Key Points of the UB-04 (2010 update)

Editor's note: This update replaces the October 2006 practice brief "Key Points of the UB-04."

In 2005 the National Uniform Billing Committee (NUBC) approved the Uniform Bill (UB-04) paper claim and data set as the replacement to the UB-92 paper form.[1] Currently, all paper claims must be submitted using the UB-04. However, the UB-04 applies only to claims submitted on paper, which are now in the minority.

Although this practice brief addresses the latest update to the paper UB-04 and what it means for HIM professionals, including the two UB-04 data elements that will have the greatest effect on HIM, it also provides a brief overview of the electronic institutional claim, the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N (Insurance Subcommittee) 837 version 5010.

What Is the UB-04?

The UB-04 is the current version of the paper uniform bill used by institutional providers and contains data elements identified as necessary for claims processing in the paper environment. The form has numbered spaces, referred to as "form locators (FLs)," and general fields for data elements that are occasionally needed.

The UB-04 is maintained by NUBC, which is a voluntary and multidisciplinary committee that develops data elements for claims and claim-related transactions and is responsible for the design and printing of the current UB-04 form.

The UB-04 contains a number of improvements from the UB-92 and enhancements that resulted from nearly four years of research, including better alignment with the electronic (HIPAA ASC X12N 837 institutional transaction standard. Although the billing form is standardized, not all payers require the same data elements, so payers should be contacted for their exact billing requirements.

Comparison: The UB-92 to the UB-04

Improvements and enhancements made to the UB-04 claim form included:

- Expansion of the diagnosis field sizes to accommodate the ICD-10-CM codes and present on admission (POA) reporting and expansion of procedure field sizes to accommodate ICD-10-PCS codes
- Increased number of condition code fields, from seven to 11 (FL18–28)
- New field to denote version of ICD classification used (FL66)
- Expansion of the number of fields for diagnoses to 18 (FL67, FL67A–Q) from nine (FL67–75 on UB-92)
- Addition of three distinct fields for patient's reason for visit (FL70a–c)
- Three distinct fields for E code reporting (FL72a–c)
- Field to identify national provider identifier (FL56 formerly unlabeled)
- Revised physician fields (FL76–79) include distinct fields for national provider identifier (NPI) and qualifications, as well as first and last names
- Elimination of the provider representative signature field (FL85 on UB-92 form)
- Expanded line 23 under FL43–44, which provides space to identify multiple page claim forms (Page ___ of ___), as well as the reporting of the date the claim form was created (creation date)

It is important to keep current on changes to the UB-04, so organizations should check the NUBC Web site on a regular basis for additional updates. Upcoming changes are posted at www.nubc.org/public/whatsnew/12_03_09%20NUBC%20Billing%20Alert.pdf.

The table below compares the past and current inclusion of HIM-related data elements. Two of the changes had a significant effect on HIM professionals: the addition of distinct fields for patient's reason for visit and expansion of the fields to accommodate POA reporting.

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

Patient’s Reason for Visit

In the UB-04, the reason for visit has a designated FL (FL70a-c) and is used to capture as many as three reasons for visit codes for outpatient encounters.

According to the UB-04 manual, FL70a-c 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-04 manual specifies the patient’s reason for visit is required for all unscheduled outpatient visits. An unscheduled outpatient visit is defined as an outpatient type of bill 013X or 085X, together with FL14 codes 1, 2, or 5 and revenue codes 045X, 0516, 0526 or 0762 (observation room). In addition, the patient’s reason for visit can be reported for scheduled outpatient visits when the diagnosis codes provide additional information to support medical necessity.

Coding professionals should be aware that they can report as many as three reasons for visit codes for outpatient claims.

POA Indicator

The POA is a data element for the UB-04 (FL67, FL67A-FL67Q, FL72 a-c). Introduced as a result of the Deficit Reduction Act of 2005, reporting of the POA indicator has been mandated for inpatient prospective payment system hospitals since October 1, 2007. The POA indicator identifies whether a condition was present at the time that an order for inpatient admission occurs, including conditions that develop during an outpatient encounter such as an emergency department visit, observation, or outpatient surgery.

A POA indicator is listed next to each principal and secondary diagnosis code for claims involving inpatient admissions to general acute care hospitals. The intent is to differentiate POA conditions from those that develop during the inpatient admission. Specific details are available in appendix I of the “ICD-9-CM Official Guidelines for Coding and Reporting.”

The provider must report one of the five POA indicators for each diagnosis:

Y = yes (POA at the time of inpatient admission)

N = no (not present at the time of inpatient admission)

U = unknown (documentation is insufficient to determine whether condition was present at the time of admission)

W = clinically undetermined (provider is unable to clinically determine whether condition was POA)

1 (on electronic claims) or blank (for paper claims) = exempt from POA reporting

The consistent and accurate assignment of POA indicators has become an important responsibility for the HIM department and the facility.

UB-04 Compared to Electronic Institutional Claim, the ASC X12N 837 Version 5010

The paper UB-04 provides a placeholder for items that will be required for billing purposes in the future (for example, ICD-10-CM/PCS). The current version of the electronic institutional claim, the ASC X12N 837I version 4010, will be upgraded to version 5010 and will conform to the data elements that are now required on the paper UB-04. For instance, the paper UB-04 provides a new field to show which version of ICD is used. This cannot be reported in version 4010 but can be reported in version 5010.

HIM professionals should be familiar with the planned upgrade to version 5010 and recognize the difference between the electronic version and the current paper UB-04. According to the Medicare Learning Network *Matters* article:[2]

> Over 99 percent of Medicare Part A claims and over 95 percent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically.
>
> Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, Version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on admission," and accommodating the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.HIM professionals must 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.

Resources for Updates

- NUBC, www.nubc.org
- AHIMA, www.ahima.org
- Centers for Medicare and Medicaid Services, www.cms.hhs.gov

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. Centers for Medicare and Medicaid Services. "An Introductory Overview of the HIPAA 501." MLN Matters Number: SE0904. Available online at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf.

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