Claim Completion: UB-04

Page updated: September 2020

The examples in this section assist providers billing for Family Planning, Access, Care and Treatment (Family PACT) Program services on the *UB-04* claim form. While Family PACT claims are generally billed with the same method as Medi-Cal claims, there are some unique differences for Family PACT. Providers should carefully read information in this manual concerning Family PACT ICD-10-CM diagnosis codes and additional ICD-10-CM documentation requirements. Refer to Benefits: Family Planning and Benefits: Family Planning-Related Services sections of this manual for detailed policy information.

Claim Completion Instructions Overview

For general claim completion instructions, refer to the following sections in the Part 2 Medi-Cal manual:

- Correct Coding Initiative: National
- UB-04 Completion: Outpatient Services
- UB-04 Special Billing Instructions for Outpatient Services
- UB-04 Submission and Timeliness Instructions
- UB-04 Tips for Billing: Outpatient Services
- Physician-Administered Drugs NDC: UB-04 Billing Instructions

Claim Examples

This section includes examples of family planning and family planning-related services that require appropriate ICD-10-CM coding for reimbursement. It also includes an example of when two claim forms are required for the same date of service because different additional ICD-10-CM diagnosis codes are required for treatment services provided in a single visit.

Because these claims are 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: These are examples only. National Drug Code (NDC) numbers and charges used for the examples may be fictitious or outdated and are not intended for use on the actual claim form. Adapt to your billing situation.

Billing Tips When completing claims, do not enter the decimal points in any 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.

Office visit, pregnancy test, symptomatic urinary tract infection (UTI) diagnostic test and onsite dispensing

«In this example, a client has an initial family planning visit at a community clinic including a pregnancy test which was negative. The client complains of dysuria, so a point-of-care urine dipstick (without microscopy) is done. The client receives counseling about all contraceptive methods. The clinician dispenses 13 cycles of oral contraceptives as her primary method of family planning, with condoms as a back-up method and 3 days of ciprofloxin tablets for a presumptive UTI. The total time of the clinician visit is 32 minutes, including time for charting in the medical record.

The health educator, under direct supervision of the clinician, provides individual orientation to Family PACT, which includes information on the scope of the program, family planning methods, and select family planning-related conditions.

Both the product ID qualifier (N4) and National Drug Code (NDC) are required on the claim because the oral contraceptive dispensed (claim line 4) is a "physician-administered" drug. Providers enter the product ID qualifier/NDC number immediately followed by the unit of measure/numeric quantity for the contraceptive in the Description field (Box 43). HCPCS codes for contraceptive supplies are exempt from being billed in connection with an NDC.

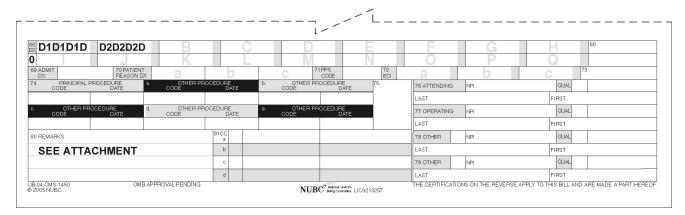
Notes:

- Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.
- Section 340B drugs may be billed on the same claim as non-340B drugs, but the 340B drugs must include modifier UD with the applicable HCPCS and NDC codes. Refer to the appropriate Part 2 manual section *Physician-Administered Drugs NDC: UB-04 Billing Instructions* for details on NDC and 340B billing requirements.

Family PACT – Claim Completion: UB-04

Figure 1: Example form for office visit, pregnancy test, symptomatic urinary tract infection (UTI) diagnostic test and onsite dispensing

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	OFFICE VISIT, NEW	99203	100115	1	65 00	:	
	PREGNANCY TEST	81025	100115	1	10 00		
	UA DIPSTICK W/OUT MICROSCOPY	81002	100115	1	8 00		
	N400062190115UN000013000	S4993	100115	13	156 00		
	N101234567891UN000001000	S5000	100115	1	5 28		
	MALE CONDOMS	A4267	100115	35	10 78		
	INDIVIDUAL ORIENTATION TO FPACT	S9445	100115	1	15 00		
	PAGE OF	CREATION DATE		TOTALS	270 06		



As indicated in the *Remarks* field (Box 80) above, on an $8\frac{1}{2}$ x 11-inch sheet of paper, document the following and attach to the claim:

- L4: norgestimate and ethinyl estradiol 13 packs at \$12.00 equals \$156.00
- L5: ciprofloxin number 6 250 mg at \$.38 equal \$2.28 plus cdf at \$3.00 equals \$5.28
- L6: male condoms number 35 at \$.28 equals \$9.80 plus cdf at \$.98 equals \$10.78

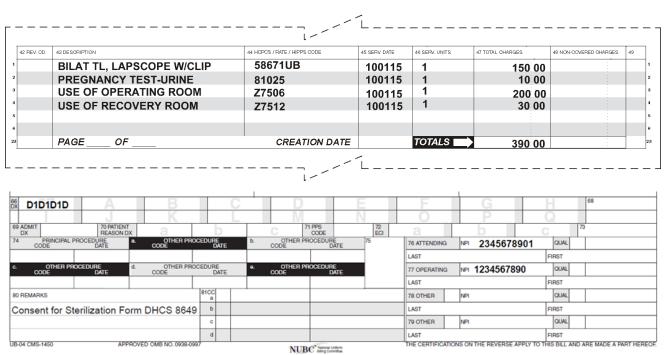
Page updated: October 2025

Facility claim for a bilateral tubal ligation performed at a surgery center

In this example, a pregnancy test is performed onsite, followed by a tubal ligation. The outpatient surgery center bills for supplies and the necessary treatment and recovery rooms required for the surgery on a *UB-04* claim form. (The surgeon submits a *CMS-1500* claim form.)

"The referring provider must be an enrolled Family PACT provider and must ensure that the Medi-Cal non-Family PACT rendering provider and the facility have received a copy of the client's *Consent For Sterilization Form* (DHCS 8649). A DHCS 8649 form must be attached to the hard copy claim form by the rendering provider. Enter the referring provider's NPI in Box 76, and the rendering provider's NPI in Box 77.

Figure 2: Example of facility claim for a bilateral tubal ligation performed at a surgery center



Dispensing supplies, collection and handling of blood specimen, and in-house lab work (an additional ICD-10-CM diagnosis code is required)

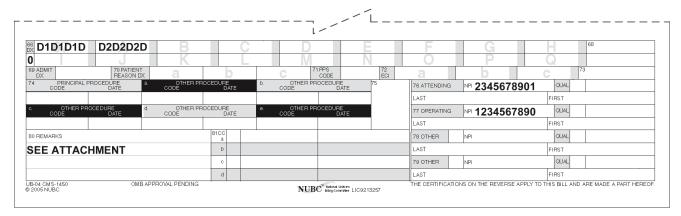
«In this example, the services performed in a hospital outpatient department include an initial visit for contraception with a complete client history, a blood pressure check and contraceptive and sexually transmitted infection (STI) counseling. Total clinician time is 35 minutes. Point-of-care laboratory work includes a pregnancy test and dipstick urinalysis for vague symptoms suspicious for a UTI.

To screen for HIV and syphilis a blood specimen is collected in the office and sent to an outside laboratory. Foam, condoms and a sample pack of oral contraceptives (at no charge) are dispensed. The client also receives a written prescription for an antibiotic for the UTI.>>

The *Remarks* field (Box 80) must include a required statement that lists dispensed supplies and indicates the blood specimen was sent to an unaffiliated lab.

Figure 3: Example form for dispensing supplies, collection and handling of blood specimen, and in-house lab work

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	OFFICE VISIT, NEW	99203	100115	1	80 00		
	PREGNANCY TEST	81025	100115	1	10 00		
	URINE DIPSTICK	81002	100115	1	8 00		
	CONDOMS, MALE	A4267	100115	20	6 16		
	SPERMICICAL GEL/JELLY/FOAM	A4269U1	100115	30	6 93		
	PAGE OF	CREATION DATE		TOTALS	111 09		1



As indicated in the *Remarks* field (Box 80) above, on an $8\frac{1}{2}$ by 11-inch sheet of paper, document the following and attach to the claim:

- L5: foam at .21 times 30 gm equal 6.30 plus CDF .63 equals \$6.93
- L4: male condoms at .28 times 20 equal \$5.60 plus CDF .56 equals \$6.16

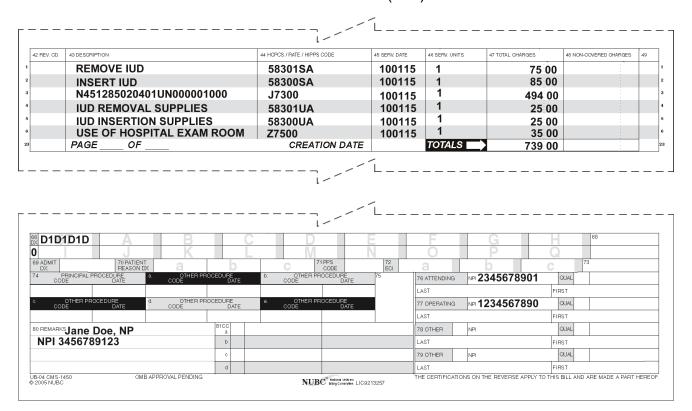
Outpatient facility for removal and insertion of an intrauterine device (IUD) (client referred by a Family PACT provider)

In this example, the established client is referred by her Family PACT provider to a nearby Medi-Cal Nurse Practitioner (NP). The NP, who works under the supervision of a physician, removed the client's intrauterine copper contraceptive that has been in place for 10 years. The client has no plans for childbearing and wants a new IUD. Enter the referring provider's NPI in Box 76, the supervising physician's NPI in Box 77, and enter the name of the NP, title, and the individual NPI number in Box 80.

Both the product ID qualifier (N4) and National Drug Code (NDC) are required on the claim because the intrauterine copper contraceptive dispensed (claim line 3) is a "physician-administered" drug. Providers enter the product qualifier/NDC number immediately followed by the unit of measure/numeric quantity for the contraceptive in the Description field (Box 43). (Refer to Part 2, Medi-Cal manual section *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* for help.)

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

Figure 4: Example form for outpatient facility for removal and insertion of an intrauterine device (IUD) >>



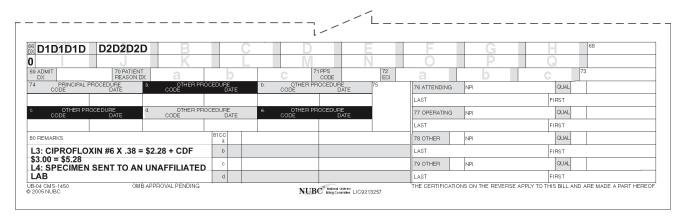
Contraceptive patch user with symptoms of burning upon urination, and partner reports exposure to a sexually transmitted infection (STI) (two claim forms required)

«In this example, an established client, who is seen for a refill of contraceptive patches, reports that she has burning upon urination and that her partner has been exposed to chlamydia. The clinician performs a urine microscopy which shows numerous white blood cell count (WBC) and the clinician dispenses ciprofloxin tablets to treat acute cystitis and azithromycin 1 gram orally for presumptive treatment of a chlamydia infection. A screening nucleic acid amplification test (NAAT) for chlamydia is sent to an outside laboratory. Blood was drawn for syphilis and HIV screening tests and sent to the same outside laboratory».

Two claim forms are required for the same date of service, because there are two different family planning-related conditions requiring two ICD-10-CM diagnosis codes for the two treatments dispensed. Each claim has the same family planning ICD-10-CM diagnosis code. Refer to the following page for the required second claim form. The office visit may not be billed twice. The community clinic has opted to include the clinic dispensing fee in computing costs for drugs dispensed onsite.

Figure 5: Example first form for a contraceptive patch user with symptoms of burning upon urination, and partner reports exposure to a Sexually Transmitted Infection (STI)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	OFFICE VISIT ESTABLISHED	99214	100115	1	45 00	:	
	URINE MICROSCOPY	81015	100115	1	8 00		
	N451285020401UN000001000	S5000	100115	1	5 28		
	BLOOD DRAW	99000	100115	1	10 00		
	PAGE OF	CREATION DAT	F	TOTALS	68 28		

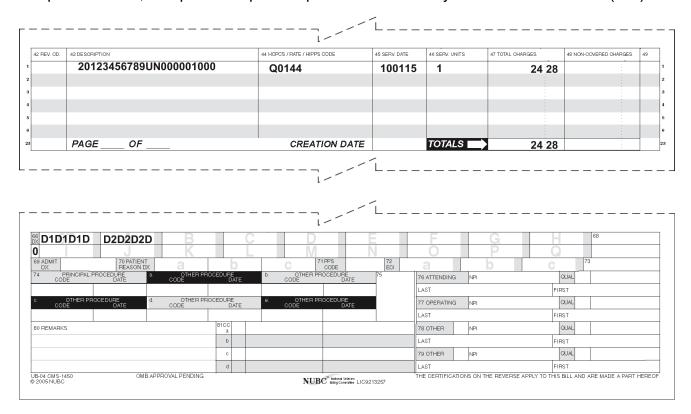


Contraceptive patch user with symptoms of burning upon urination, and the partner reporting exposure to a Sexually Transmitted Infection (STI) (second claim form) (continued)

The second claim form includes the drug to treat STI exposure onsite (refer to the first claim form on the preceding page). Both the product ID qualifier (N4) and NDC are required on the claims.

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

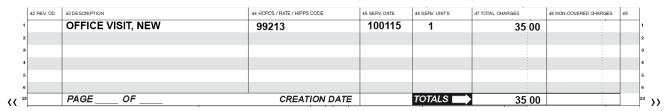
«Figure 6: Example second form for a contraceptive patch user with symptoms of burning upon urination, and partner reports exposure to a Sexually Transmitted Infection (STI)»

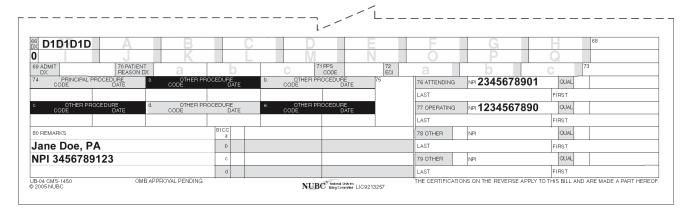


Education and counseling visit with a Physician's Assistant (PA)

«In this example a female client who is an established depo medroxyprogesterone acetate (DMPA) user is seen for concerns with irregular vaginal bleeding. She receives counseling from a PA regarding the side effects of DMPA and wants to continue with the method. The total time of the visit is 20 minutes». This example shows how the rendering provider bills for the procedure. The PA works under the supervision of a physician. Enter the supervising physician's individual NPI in Box 76, the billing Family PACT provider's NPI in Box 77 and the name of the PA, title and the PA's individual NPI in Box 80.

Figure 7: Example form for education and counseling visit with a Physician's Assistant (PA)





Intrauterine contraceptive (IUC) removal and the start of oral contraceptives on the same date of service (two claim forms required)

In this example an established client has an expired IUC for removal and would like to start using an oral contraceptive.

After uncomplicated removal of the IUC, the clinician provided contraceptive counseling and prescribed and dispensed 13 cycles of oral contraceptives.

The total time of the visit (excluding the IUD removal) was 23 minutes.

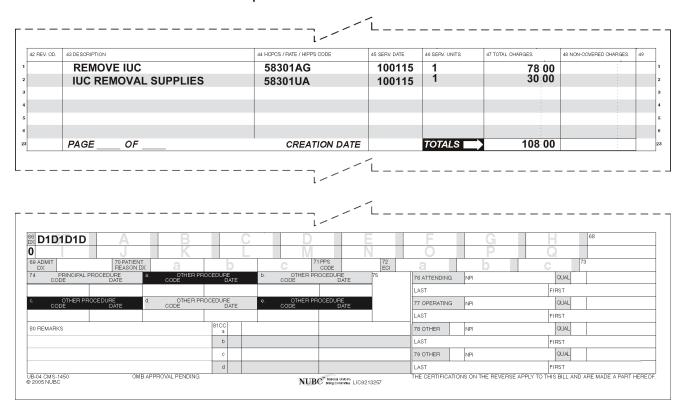
The clinician provided 15 minutes of contraceptive counseling

Two claim forms are required for the same date of service because there are two contraceptive management ICD-10-CM diagnosis codes

Refer to the following page for the second claim form

The first claim form should include the information below. Do not bill for an Evaluation and Management (E&M) visit with IUC removal on the same date of service

Figure 8: Example first form for Intrauterine contraceptive (IUC) removal and the start of oral contraceptives on the same date of service



Intrauterine contraceptive (IUC) removal and the start of oral contraceptives on the same date of service (second claim form) (continued)

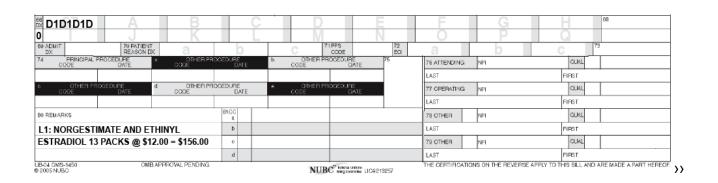
The second claim form includes the oral contraceptives dispensed onsite (refer to the first claim form on the preceding page).

Both the product ID qualifier (N4) and National Drug Code (NDC) are required on the claim because the oral contraceptive dispensed (claim line 1) is a "physician-administered" drug. Providers enter the product ID qualifier/NDC number immediately followed by the unit of measure/numeric quantity for the contraceptive in the *Description* field (Box 43). Refer to Part 2, Medi-Cal Manual section *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* for help.

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

Figure 9: Example second form for Intrauterine contraceptive (IUC) removal and the start of oral contraceptives on the same date of service

	PAGE OF	CREATION DATE		TOTALS	191 00	:	
							П
	OFFICE VISIT, ESTABLISHED	99213-25	100115	1	35 00		
	N400062190115UN000013000	S4993	100115	13	156 00		
2 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49



Office visit, positive sexually transmitted infections (STI) test results and drug onsite administration

«In this example, an established client who uses oral contraceptives tested positive for syphilis (with a positive confirmatory test) at her previous family planning visit». She receives an intramuscular injection of penicillin G benzathine, 2,400,000 units.

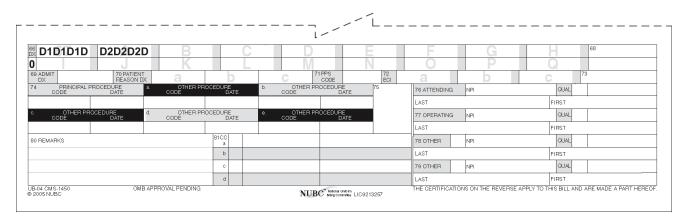
Both the product ID qualifier N4 and National Drug Code (NDC) are required on the claim because the drug dispensed (claim line 2) is a "physician-administered" drug (PAD). Providers enter the product ID qualifier/NDC number immediately followed by the unit of measure/numeric quantity for the drug in the *Description* field (Box 43). Refer to Part 2, Medi-Cal Manual section Physician-Administered Drugs – NDC: UB-04 Billing Instructions for help.

To calculate the charges for penicillin G benzathine, the cost of the injection and the administration fee must be determined. The price listed on the Medi-Cal Rates page of the Medi-Cal website for penicillin G benzathine includes a one-time administration fee. Since the administration fee is paid only once for each drug administered, subsequent units claimed must have the administration fee subtracted from the published rate. This difference is the cost of the injection. Multiply this cost with the number of units. For penicillin G benzathine, this would include the cost per unit multiplied by 23 units. To calculate the total charge, the cost for 23 units is added to the rate of the drug on file (which includes the one-time administration fee). Refer to the *Drugs: Onsite Dispensing Billing Instructions* section of this manual for specific instructions on the one-time administration fee.

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

Figure 10: Example form for office visit, positive STI test results and drug onsite administration

42	2 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	7
1		OFFICE VISIT, ESTABLISHED	99213	100115	1	35 00	:		7
2		N412345678901ML0000004000	J0561	100115	24	123 00			
3									7
4									
5									1
6									
23		PAGE OF	CREATION DATE		TOTALS -	158 00	:	1	2

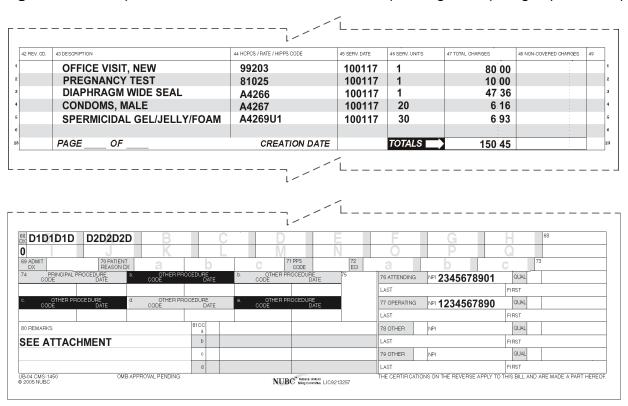


Initial visit with on-site dispensing of diaphragm (wide seal)

«In this example, the services of a hospital outpatient department include an initial visit for contraception with a complete client history and counseling. The point-of-care pregnancy test is clinically indicated and is negative. Contraceptive diaphragm (wide seal), condoms and jelly were dispensed on-site. Total clinician time is 35 minutes.»

The Remarks field (Box 80) must include a required statement that lists dispensed supplies.

Figure 11: Example form for Initial visit with on-site dispensing of diaphragm (wide seal)



In the *Remarks* field (box 80) above, or on an 8.5 by 11-inch sheet of paper, document the following and attach to the claim:

- L3: Diaphragm Wide Seal at 43.05 times 1 equals \$43.05 plus CDF 4.30 equals \$47.35
- L4: Male Condoms at .28 times 20 equals \$5.60 plus CDF .56 equals \$6.16
- L5: ((Jelly)) at .21 times 30 gm equals \$6.30 plus CDF .63 equals \$6.93

«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.