

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Blood and Blood Derivatives

Billing Examples: CMS-1500

blood cms

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Examples in this section are to assist providers in billing for blood and blood derivatives on the *CMS-1500* claim form. Refer to the *Blood and Blood Derivatives* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* 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-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Separate Manufacturers' AHF on One Claim Line

Figure 1. Blood factors billed together on the same claim line.

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

In this example, six units (vials) of Factor VIII are billed on an inpatient basis. Enter J7190 (Factor VIII, antihemophilic factor, human, per IU) in the *Procedures, Services or Supplies* field (Box 24D).

The product qualifier (N4) and the National Drug Code (NDC) are required on the claim because antihemophilic factor (AHF) is a “physician-administered” drug. Providers enter the product qualifier/NDC number in the shaded area of Box 24A. The unit of measure and numeric quantity for the AHF is entered in the shaded area of Box 24D. (Refer to section *Physician-Administered Drugs – NDC: CMS-1500 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 *Reserved for Local Use* field (Box 19).

- Notes:**
- 1) The unit of measure and numeric quantity in the shaded area of Box 24D are optional. Absence of these two elements will not result in claim denial.
 - 2) Blood factor codes (HCPCS codes J7183, J7185, J7186, J7187, J7189, J7190, J7192 – J7195, J7197 and J7198) are reimbursed using the lower of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charge.
 - 3) 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 the date of service, November 17, 2008, as 111708 in the *Date(s) of Service* field (Box 24A). Enter Place of Service code 21 (inpatient) in Box 24B.

Enter the number of units (vials) of factor administered in the *Days or Units* field (Box 24G).

Reminder: The International units or micrograms represented by the vials dispensed must be entered in the *Reserved for Local Use* field (Box 19).

Calculate the charges by multiplying the units per vial by the usual and customary charge (refer to the *Blood and Blood Derivatives* section of this manual). Enter the amount in the *Charges* field (Box 24F).

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										PICA <input type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN				3. PATIENT'S BIRTH DATE MM DD YY 06 21 62		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9000000A95001			
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY ANYTOWN		STATE CA		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE 95823		TELEPHONE (Include Area Code) (916) 555-5555		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED _____ DATE _____						SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
19. RESERVED FOR LOCAL USE Line 1: 38038 IU				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____				2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #	
11 17 08		21		F20038038000 J7190		129000		6		NPI 0123456789	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 129000		29. AMOUNT PAID \$ 129000	
30. BALANCE DUE \$ 129000		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Jane Doe</i>		32. SERVICE FACILITY LOCATION INFORMATION a. NPI		33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555		b. 1234567890		DATE 12/02/08	
NUCC Instruction Manual available at: www.nucc.org											

Figure 1. Blood Factors Billed Together on the Same Claim Line.

**Separate Manufacturers'
Blood Factors Billed on
Two Claim Lines**

*Figure 2. Blood factors: Bleeding and clotting disorders.
Billing separate manufacturers' blood factors on two claim lines.*

In this example, the six units (vials) of Factor VIII are billed as two entries on the claim. Enter J7190 (Factor VIII, antihemophilic factor, human, per IU) on claim lines 1 and 2 in the *Procedures, Services or Supplies* field (Box 24D).

The product qualifier (N4) and the National Drug Code (NDC) are required on the claim because antihemophilic factor (AHF) is a "physician-administered" drug. Providers enter the product qualifier/NDC number in the shaded area of Box 24A. The unit of measure and numeric quantity for the AHF is entered in the shaded area of Box 24D. (Refer to section *Physician-Administered Drugs – NDC: CMS-1500 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 *Reserved for Local Use* field (Box 19).

- Notes:**
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Enter the number of (vials) of factor administered in the *Days or Units* field (Box 24G).

Reminder: The International units or micrograms represented by the vials dispensed must be entered in the *Reserved for Local Use* field (Box 19).

Calculate the charges by multiplying the units per vial by the provider's usual and customary charge (refer to the *Blood and Blood Derivatives* section of this manual). Enter the amount in the *Charges* field (Box 24F).

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Figure 2. Blood Factor Products Billed on Separate Claim Lines.