National Uniform Billing Committee

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Workgroup on Quality
National Committee on Vital and Health Statistics
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Perspectives on Informational Needs on Quality

Presented by
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My name is George Arges. I work at the American Hospital Association, but I am here today as the chair of the National Uniform Billing Committee (NUBC). The NUBC is a voluntary committee that has been a major force in establishing the data reporting requirements for the institutional provider setting since its creation in 1975. The NUBC approved its first data set in 1982 along with the corresponding paper form commonly referred to as the UB-82 or the HCFA-1450. In 1992, the NUBC voted to replace the UB-82 with the UB-92 data set. This came about after numerous surveys and study.

When the committee approved the UB-92, they also adopted a similar 10-year moratorium on the structure of the data set. That moratorium expired at the end of 2002. The HIPAA administrative transactions were also earmarked for implementation during this period. The NUBC deferred making changes to the UB-92 to allow the health care community to focus primarily on HIPAA implementation. Since 2002, we have been busy undertaking a review of the UB-92 data set for possible redesign. There are several reasons why we did this:

- NCVHS request in 2003 to align the paper UB with the HIPAA electronic 837i standard
- Public Health Needs – effort to bring a national approach on research data needs
- New Reimbursement Models – that include quality or performance based payment adjustments
- Other – to focus on increasing the overall administrative efficiency of the existing transaction standard; recognizing the growing importance of clinical coding and the eventual implementation of ICD-10-CM; the eventual release and adoption of future HIPAA identifiers for provider and health plans; as well as improving the handling of liability claims
- State variation in handling local health care needs

The result of our study has been the development of the UB-04.

In terms of alignment with the 837i, we sought to closely match as much of the 837i components that pertain to the development of a claim. We added the "pay-to" provider instructions; removed marital status, employer status codes, and, employer address. We created distinct areas within the form to handle city, state, zip code, last and first name, and accident information.

The UB-04 data set, like its predecessor, is robust in its design and is likely to meet future challenges that may arise from federal and state legislation or from new reimbursement models that build on rewarding quality based performance.

Over the years, we have seen greater reliance on clinical information to determine reimbursement for the services rendered to the patient. Therefore, the most significant change in the UB-04 design is the accommodation for the ICD-10-CM diagnosis coding structure for diagnosis reporting on all patient services. Not only did we expand the field size, we also expanded the number diagnosis codes that can be reported on the paper form from nine to sixteen. We also added the ability to report within each diagnosis field whether a particular diagnosis code was present at the time of admission. Collectively, these changes provide a better understanding of the services rendered.

Similarly, we expanded the field size for procedure code reporting both at the line level as well as at the claim level. For inpatient services, the procedure code can now accommodate the new ICD-10-PCS field size. For outpatient claims, we expanded the field size for procedure code reporting at the individual service level to 14 characters. This change allows for the reporting of a five-digit HCPCS along with up to four modifiers. Previously we could report the HCPCS and only two modifiers. The added field size can now accommodate the reporting of some of the new cancer drugs now covered under MMA using the NDC.

An important new feature of the UB-04 data set is the introduction of a "Code–Code Field". This field allows the reporting of data from external (non-NUBC) code sets that may be important to the adjudication or review of the claim. For instance, the *Code-Code* field could indicate the reporting of a LOINC, followed by the particular LOINC, and then the associated value tied to that LOINC. The purpose of this feature is to reduce the frequency of attachments when unusual events commonly require the reporting of a particular clinical value or measure. Additionally, the design of this field can accommodate overflow reporting of internal NUBC code fields such as Condition Codes, Value Codes, or Occurrence Codes. Again, the intent is to reduce the reliance on developing costly attachments for submission after sending the claim.

Another feature includes the establishment of a distinct field for handling the reporting of an accident. Previously we could only report the nature of the accident (e.g., auto) along with the date. We heard from various health plan organizations that they also needed to know the state where the accident occurred. Consequently, a state identifier is now part of the data field. This change would help health plans and workers compensation organizations in their review of claims resulting from an accident.

Let me now address the questions pertaining to the eight recommendations proposed by the quality workgroup.

1) **Creating a mechanism for reporting selected inpatient and outpatient laboratory results in a standard transaction.**

The UB data set can accommodate the reporting of laboratory results by either using Value Codes or the "Code-Code" Field. For instance, we currently utilize value codes for reporting the number of units of EPO furnished. On a more recent note, we established new value codes to report the weight and height of the patient. These latest changes allow CMS to determine the Body Mass Index of the patient for additional payment to the ESRD provider.

2) **Create a mechanism for reporting select vital signs and objective data measurements for inpatient encounters and outpatient visits in a standard transaction.**

Similar answer to the above solution – Value Codes and the new Code-Code Field can accommodate the reporting of these measures. Whether it is the heart rate, blood pressure, temperature, respiratory rate, or other vital sign we can accommodate these if we have a better understanding of the use of these during the review of the claim. We will also need to know more precisely when to take these vital signs for reporting purposes. As new treatments and technology arise, these data attributes or measures are likely to change or influence how one views these data components in their application of quality-based performance. Providers are concerned about the frequency of such changes and the implications it may impose on their routine data collection processes.

3) **Facilitate the reporting of a diagnosis modifier to flag diagnoses that were present on admission on secondary diagnosis fields in all inpatient claims transactions.**

The UB-04 design, as mentioned earlier, allows reporting of this modifier with each ICD-10-CM diagnosis reported. The current UB-92 does not have this feature. The primary reason for the re-design of the UB data set is to accommodate ICD-10-CM. If progress toward ICD-10-CM implementation does not move forward then it is unlikely that the NUBC will adopt a date certain for the implementation of the UB-04. Again, the main reason for adoption of the UB-04 is to accommodate the clinical code enhancements.

4) **Modify the usage instructions for the existing data element for Operating Physician such that it is a required data element for the principal inpatient procedure.**

The UB-04 will have a distinct field for reporting "Operating" physician responsible for the principal surgical procedure. The NUBC is working together with the X12 claim

workgroup to better define attending, operating, referring, and other provider types for reporting in a claim transaction.

5) **Modify the requirements for reporting Admission Date/Time and selected Procedure Dates/Times on institutional claim transactions.**

The current UB allows the reporting of the Admission Date and Time (hourly code range). It also allows the reporting of the corresponding date with each procedure code reported. We do not have a distinct field for reporting the procedure hour. There are options that we could undertake to handle this reporting for procedure codes, however, we need to better understand the merits of undertaking this detail level of reporting and weigh the benefits derived from the additional collection and reporting burden.

6) **Encourage payers to modify billing instructions to providers to align procedure start and end dates with services included in selected global procedure codes in standard HIPAA claim transactions.**

Global procedure code reporting is not part of the institutional billing process. It is more common to find global billing on physician claims. Physicians may use a global procedure code to indicate billed services that also include postoperative care and/or follow-up care. We would encourage health plans to come to agreement on the provisions of global procedure code reporting and present those recommendations to the NUCC.

7) **Review the available options for coding patient's functional status in EHRs and other clinical data sets and recommend standard approaches. Conduct the research recommended by NCVHS in 2001 and CHI in 2003, as endorsed by NCVHS.**

The UB data set can accommodate the reporting of functional status. It is unclear as to when one also intends to gather and report the functional status of the patient. We need

additional guidance as well as a better understanding of the implications for collecting functional status. As mentioned before, we expanded on the number of diagnosis codes the UB-04 can report; this change should help by providing additional knowledge about any chronic or underlying medical condition of the patient. We would welcome additional guidance on the clinical reporting aspects. In terms of other functional status measures, we have the right data element design to accommodate such reporting. For instance, CMS requires a skilled nursing provider to complete the MDS assessment for assignment of a RUG category. The UB captures the RUG assignment. Similarly, CMS requires Home Health providers to complete the OASIS assessment instrument and then report the HRG assigned. Again, the UB can capture the HRG assignment.

While collecting certain data is important there is much more work in how health plans utilize and apply data on a routine basis. At the recent August NUBC meeting, we discussed health plan differences in their use of the "From and Through Date" fields. For instance on an inpatient claim, CMS currently requires the provider to report the admission date within the Statement From Date field on a claim even though a distinct admission date field is present.

The NUBC recommends that the Statement From and Through dates represent dates pertaining to the entire list of services represented on this billing statement. The intent is to reflect services provided before the admission but included on the inpatient bill. Distorting the data reported in the From date field could create problems in how one applies quality measures and therefore their view on provider performance.

It is clear we need to further standardize the practices among health plans for each of the data items within the data set. This is especially true if we are to consistently compare claims data. We are working to make these improvements, not only in the date fields reported, but also for other data elements such as the reporting of Patient Discharge Status Codes. These codes are important for reimbursement purposes as well as for health researchers who look to these codes for analysis of the outcomes of care. Currently, there is wide variation as to the appropriate use of the code to denote the

discharge or transfer disposition of the patient. A simple example: What code do you report if the discharge is to the patient's home? We have a code for home but what code do you report if the patient's home is a nursing facility? While there are also codes to indicate nursing facilities we may need to make better distinction of the nursing facility being the patient's home.

8) Facilitate the reporting of a diagnosis modifier to flag diagnoses were present on admission on secondary diagnosis fields in all inpatient claim transactions. (Functional Status section)

The UB-04 accommodates this recommendation; it is not part of the existing UB-92. As mentioned before, the adoption of the UB-04 is predicated on whether the nation intends to move forward with the adoption of ICD-10-CM for diagnosis reporting. Without clear evidence that this will take place, there is no compelling reason for our committee to move forward with the UB-04 implementation.

Summary

Overall, the other questions can only be answered when the NUBC receives specific requests for each of the informational pieces along with sufficient detail as to when it would be reported, how it would be applied, and what the reporting of this information intends to accomplish. The NUBC seeks to determine the relevance for the information and looks for a reasonable set of development expectations that go along with the request. We recently approved a request that came from the PHDSC for the reporting of an indicator that the patient has signed a Do Not Resuscitate (DNR) order. The NUBC has set aside a series of codes specifically for public health reporting. The NUBC will then review assignment of new public health codes when the need arises. The review and assignment of other codes, such as race and ethnicity, will also be done on a case-by-case basis. (Note: This is something that could be accommodated via the Code-Code field.) While the UB data set has the capability to handle many of the recommendations of the

quality workgroup, we need a better understanding of the business case for each of the items requested before we can adopt these as part of the routine process for claim submission. This also includes having sufficient information about proposed performance adjustment factors and how they are applied and whether these are appropriate. We believe the new UB-04 data set will provide better clinical information. In turn, better clinical information will aide our understanding of the care provided.

Again, on behalf of the NUBC I would like to thank the members of this subcommittee for the opportunity to comment.