Blood and Blood Derivatives Billing Examples: UB-04

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

Part 2 – Blood and Blood Derivatives Billing Examples: UB-04
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).
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.»

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