Key Points of the UB-04

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In February 2005 the National Uniform Billing Committee (NUBC) approved the UB-04 paper claim and data set as the replacement to the existing UB-92 paper form.[1] After May 27, 2007, all paper claims must be submitted using the UB-04.

It is important to stress that the change applies only to claims submitted on paper, which are now in the minority. According to NUBC, "Today, more than 98 percent of hospital claims are submitted electronically to the Medicare program. Overall, more than 80 percent of all institutional claims are being submitted electronically."[2] This rate will continue to increase.

The preparation for the UB-04 conversion going on right now has limited impact on the provider community, since it allows for either a specific location on the paper claim for items that are already being collected or provides a placeholder for items that may be required for billing purposes in the future (for example, ICD-10). The current version of the electronic institutional claim, the ANSI X12N 837, will be upgraded and conform to the data elements that will now be required on the paper UB-04.

This practice brief addresses what this latest update means for HIM professionals. It also discusses the two UB-04 data elements that will have the greatest impact on HIM.

What Is the UB-04?

NUBC maintains the billing data set known as the Uniform Bill (UB) designed for institutional healthcare providers. A uniform hospital bill, currently the UB-92, is the required billing mechanism that contains data elements identified as necessary for claims processing in the paper environment. In most cases, data elements are assigned designated spaces on the paper claim form. The designated spaces are referred to as form locators (FLs), and each has a unique number.

The UB-92 form was reviewed and upgraded to the approved UB-04 version. Clearinghouses and health plans must be ready to accept the paper UB-04 format on March 1, 2007. Providers will be able to submit claims via UB-92 or UB-04 from March 1 to May 27, 2007. However, after May 27, 2007, all paper claims must be submitted using the UB-04 format. All rebilling of paper claims must also use the UB-04 from that date forward, even though earlier submissions may have been on the UB-92.

The UB-04 contains a number of improvements and enhancements that resulted from nearly four years of research, including better alignment with the electronic HIPAA ASC X12N 837-Institutional transaction standard. This change addresses items that are collected today and submitted in the electronic format that the UB-92 paper version does not adequately identify. For example, the paper UB-92 limits the number of diagnoses included on the claim tied to a specific form locator (overflow diagnosis codes may be listed in the remark section), but the current electronic transaction is already accepting an increased number of diagnosis codes. The UB-92 was reviewed and upgraded to the UB-04 in part because of the discrepancy between the required elements for the electronic transaction standard today and the paper format.

The UB-04 is expected to last 10 years. In order to be proactive, some new data elements are included on the paper UB-04 claim that are not yet supported in the electronic standard. There is no definitive timeline of the current electronic transaction to be upgraded to the next version. It is anticipated that the implementation date of the updated electronic transaction standard will not occur before 2009.

Changes to the UB-04 Claim Form

Changes to the UB-04 claim form include:

- New field for diagnosis present at time of admission
- Expansion of the diagnosis and procedure field sizes to accommodate the ICD-10-CM and ICD-10-PCS codes

- New field to denote version of ICD classification used
- Expansion of the number of fields for secondary diagnoses
- Addition of distinct fields for patient's reason for visit
- Distinct fields for E-code reporting
- Field to identify national provider identifier (NPI)

The table [below] compares the current and anticipated inclusion of HIM-related data elements. Two changes are expected to have the greatest impact on HIM professionals: the addition of distinct fields for patient's reason for visit and the new field for diagnosis present at time of admission.

Patient's Reason for Visit

FL76 on the UB-92 is currently a dual-purpose field depending on whether the bill is for inpatient or outpatient services. On outpatient bills, FL76 is used to report the ICD-9-CM diagnosis code for the patient's reason for visit. In the UB-04, the reason for visit will have its own designated form locator (FL 70A-C) and will be expanded to capture up to three reason for visit codes for certain outpatient encounters.

According to the UB-92 manual, FL76 is used on outpatient claims to report the ICD-9-CM diagnosis code describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. In addition, the UB-92 manual specifies a revenue code requirement that "the patient's reason for visit information should be reported for all unscheduled outpatient visits when revenue codes 45X [emergency room], 516 [urgent care clinic], 526 [free-standing urgent care clinic], or 762 [observation] are present."

The expanded reason for visit requirement will alleviate payment delays that occur when the outpatient claim is suspended because of the need for additional information regarding the circumstances of the encounter or visit. Payers use ICD-9-CM diagnosis codes to adjudicate claims and to determine whether the services provided meet medical necessity. Coders should be aware that they can now report up to three reason for visit codes for certain outpatient claims. To review the history and the coding advice related to reason for visit, consult the fourth quarter 1999 and second quarter 2000 issues of the American Hospital Association's *Coding Clinic for ICD-9-CM*.

Present on Admission Indicator

Among the new UB-04 data elements is the present on admission (POA) indicator. Its purpose is to differentiate between conditions present at admission and conditions that develop during an inpatient admission.

The definition of "present on admission" poses challenges. It is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter such as the initial emergency department visit or during observation are considered as present on admission. The NUBC work group considered "present on admission" versus "present on arrival" and concluded variable payer requirements regarding the inclusion of outpatient services on the inpatient claim and issues with the multiple avenues that lead to an inpatient admission would cause a "present on arrival" definition difficult and inconsistent data would result.

Furthermore, the POA indicator definition is not only based on conditions known at the time of admission but also includes those conditions that were clearly present, but not diagnosed, until after the admission took place. For example, should a patient have a documented skin lesion on admission that is later diagnosed as malignant melanoma, this diagnosis would be assigned POA indicator Y (yes).

Conditions that are suspected at the time of admission and subsequently confirmed during the hospitalization also are considered to be present on admission. For example, a patient is admitted for syncope. After study this symptom is attributed to new onset of atrial fibrillation and would have the POA indicator Y assigned for atrial fibrillation.

Principal diagnosis is to be assigned a POA indicator under the UB-04 reporting requirements. In some state reporting, such as Florida, this assignment is not required. Logically the vast majority of the time the principal diagnosis would have a POA indicator of Y. However, ICD-9-CM combination codes and instances when an acute exacerbation of a chronic condition

occurs during the admission warrant consideration. Without standardized reporting guidelines cases such as an obstetric patient with the principal diagnosis of 664.21, third-degree perineal laceration during delivery, could be unreliably reported. The cooperating parties are developing a set of guidelines for reporting the present on admission indicator, which will be included as a special section in the October 2006 version of the ICD-9-CM Official Guidelines for Coding and Reporting.

The goal is to assess when the condition was present. The addition of this data element is viewed by many as a method for improving the utility of administrative claims data to assess the quality of healthcare. The National Committee on Vital and Health Statistics and the Agency for Healthcare Research and Quality are among those entities that consider this information valuable in performing risk adjustment and other quality measurement activities.

With the implementation of present on admission reporting in 2007 the Florida Agency for Health Care Administration is planning to publish the rate of certain complications such as infections that occur after admission to the hospital on its Web site. MEDPAC, the federally appointed advisory committee to Medicare and Congress on Medicare, urged Medicare to adopt the POA indicator for inclusion in Medicare's pay-for-performance system. While Medicare has not formally announced its intentions, the indicator is clearly being considered.

New York and California have required hospitals to report the timing of each diagnosis as a component of the medical discharge information submitted to the state since 1993 and 1996, respectively. Diagnoses reported include a flag indicating if the condition was present on admission or not. This additional information is useful when developing risk adjustment models for hospitalized patients, because conditions present on admission (comorbidities) can be distinguished from conditions that develop during the hospital stay (complications) and are therefore potentially reflective of a service of care quality problem. Indeed, the POA indicator currently used for California and New York has been helpful in distinguishing conditions and infections that occurred during the patient's stay or prior to hospitalization.

As approved by NUBC, the POA indicator applies to the diagnosis codes for claims involving inpatient admissions to general acute care hospitals and other facilities, as required by state law or regulations for public health reporting. The indicator is to be reported for the principal and all secondary or other diagnoses using the following reporting options:

- Y: yes
- N: no
- U: no information in the record
- W: clinically undetermined
- - Unreported/Not used—exempt from POA reporting

The cooperating parties have yet to compile the list of ICD-9-CM codes that will not require a POA indicator. It is expected this list will be published in the October 2006 updated version of the ICD-9-CM Official Guidelines for Coding and Reporting. The indicator can be left unreported only for the codes on this list. Many V codes in the "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services" chapter are expected to be on the exempt list.

NUBC did not exclude E codes from the POA indicator, as members of the NUBC work group that developed recommendations for the UB-04 POA reporting requirements felt that E codes should be included because of the importance of this information from a patient safety perspective. The California Office of Statewide Health Planning and Development and New York State specifically exclude E codes from the present on admission reporting for secondary diagnoses. E codes will be excluded as well in January 2007 when Florida hospitals begin using the POA indicator when reporting inpatient data to the Agency for Health Care Administration.

For POA indicator reporting consistency and accuracy further parameters are necessary. Available data and lessons learned from states that have implemented this reporting requirement are available and can be used to guide this process. This data may be used for many purposes, including adjusting for patient risk for quality outcome measures and in determining patient complexity for payment purposes. In the future, reporting a POA indicator for diagnoses will be a new and important responsibility for all hospitals when this becomes a billing requirement; however, many facilities, based upon state reporting requirements, may be affected sooner.

In preparation for the UB-04, with particular emphasis on reason for visit and present on admission data elements, organizations should consider items in the following checklist.

UB-04 Readiness Checklist

Remember that this information only applies if your facility performs paper billing with the UB, and it is not applicable for facilities using the electronic format.

Investigation Tasks

- Perform gap analysis to identify software programs that contain ICD-9-CM codes.
- Talk with all vendors that have software with ICD-9-CM codes and discuss their plans for field expansion, including number of diagnosis, E codes, and reason for visit. Also inquire as to the ability to capture POA indicators.
- Identify interfaces that will be affected by the updates related to UB-04.
- Develop a plan with vendors and IT representatives to update interfaces, if applicable.
- Even though POA is not a billing requirement at this time, investigate if other agencies are requiring this information to be collected and reported (e.g., state reporting).

Training Tasks

- Develop UB-04 (paper) education for patient financial services, compliance, HIM, and patient access staff. All departmental managers and an executive champion should also be present.
- Include UB-04 (paper) education in compliance training.
- Ensure coders are aware of the changes and implement them into their daily coding practices (e.g., begin reporting three reason for visit codes).

Policies

- Evaluate the need to update internal coding guidelines regarding the number of diagnoses, procedures, and E-codes abstracted.
- Update internal abstracting guidelines regarding reason for visit and (if applicable) present on admission.

External Tasks

- Discuss UB-04 requirements with fiscal intermediary to understand its position and preparation process. If it is necessary to process a paper UB-04 claim, when will the intermediary be ready?
- Evaluate other payers' readiness to accept paper UB-04 claims. Patient financial services should prioritize those payers that do not accept claims submitted electronically because those will be the entities most affected by this change.
- Discuss UB-04 with the state reporting agency to understand how it will utilize the data.

Areas to Involve within the Organization

- Executive
- Contracts management
- Finance
- Patient financial services
- Revenue cycle management
- Performance improvement, quality improvement
- HIM
- Risk management
- Infection control
- Case management, utilization review, disease management
- Physicians
- Compliance

Web Sites to Monitor for Updates

- National Uniform Billing Committee, www.nubc.org
- AHIMA, www.ahima.org
- Centers for Medicare and Medicaid Services, 2006 Transmittals, www.cms.hhs.gov

As an HIM professional, it is important to be aware of the changes that will affect claim submission in both the electronic and paper environments. HIM professionals are encouraged to be proactive and to be a resource within their organizations when questions arise related to the HIM data elements included within the billing process.

Comparing the Current and Anticipated HIM-related Data Elements in the Uniform Bill

HIM-related Data Element	UB-92 Paper Format	Current Electronic Transaction	Upcoming UB-04 Requirements	Need to Consider for Future Electronic Standard Update?
Expansion of the diagnosis and procedure field sizes to accommodate ICD-10-CM and ICD-10-PCS codes	Does not accommodate	Accommodates ICD-10-CM/PCS codes, but does not identify the assigned code version	Field size will be increased to allow for ICD-10-CM and ICD-10-PCS codes	Yes--even though the ICD-10 format can be accepted, the current electronic standard does not identify the version of ICD being submitted.
Expansion of the number of fields for secondary diagnoses and distinct fields for E codes	Does not accommodate	Accommodates the increased number of secondary diagnoses but limits the number of E codes	Number of secondary diagnoses will increase, and E codes will have distinct fields	Yes--the current electronic standard will need to address the current E-code limitation.
Addition of distinct fields for patient's reason for visit	Uses FL76 as a dual field	Uses FL76 as a dual field	Will separate reason for visit into a separate field and will allow reporting of up to three codes	Yes--the current electronic standard does not accommodate
New field to denote version of ICD classification used	Does not accommodate	Does not accommodate	Will have a separate field	Yes--the current electronic standard does not accommodate
Addition of national provider indicator	Does not accommodate	Does accommodate	Will include this as a field	No--the current electronic standard accommodates
New field for diagnosis present at time of admission	Does not accommodate	Does not accommodate	Will be a separate one-character field at the end of each diagnosis and E-code assigned	Yes--the current electronic standard does not accommodate

Notes

1. Established in 1975, the NUBC is the official data content body responsible for maintaining the data set for institutional healthcare providers. Representation includes provider, payer, electronic standards development organizations, public health data standards organizations, and others. NUBC is also one of six designated standard maintenance organizations responsible for the maintenance and development of HIPAA administrative simplification transaction standards. Visit www.nubc.org for more information.
2. National Uniform Billing Committee. “History.” Available online at www.nubc.org/history.htm.

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