The examples in this section are to assist providers in billing for transplant services on the UB-04 claim form. Refer to the Transplants section in this manual for detailed policy information. Refer to the UB-04 Completion: Inpatient 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. For information about the diagnosis-related group (DRG) reimbursement methodology, refer to the Diagnosis-Related Groups (DRG): Inpatient Services section in this provider manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM/PCS 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.

Inpatient Claim for Double Lung Transplant: Two Donors

Figures 1a, 1b and 1c. Double lung transplant. Two donors. DRG-reimbursed hospital. These are samples only. Please adapt to your billing situation.

Case Description

A young boy requires a double lung transplant. The lungs are harvested from two separate donors. Individual claims are submitted for each person: the recipient, donor 1 and donor 2.

Lung Recipient’s Claim

Figure 1a: Lung recipient’s claim.

In this example an inpatient provider bills revenue code 203 (intensive care, pediatric) for accommodation services for a boy’s double lung transplant.

Enter the two-digit facility type code “11” (hospital – inpatient) and one-character claim frequency code “1” as “111” in the Type of Bill field (Box 4).
Enter the date of admission, October 9, 2015, as 100915 in the Admission Date field (Box 12). Enter the 9 a.m. hour of admission in military terms (9) in the Admission Hour field (Box 13). In the Admission Type field (Box 14), enter the “type” of admission. In this case, the “3” indicates an elective admit.

The total length of stay is entered in the Statement Covers Period field (Box 6). Enter the dates (100915 and 102315) in six-digit format. The day of admission is entered as the “From” date and the day of discharge is entered as the “Through” date. Enter the hour of discharge in military time (11) in the Discharge Hour field (Box 16) and the type of discharge (to home, transferred, etc.) in the Status field (Box 17). In this case, the “01” indicates the boy was “discharged to home.”

Enter revenue code 203 (intensive care, pediatric) and revenue code 151 (room and board, ward) and descriptors in the Revenue Code and Description fields (Boxes 42 and 43). All ancillary services are listed, though they are not reimbursed separately. On the first claim line, enter the number of intensive care days in the Service Units field (Box 46). On the second claim line, enter the number of non-intensive care days in Box 46. Do not count the day of discharge. Units of service are not required for ancillary services.

Enter the usual and customary charges in the Total Charges field (Box 47). Enter code 001 in the Revenue Code column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in TOTALS (Box 47, line 23).

All transplant services require a Treatment Authorization Request (TAR). Enter the TAR control number in the Treatment Authorization Codes field (Box 63). In this case, TAR approval is required for the boy’s entire stay.

Enter an appropriate ICD-10-CM diagnosis code in Box 67. In this case, ICD-10-CM diagnosis code J81.1 represents pulmonary congestion and hypostasis and is entered on the claim as J811.
**Note:** Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable diagnosis codes (up to 18 on a paper claim) in the Diagnosis Codes fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, the pulmonary congestion and hypostasis was present on admission so the POA indicator “Y” (yes) is entered for diagnosis code J81.1.

ICD-10-PCS code 0BYM0Z0, representing bilateral lung transplantation, is entered in the Principal Procedure field (Box 74).

The date of the transplant surgery, October 9, 2015, is entered as 100915.

**Note:** Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the Principal/Other Procedure fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician’s NPI in the Attending field (Box 76). Enter the operating physician’s NPI in the Operating field (Box 77). Enter the admitting physician’s NPI in the first Other field (Box 78).

To designate this as the recipient’s claim, enter “TRANSPLANT RECIPIENT” in the Remarks field (Box 80).
Figure 1a. Double Lung Transplant. Recipient's Claim. DRG-Reimbursed Hospital.
Lung Donor 1 Claim

Figure 1b: Lung donor 1 claim.

Enter the two-digit facility type code “11” (hospital – inpatient) and
one-character claim frequency code “1” as “111” in the Type of Bill field (Box 4).

Recipient Information Required on Donor Claim

This claim is submitted for services rendered to the transplant donor, but the claim requires
the transplant recipient’s birthdate in the Birthdate field (Box 10), the transplant recipient’s
sex in the Sex field (Box 11) and the transplant recipient’s Medi-Cal ID number in the
Insured’s Unique ID field (Box 60).

Enter the date of admission, October 8, 2015, as 100815 in the Admission Date field (Box
12). Enter the 1 p.m. hour of admission in military terms (13) in the Admission Hour field
(Box 13). In the Admission Type field (Box 14), enter the “type” of admission. In this case,
the “3” indicates an elective admit.

The total length of stay is entered in the Statement Covers Period field (Box 6). Enter the
dates (100815 and 101215) in six-digit format. The day of admission is entered as the
“From” date and the day of discharge is entered as the “Through” date. Enter the hour of
discharge in military time (11) in the Discharge Hour field (Box 16) and the type of discharge
(to home, transferred, etc.) in the Status field (Box 17). In this case, the “01” indicates the
donor was “discharged to home.”

Enter revenue code 151 (room and board, ward) and descriptors in the Revenue Code and
Description fields (Boxes 42 and 43). All ancillary services are listed though they are not
reimbursed separately. Enter the number of days of care for each revenue code in the
Service Units field (Box 46). Do not count the day of discharge. Units of service are not
required for ancillary services.

Enter the usual and customary charges in the Total Charges field (Box 47). Enter code 001
in the Revenue Code column (Box 42, line 23) to designate that this is the total charge line
and enter the totals of all charges in TOTALS (Box 47, line 23).
Enter an “11” (donor) in the **Patient’s Relationship to Insured** field (Box 59). Enter the **transplant recipient’s Medi-Cal ID number** in the **Insured’s Unique ID** field (Box 60).

All transplant services require a TAR. Enter the TAR control number in the **Treatment Authorization Codes** field (Box 63). In this case, TAR approval is required for the donor's entire stay.

ICD-10-PCS code 0BTK0ZZ or 0BTL0ZZ, representing pneumonectomy, is entered in the **Principal Procedure** field (Box 74). The date of the pneumonectomy, October 8, 2015, is entered as 100815.

**Note:** Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable **procedure codes** (up to six on a paper claim) in the **Principal/Other Procedure** fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician’s NPI in the **Attending** field (Box 76). Enter the operating physician’s NPI in the **Operating** field (Box 77). Enter the admitting physician’s NPI in the first **Other** field (Box 78).

To designate this as a donor claim, and more specifically as the first of two donors, enter the following in the **Remarks** field (Box 80): “(NAME OF DONOR) IS LUNG TRANSPLANT DONOR FOR JOHN DOE. DONOR 1 OF 2.”
Figure 1b. Double Lung Transplant. Lung Donor 1 Claim. DRG-Reimbursed Hospital.
Lung Donor 2 Claim

Figure 1c: Lung donor 2 claim.

Enter the two-digit facility type code “11” (hospital – inpatient) and one-character claim frequency code “1” as “111” in the Type of Bill field (Box 4).

Recipient Information Required on Donor Claim

This claim is submitted for services rendered to the transplant donor, but the claim requires the transplant recipient’s birthdate in the Birthdate field (Box 10), the transplant recipient’s sex in the Sex field (Box 11) and the transplant recipient’s Medi-Cal ID number in the Insured’s Unique ID field (Box 60).

Enter the date of admission, October 8, 2015, as 100815 in the Admission Date field (Box 12). Enter the 11 a.m. hour of admission in military terms (11) in the Admission Hour field (Box 13). In the Admission Type field (Box 14), enter the “type” of admission. In this case, the “3” indicates an elective admit.

The total length of stay is entered in the Statement Covers Period field (Box 6). Enter the dates (100815 and 101315) in six-digit format. The day of admission is entered as the “From” date and the day of discharge is entered as the “Through” date. Enter the hour of discharge in military time (10) in the Discharge Hour field (Box 16) and the type of discharge (to home, transferred, etc.) in the Status field (Box 17). In this case, the “01” indicates the donor was “discharged to home.”

Enter revenue code 151 (room and board, ward) and descriptors in the Revenue Code and Description fields (Boxes 42 and 43). All ancillary services are listed, though they are not reimbursed separately. Enter the number of days of care for each revenue code in the Service Units field (Box 46). Do not count the day of discharge. Units of service are not required for ancillary services.

Enter the usual and customary charges in the Total Charges field (Box 47). Enter code 001 in the Revenue Code column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in TOTALS (Box 47, line 23).
Enter an “11” (donor) in the Patient’s Relationship to Insured field (Box 59). Enter the transplant recipient’s Medi-Cal ID number in the Insured’s Unique ID field (Box 60).

All transplant services require a TAR. Enter the TAR control number in the Treatment Authorization Codes field (Box 63). In this case, TAR approval is required for the donor’s entire stay.

ICD-10-PCS code 0BTK0ZZ or 0BTL0ZZ, representing pneumonectomy, is entered in the Principal Procedure field (Box 74). The date of the pneumonectomy, October 8, 2015, is entered as 100815.

**Note:** Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the Principal/Other Procedure fields (Boxes 74 through 74E) so the claim will reimburse at the appropriate level.

Enter the attending physician’s NPI in the Attending field (Box 76). Enter the operating physician’s NPI in the Operating field (Box 77).

To designate this as a donor claim, and more specifically the second of two donors, enter the following in the Remarks field (Box 80): “(NAME OF DONOR) IS LUNG TRANSPLANT DONOR FOR JOHN DOE. DONOR 2 OF 2.”
**Figure 1c.** Double Lung Transplant. Lung Donor 2 Claim. DRG-Reimbursed Hospital.

### Part 2 – Transplants: Billing Examples for Inpatient Services
Inpatient Provider Billing For Bone Marrow Procurement Submits Outpatient Claim

Figure 2. Inpatient provider billing for bone marrow procurement submits an outpatient claim. DRG-reimbursed hospital.

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

Case Description

In this example, an inpatient hospital’s payment reimbursement method allows separate reimbursement for bone marrow donor search. All hospitals paid according to the DRG-reimbursement method may separately bill for this service. Refer to the Diagnosis-Related Groups (DRG): Inpatient Services section in this manual for information about transplants.

The inpatient hospital must bill CPT® code 38204 (management of recipient hematopoietic progenitor cell donor search and cell acquisition) on an outpatient basis in the “from-through” format using the hospital’s outpatient provider number and include a surgery modifier such as modifier AG (primary physician).

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

Start the “from-through” billing on claim line 1 by entering a description of the service rendered (bone marrow donor search management) in the Description field (Box 43). Enter the “from” date of service (October 1, 2015) in the Service Date field (Box 45) as 100115.

Complete the “from-through” billing on claim line 2. Enter the description of the service, if necessary, and list all dates of service (10/2, 10/7, 10/10, 10/16, 10/25 and 10/30) in the Description field (Box 43). Enter code 38204 in the HCPCS/Rates field (Box 44) and the “through” date of service (October 30, 2015) in the Service Dates field (Box 45) as 103015. Code 38204 requires a surgery modifier. In this case, modifier AG (primary physician.)

Enter a 1 in the Service Units field (Box 46) for code 38204. The specific dates and total charges will be reflected on the invoice. Enter the total invoice charges in the Total Charges field (Box 47).

Enter code 001 in the Revenue Code column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in TOTALS (Box 47, line 23).

The inpatient provider’s outpatient National Provider Identifier (NPI) is entered in the NPI field (Box 56).
Enter the TAR control number in the *Treatment Authorization Codes* field (Box 63).

Enter an appropriate ICD-10-CM *diagnosis* code in Box 67. In this case, ICD-10-CM diagnosis code C92.01 represents myeloid leukemia in remission and is entered on the claim as C9201.

**Note:** Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable *diagnosis* codes (up to 18 on a paper claim) in the *Diagnosis Codes* fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level.

Also, a present on admission (POA) indicator, if required, is entered in the shaded area to the right of each diagnosis code. In this example, the myeloid leukemia was present on admission so the POA indicator “Y” (yes) is entered for diagnosis code C92.01.

Enter the attending physician’s NPI in the *Attending* field (Box 76). Enter the operating physician’s NPI in the *Operating* field (Box 77).

Include “See attached invoice” in the *Remarks* field (Box 80).

**Note:** The invoice must be from either a National Marrow Donor Program or an equivalent registry. The invoice must be date specific for the search (for example, 10/2, 10/7, 10/10, 10/16, 10/25 and 10/30). Dates must match on the invoice and claim and must be within the dates on the TAR.

Refer to the *Transplants* section of this manual for invoice requirements.
Figure 2. Bone Marrow Procurement. Outpatient Claim Required. DRG-Reimbursed Hospital.
Legend

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

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