7.16 Frequently Asked Questions (FAQ)

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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. 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.	07/2019
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,	03/2020

		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.	
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 limits. Is there a 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?	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 is a common restriction, not unique to us. The rule applies to production files too.	02/18
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, 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

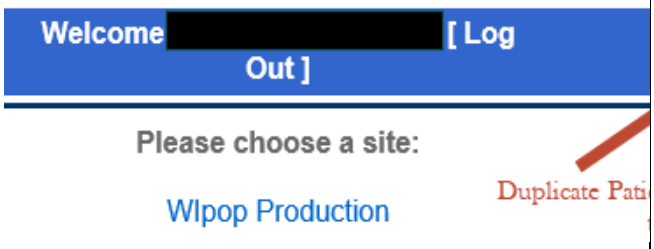
Discharge Date and Time	The Discharge date is required on Inpatient and Emergency claims. The Discharge hour is required only on inpatient claims. What should we use for time on ER claims?	We would like the discharge time even on ER claims. But if the time just isn't available, you can report it as 0000 (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 do not 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 it 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	12/2017

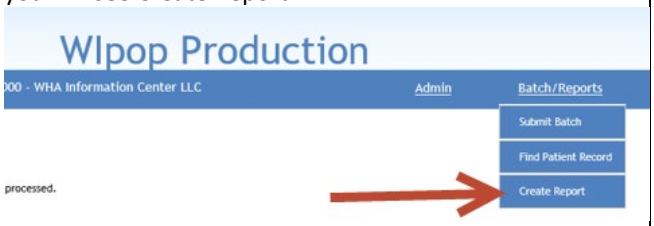
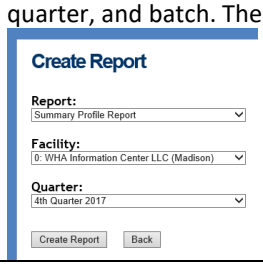
		occurred during the course of treatment. In order for the bypass edit to work the record must contain multiple service dates, a 0450 revenue code, a statement 'From and Through' date of at minimum 7, 14 or 30 days that match the service dates in the revenue line item detail. **To clarify:** 1. If the 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
Edits	What are the Medicare Code Edits	The WHAIC edits are taken from the CMS tools and resources: Reference: Definitions of Medicare Code Edits_v_39_revised_7_16_21.pdf	01/2022
File	What is an 837 file	EDI HEALTH CARE CLAIM TRANSACTION SET (837) Used to submit health care claim billing information, encounter information, or both, except for retail pharmacy claims (see EDI Retail Pharmacy Claim Transaction). It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. Source: HIPAA EDI Document Standard | EDI Basics	
File	Our hospital's 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, unless they choose to have an 837I or R created by an affiliated hospital. 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. 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.	10/30/17 Updated: 8/18
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's name and we will investigate if it's a commercial or private payer plan. If we plan to add a commercial payer, it will be added at the first of the year.	12/1/17

		Before contacting WHAIC, please do a quick google search to verify if the payer is actually a third-party benefit administrator	
Payer	*Payer ID* We have a small number of claims that are sent paper and not electronically. We do not 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?	
Place of Service Edits	*I want to change the place of service, but it will not change.*	If after correcting edits for all the other data types and you mark each of them complete as you fix edits, you cannot 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** / payers. How come I am getting edits now?*	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. 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.	12/1/17
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 is 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	12/1/17

		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	
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,	12/1/17

		in his/her WHAIC portal messages at https://portal.whainfocenter.com 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.	12/1/17

		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 is 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.	
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.  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	11/30/17
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	12/1/17

		complete representation of all patient data regardless of payer that provides greater value to the data users.	
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 is 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 cannot 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 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: Medicaid = Elderly, Blind or Disabled	12/1/17

		BadgerCare = Families (parents, pregnant women, and children) Childless adults.	
Terminology	*I am 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* 1 = an admit through discharge claim	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. CLM05 – 1 Facility Type Code Used by WHAIC CLM05 – 2 Facility Code Qualifier WHAIC Ignores Value CLM05 – 3 Claim Frequency Code Used by WHAIC	12/1/17
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 is 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 would not 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 is 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 do not match, submit missing data, correct edits & request new reports. 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.	10/30/17
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 did not 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 are 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 837 file spec. It is missing some of the data elements. Where we can get a complete 837 spec requirements for WIPOP.	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 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/	12/1/17
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 *regular 837I file. Are we expected to do modifications to what is originally submitted on the claim to a payer?* .	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. *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.*	12/1/17

		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? You want us to use a manual web app to upload files. That would be our very last choice (we do not 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 is 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 is not in the spec, you do not 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	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.	

<table>
<tr><td></td><td>file I have many edits because the Policy /Group number is blank.</td><td></td><td></td></tr>
<tr><td>Payer Codes</td><td>How often will WHAIC be adding new codes?
How will we know when a new code is added?</td><td>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.</td><td></td></tr>
<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 is 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><td colspan="5">LOOP ID 2310 (A – F) PROVIDER Information</td></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 Service Data Reporting Guide 837R?</td><td>Very Close, especially the 5010 Versions of each guide. 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 case for the collection of any coordination of</td><td></td></tr>
</table>

		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

7.17 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: WHA Information Center for the most recent version of this document and any supplemental resources.

Change Number	Date	Author of Change	Update includes
1	1/24/17	Cindy	Created date
2	3/2/17	Cindy	Posted Manual online
3	05/08/17	Jim	Updated Statement of intent with the 837 specification and that it is not intended to serve as an entire full specification.
3.1	5/08/17	Jim	Added NTE01 reporting option for 837R file users to report provider-based billing.
4	5/11/17	Cindy	Updated Special Character : and -
4.1	5/11/17	Cindy	Updated type of bill to remove leading zero. Submitter may use a leading zero, but it is not required.
4.2	5/11/17	Cindy	Added Interchange Control and Functional Group Specification as requested by developers.