Blood and Blood Derivatives Billing Examples: UB-04

Page updated: September 2020

Examples in this section are to assist providers in billing for blood and blood derivatives on the *UB-04* claim form. Refer to the *Blood and Blood Derivatives* section of this manual for detailed policy information. Refer to the *UB-04 Completion: Outpatient Services* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Separate Manufacturers' Blood Factors on One Claim Line

Figure 1. Separate manufacturer's blood factors on one claim line.

This is a sample only. Please adapt to your billing situation.

In this example, six units (vials) of Factor VIII (antihemophilic factor, human) are billed on one claim line.

Enter the two-digit facility type code "13" (hospital – outpatient) and one character frequency code "1" as "131" in the *Type of Bill* field (Box 4).

Enter code J7190 in the *HCPCS/Rate* field (Box 44). Both a product qualifier (N4) and National Drug Code (NDC) are required on the claim because antihemophilic factor (AHF) (claim line 1) is a "physician-administered" drug. Providers enter the product qualifier and NDC immediately followed by the unit of measure/numeric quantity for the AHF in the *Description* field (Box 43). (Refer to section *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* for help.) Due to the large quantities of AHF dispensed, providers must include the number of international units or micrograms dispensed in the *Remarks* field (Box 80).

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Enter the date of service, in a six-digit format, in the *Service Date* field (Box 45) and the usual and customary charges in the *Total Charges* field (Box 47, line 23).

Note: Providers participating as covered entities, and purchasing drugs through the Public Health Service (PHS) program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Participants may also bill for a dispensing fee or markup, as allowed by Medi-Cal. Entities billing for PHS purchased factor must include the modifier UD in the modifier area (unshaded) of Box 24D.

Enter a "6" in the *Service Units* field (Box 46) on the same claim line as code J7190 to reflect the number of units of AHF that were administered.

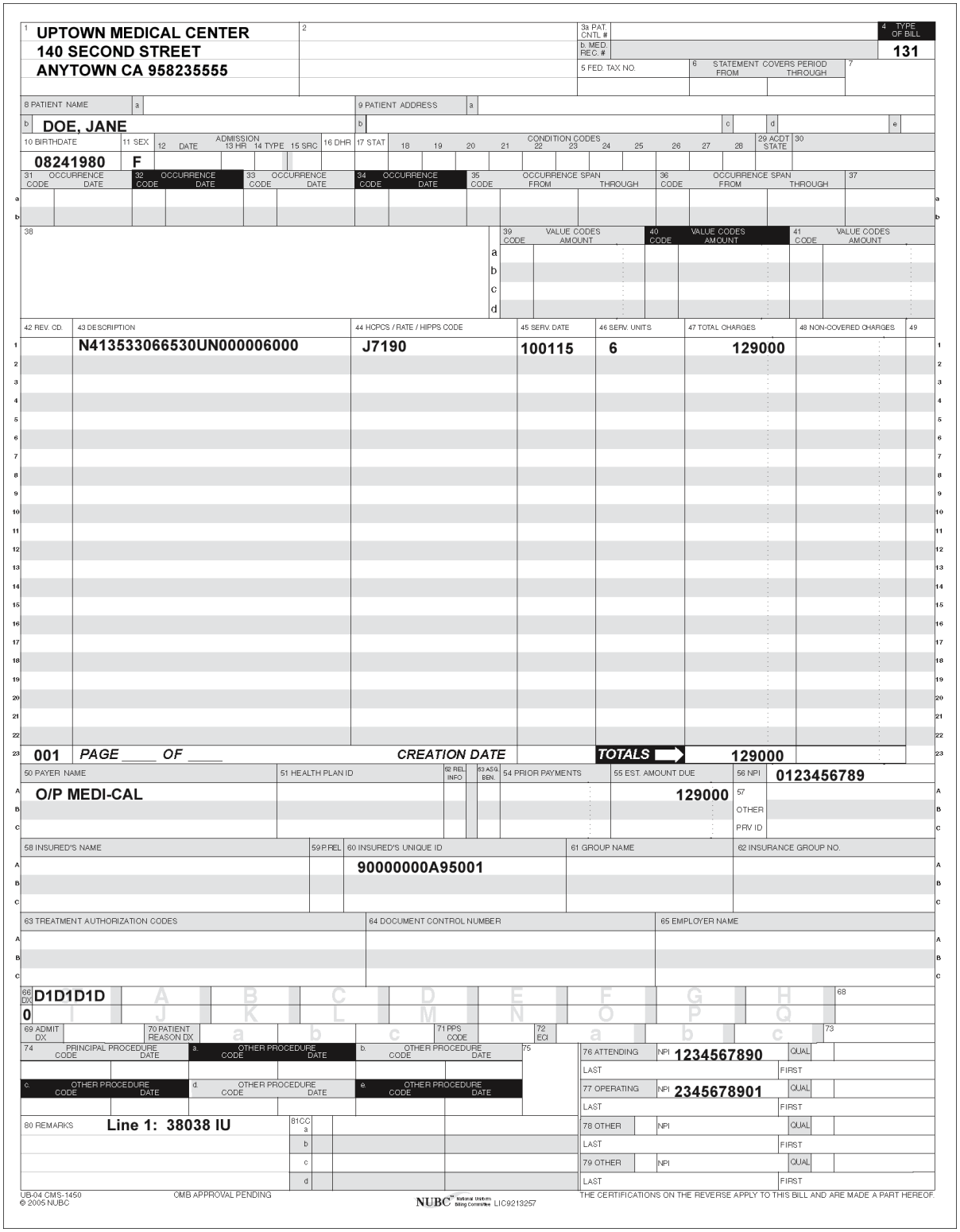
Note: The unit per vial vary from product to product.

Enter "O/P Medi-Cal" to indicate the type of claim and payer in the *Payer Name* field (Box 50). The outpatient hospital's NPI number is placed in the *NPI* field (Box 56).

An appropriate ICD-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Note: Blood factor codes (HCPCS codes J7183, J7185, J7186, J7187, J7189, J7190, J7192 thru J7195, J7197 and J7198) are reimbursable using the lower of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charge. Providers should submit claims with the usual and customary charge in the *Total Charges* field (Box 47, line 23).

Enter the referring/prescribing provider's NPI number in the *Attending* field (Box 76) and the rendering provider's NPI number in the *Operating* field (Box 77).



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	N413533066530UN000006000	J7190	100115	6	129000	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	129000	

50 PAYER NAME: O/P MEDI-CAL | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE: 129000 | 56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

80 REMARKS: Line 1: 38038 IU

UB-04 CMS-1450 | OMB APPROVAL PENDING | NUBC LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 1: Billing Separate Manufacturer's Blood Factor on One Claim Line.

Separate Manufacturers' Blood Factors on Two Claim Lines

Figure 2. Blood factors. Billing separate manufacturer's blood factors on two claim lines.

This is a sample only. Please adapt to your billing situation.

In this example, 3 units (vials) of Factor VIII (antihemophilic factor, human) from manufacturer XYZ is billed on one claim line and 3 units (vials) of Factor VIII from manufacturer ABC is billed on the second claim line.

Enter the two-digit facility type code "13" (hospital – outpatient) and one-character frequency code "1" as "131" in the *Type of Bill* field (Box 4) [not pictured].

Enter J7190 for each manufacturer in the *HCPCS/Rate* field (Box 44). Both a product qualifier and National Drug Code (NDC) are required on the claim because antihemophilic factor (claim lines 1 and 2) is a "physician-administered" drug. Providers enter the product qualifier and NDC number immediately followed by the unit of measure/numeric quantity for the antihemophilic factor in the *Description* field (Box 43). (Refer to section *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* for help.) Due to the large quantities of AHF dispensed, providers must include the number of international units or micrograms dispensed in the *Remarks* field (Box 80).

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Enter the date of service, in a six-digit format, in the *Service Date* field (Box 45) and the usual and customary charges in the *Total Charges* field (Box 47, line 23).

Note: Providers participating as covered entities, and purchasing drugs through the Public Health Service (PHS) program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Participants may also bill for a dispensing fee or markup, as allowed by Medi-Cal. Entities billing for PHS purchased factor must include the modifier UD in Box 44, following the HCPCS code.

Enter a "3" in the *Service Units* field (Box 46) for each manufacturer to reflect the number of units of AHF that were administered.

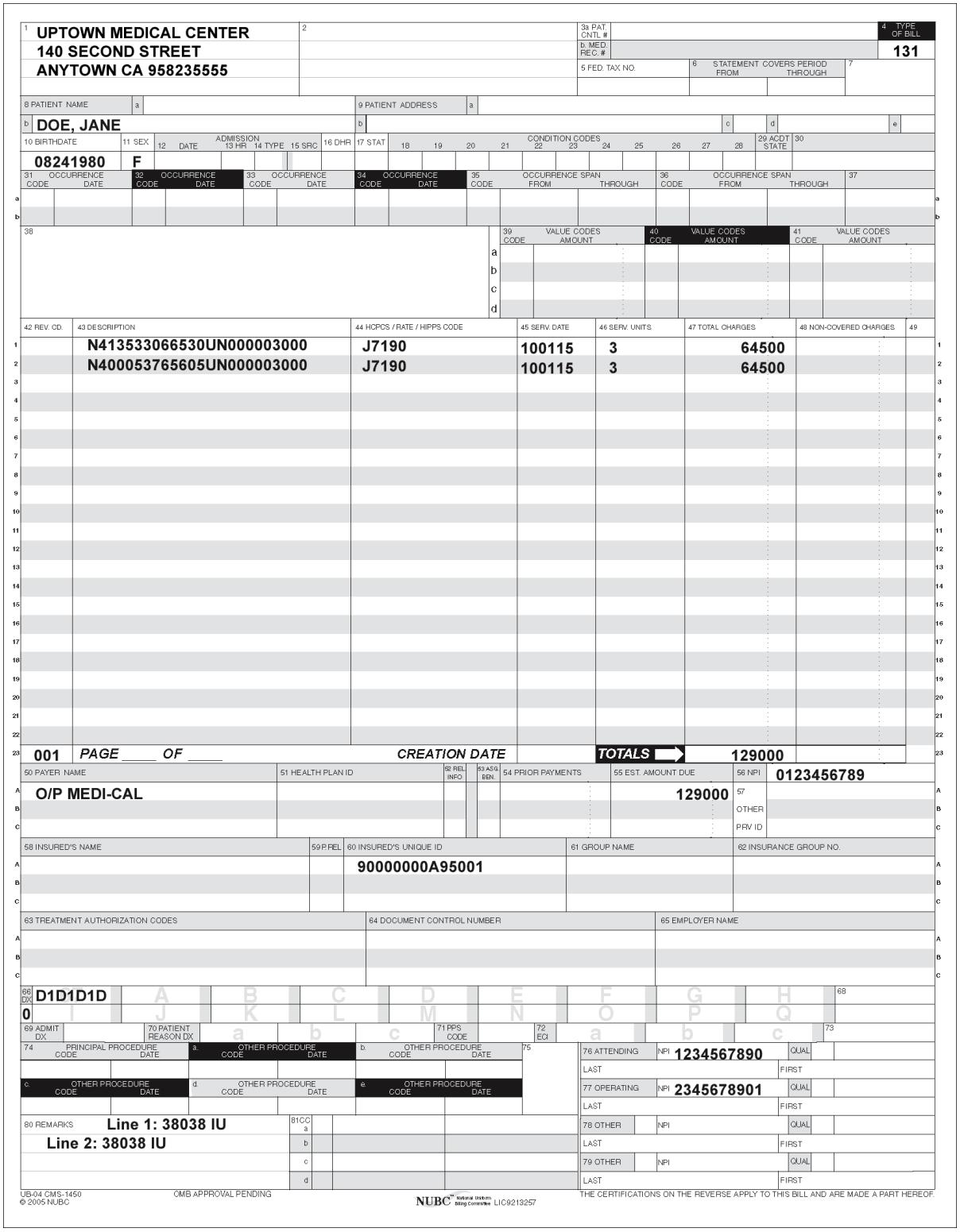
Note: The units per vial vary from product to product.

Enter “O/P Medi-Cal” to indicate the type of claim and payer in the *Payer Name* field (Box 50). The outpatient hospital’s provider number is placed in the *NPI* field (Box 56).

An appropriate ICD-10-CM diagnosis code is entered in Box 67. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An Indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Note: Blood factor codes (HCPCS codes J7183, J7185, J7187, J7189, J7190, J7192 thru J7195, J7197 and J7198) are reimbursable using the lower of the manufacturer’s Average Selling Price (ASP) plus 20 percent or the provider’s usual and customary charge. Providers should submit claims with the usual and customary charge in the *Total Charges* field (Box 47, line 23).

Enter the referring/prescribing provider’s NPI number in the *Attending* field (Box 76) and the rendering provider’s NPI number in the *Operating* field (Box 77).



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	N413533066530UN000003000	J7190	100115	3	64500	
	N400053765605UN000003000	J7190	100115	3	64500	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	129000	

50 PAYER NAME: O/P MEDI-CAL | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE: 129000 | 56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 1234567890
77 OPERATING NPI: 2345678901

80 REMARKS: Line 1: 38038 IU
Line 2: 38038 IU

Figure 2: Billing Separate Manufacturer's Blood Factors on Two Claim Lines.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.