data element on the CMS-1500 form.

Admission Date/Time

Discharge Date: Inpatient and Outpatient ED - Record the month, day, and year of discharge, with a two-digit entry for the month and day and a four-digit entry for the year (mmddyyyy). The stay may have ended by order of physician, against medical advice, or by death. Transfers to SNF or ICF as well as to swing bed should be considered a discharge. For example, a discharge occurring on May 8, 2015, would be recorded as 05082015.

Discharge Hour: Inpatient only - Code indicating the discharge hour of the patient from inpatient care.

Statement Covers Period FROM: Hospital Outpatient: Observation, Therapies, Lab and radiology and other outpatient except ED and OP Surgery - The beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same. Enter dates as month, day, and year (mmddyyyy). For example, a patient starting physical therapy May 8, 2011, and finishing physical therapy on May 12, 2011: "From" should be recorded 05082011 and "Through" should be recorded as 05122011.

Statement Covers Period THROUGH: Hospital Outpatient: Observation, Therapies, Lab and radiology and other outpatient except ED and OP Surgery - The beginning and ending service dates of the period included on the record submitted. For services received on the same day, the "From" and "Through" dates will be the same. Enter dates as month, day, and year (mmddyyyy). For example, a patient starting physical therapy May 8, 2011, and finishing physical therapy on May 12, 2011: "From" should be recorded 05082011 and "Through" should be recorded as 05122011.

Total Charge: Total covered and non-covered charges related to the episode of care that is being reported, excluding the professional component. The charge should be entered with two place decimals (-)nnnnnnnn.nn. This is always assumed to be positive. For example, $8204.05 would be recorded as 8204.05 or $155,327.00 would be recorded as 155327.00. The field should equal zero ('0') if there are no charges. *Note: Total charge in the Primary Record must match the total charge(s) in the Revenue Record.*

Principal Diagnosis - ICD-10 code taken from the claim

Admitting Diagnosis - ICD-10 code taken from the claim. WHAIC can accept as many as the hospital records.

Patient's Reason for Visit: The ICD-10-CM diagnosis code describes the patient's reason for seeking care at the time of outpatient registration. One code required for TOB 013x and 085x, and 078x with Revenue Codes 045x, 0516, 0526, or 0762. Up to three codes allowed for any outpatient record.

045x – Emergency Room

0516 – Clinic – Urgent Care Clinic

0526 – Freestanding Clinic - Urgent Care Visit

0762 – Observation

Principal Procedure: Required on Outpatient Surgery Records – WHAIC will assign the principal procedure based on OPS revenue codes. Every effort to choose the CPT/HCPCS procedure code most related to the principal diagnosis and performed during the episode of care will be made. It is the facility that must verify.

Inpatient Records – An ICD-10 procedure code should be entered in the primary record for inpatient records where applicable. The principal procedure is the one procedure most related to the principal diagnosis. If there is more than one procedure and

both are equally related to the principal diagnosis, the most resource-intensive or complex procedure, or one that is necessary to care for a complication is usually designated as the principal procedure. If the only clinically significant procedure performed is invasive or exploratory in nature it may be reported in the principal procedure field. When more than one procedure is reported, the principal procedure should be identified by the one that relates to the principal diagnosis. (UB-04 FL 74 for inpatient records.) Refer to the official coding guidelines for best coding practices.

Principal Procedure Date: WHAIC will populate the principal procedure date based on the month, day, year the principal procedure was performed as identified in the revenue record details. ,

Principal Procedure Modifier: Outpatient Records – A data element to be *used with CPT or HCPCS Level II codes when applicable*. CPT or HCPCS Level II modifiers may be used in this field as applicable and coded on the record and/or claim. A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Up to four modifiers per CPT/HCPCS code may be entered. When there is more than one modifier that applies to a specific code, the modifier that has the most impact on payment should be listed first.

Condition Code 1: Code '17' should be entered for all inpatient and outpatient cases where a patient is homeless at the date of admission for inpatients, or date of service for outpatients when there is an unknown ZIP code.

Condition Code 1-4: WHAIC will accept all condition codes as deemed acceptable by the uniform billing requirements outlined by the NUBC – UB-04 Manual but will record only the first 4 on the claim file.

Code '45' Ambiguous Gender Category – used to allow the gender related edits to be bypassed. Example would be for transgender, hermaphrodites, or have ambiguous genitals.

Transgender – persons relating to or identifying with opposite sex.

Hermaphrodites – persons with both male and female sex organs.

Ambiguous genitalia – external genitals do not appear to be M or F or characteristics of both

837I Claim - Hospital Detail

Value Codes and Amounts – A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.

See the Official UB-04 Data Specification Manual for appropriate code usage.

Occurrence Codes and Dates – The code and associated date defining a significant event relating to the bill that may affect payer processing. Occurrence codes should be entered in alphanumeric sequence.

See the Official UB-04 Data Specification Manual for appropriate code usage. Codes identified as Payer Codes used for Payer Internal use Only will be edited.

Occurrence Span Codes and Dates – A code and the related dates that identify an event that relates to the payment of a claim. These codes identify occurrences that happened over a span of time.

See the Official UB-04 Data Specification Manual for appropriate code usage.

Additional Diagnoses and External Cause Codes:

Additional Diagnosis and External Cause Codes: The ICD-10-CM codes corresponding to additional conditions that co-exist in addition to the principal diagnosis listed on the Record, and which have an effect on the treatment or length of stay. Facilities

should submit all additional diagnosis codes that apply to each record. WIpop will accept an unlimited number of diagnosis codes. *Do Not Enter Decimals*

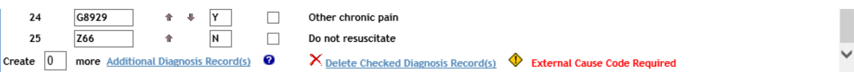
External Cause Code Range: The ICD-10-CM code used to identify the external cause of injury, poisoning, adverse effect, or cause of morbidity. As per the State Statute, facilities submitting data to WHAIC must report an external cause code as appropriate.

At least one external cause diagnosis code is required for inpatient, observation, emergency department and outpatient surgery - records with Place of Service 1-3. Place of Service 4-7 record types allow for external cause codes, but they are not required. (UB-04 FL 72 1a-1c) (CMS-1500 FL 21-(2-4). WHAIC cannot edit for the 7th character associated with the coded injury.

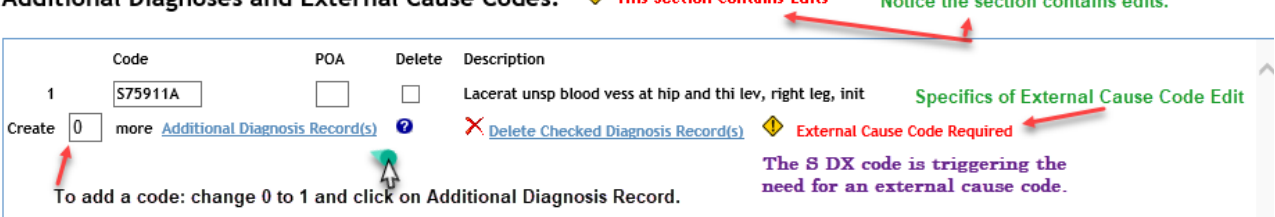
The external cause code edit 5370 applies to inpatient, outpatient surgery, emergency room, and observation with diagnosis codes in the S through T range, with some exceptions require an external cause diagnosis code in the V through Y range.

The edit will appear at the end of the section as displayed in the below.

At least one external cause code must be specified when a diagnosis exists as described in Section 5.1.6. ** External cause of injury codes are acceptable, but not required on Other Hospital Outpatient (OHO) records. This includes place of service 4-6.



REPORTING EXTERNAL CAUSE CODES: To add an additional diagnosis (external cause code) enter a number in the 'create' box and click the underline 'Additional Diagnosis Record(s)'



Present on Admission Indicator for Additional Diagnosis Codes: Inpatient only - The eighth digit of all additional diagnosis codes submitted on the record. Required to identify conditions known at the time of admission, and those that were clearly present, but not diagnosed, until after the admission took place. The five reporting options are: Y = yes, N = no, U = no information in the record, W = clinically undetermined and blank = exempt from POA reporting. Please see CMS.gov for further information.

Additional Procedure Section

Additional Procedures: **Inpatient** - The ICD-10-PCS codes corresponding to procedures performed other than the principal procedure (do not duplicate principal procedure) listed on the Primary 'A' Record that were also performed during the episode of care. Facilities should submit all additional procedure codes that apply to each record.

Outpatient - The CPT/HCPCS codes corresponding to additional procedures other than the principal procedure All significant procedures other than the Principal Procedure Code are to be reported here, unlimited. They are reported in order of significance, starting with the most significant. Codes that do not meet the definition of procedure will receive an edit:

Additional Procedure Modifier: *Outpatient* A data element used as applicable when CPT or HCPCS Level II codes are coded in the HCPCS/CPT field in the record or claim. When there is more than one modifier, the modifier that has the most impact on payment should be listed first. Only 4 modifiers will be displayed in WIpop.

Additional Procedure Date – date of the additional procedure.

Revenue Record Section

Service Date: The date that a service was provided (mmddyyyy). *Required on outpatient records only*. If used on an inpatient record the service date must be within 3 days prior to the admit date and cannot be after the discharge date.

For ED (place of service 2 records) the service date must be within 3 days prior to the admit date and cannot be after the discharge date. For all other hospital outpatient records the service date must be on or between the "from and through" dates.

Revenue Code: A code which identifies a specific accommodation, ancillary service, or billing calculation. This data element is not required for freestanding ambulatory surgery centers (FASC).

HCPCS/CPT/HIPPS Rates: Inpatient: The Room and Board (Rates) should be reported with two-place decimals. For example, a charge of $455.00 would be recorded as 455.00.

Under the Inpatient Rehabilitation Facility PPS, a five-digit HIPPS Rate/CMG Code (AXXYY-DXXYY) may be reported with revenue code 0024. Rates are always assumed to be positive.

Outpatient: HCPCS/CPT codes are required for outpatient services unless the instructions in the NUBC Manual state otherwise.

HCPCS/CPT Level I or II Modifiers: Outpatient – applicable when CPT or HCPCS codes are used, and a modifier is recorded on the claim or record. When more than one modifier applies to a specific code, the modifier that has the most impact on payment should be listed first.

Units of Service: A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, or renal dialysis treatments, etc. The value must be a positive number and a minimum of '1' regardless of if the charge is zero or greater than zero.

Charge: Charges (By Revenue/HCPCS/CPT Code): Total charges related to the revenue code or HCPCS/CPT code recorded. Total charges include both covered and non-covered charges. Positive charges should be entered with two-place decimal. For example, $2456.50 should be entered 2456.50. Any adjustment or credit to revenue service line should be entered with signed negative character (-) and two-place decimal. For example, a negative adjustment of $10.00 should be entered as –10.00.
****Total Charges in the revenue detail must match the total charges in the Primary Record.***