Transplants: Billing Examples for Inpatient Services

Page updated: September 2020

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).

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL #
b. MED. REC. #

4 TYPE OF BILL: 111

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 100915 THROUGH: 102315

7

8 PATIENT NAME a
b DOE, JOHN

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
10242005	M	100915	9	3		11	01			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

39–41 VALUE CODES CODE / AMOUNT a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
203	INTENSIVE CARE PEDIATRIC			10	1900000		
151	ROOM AND BOARD WARD			4	110000		
250	GENERAL PHARMACY				16100		
272	STERILE SURGICAL SUPPLIES				5000		
300	GENERAL LABORATORY				80000		
320	DIAGNOSTIC RADIOLOGY GEN				64000		
360	OPERATING RM SERVICES GEN				80000		
370	ANESTHESIA GEN				39000		
410	RESPIRATORY SERVICES GEN				29000		
710	RECOVERY ROOM GEN				29000		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	2352100		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
I/P MEDI-CAL					2352100	0123456789

57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
01234567890		

66 DX: 0
67: J811 Y

69 ADMIT DX; 70 PATIENT REASON DX; 71 PPS CODE; 72 ECI; 73

74 PRINCIPAL PROCEDURE CODE: 0BYM0Z0 DATE: 100915

a.–e. OTHER PROCEDURE CODE / DATE

75

76 ATTENDING NPI 1234567890 QUAL LAST FIRST

77 OPERATING NPI 2345678901 QUAL LAST FIRST

78 OTHER NPI 3456789012 QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS: TRANSPLANT RECIPIENT

81CC a b c d

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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."

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Field	Value
1 (Provider)	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555
4 TYPE OF BILL	111
6 STATEMENT COVERS PERIOD FROM	100815
6 STATEMENT COVERS PERIOD THROUGH	101215
8 PATIENT NAME	DOE, JANE
10 BIRTHDATE	10242005
11 SEX	M
12 ADMISSION DATE	100815
13 HR	13
14 TYPE	3
16 DHR	11
17 STAT	01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
151	ROOM AND BOARD WARD			4	700000	
250	GENERAL PHARMACY				11000	
272	STERILE SURGICAL SUPPLIES				5000	
300	GENERAL LABORATORY				80000	
320	DIAGNOSTIC RADIOLOGY GEN				64000	
360	OPERATING RM. SERVICES GEN				80000	
370	ANESTHESIA GEN				39000	
410	RESPIRATORY SERVICES GEN				29000	
710	RECOVERY ROOM GEN				29000	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	1037000	

Field	Value
50 PAYER NAME	I/P MEDI-CAL
55 EST. AMOUNT DUE	1037000
56 NPI	0123456789
59 P REL	11
60 INSURED'S UNIQUE ID	90000000A95001
63 TREATMENT AUTHORIZATION CODES	01234567890
66 DX	0
74 PRINCIPAL PROCEDURE CODE	0BTK0ZZ
74 PRINCIPAL PROCEDURE DATE	100815
76 ATTENDING NPI	1234567890
77 OPERATING NPI	2345678901
78 OTHER NPI	3456789012
80 REMARKS	JANE DOE IS LUNG TRANSPLANT DONOR FOR JOHN DOE. DONOR 1 OF 2.

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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."

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1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 111

6 STATEMENT COVERS PERIOD: FROM 100815 THROUGH 101315

8 PATIENT NAME: DOE, ADAM

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
10242005	M	100815	11	3		10	01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
151	ROOM AND BOARD WARD			5	900000	
250	GENERAL PHARMACY				11000	
272	STERILE SURGICAL SUPPLIES				16100	
300	GENERAL LABORATORY				5000	
320	DIAGNOSTIC RADIOLOGY GEN				80000	
360	OPERATING RM. SERVICES GEN				64000	
370	ANESTHESIA GEN				80000	
410	RESPIRATORY SERVICES GEN				39000	
710	RECOVERY ROOM GEN				29000	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	1224100	

50 PAYER NAME: I/P MEDI-CAL
55 EST. AMOUNT DUE: 1224100
56 NPI: 0123456789

59 P REL: 11
60 INSURED'S UNIQUE ID: 90000000A95001

63 TREATMENT AUTHORIZATION CODES: 01234567890

66 DX: 0

74 PRINCIPAL PROCEDURE: CODE 0BTK0ZZ, DATE 100815

76 ATTENDING NPI: 0123456789
77 OPERATING NPI: 0123456789

80 REMARKS: ADAM DOE IS LUNG TRANSPLANT DONOR FOR JOHN DOE. DONOR 2 OF 2.

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Figure 1c. Double Lung Transplant. Lung Donor 2 Claim. DRG-Reimbursed Hospital.

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 <u>outpatient</u> 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.

UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 131

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241986 | 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
	BONE MARROW DONOR SEARCH		100115			
	MGMT 10/2 10/7 10/10 10/16 10/25	38204AG	103015	1	180000	
	10/30					
001	PAGE ____ OF ____	CREATION DATE		TOTALS	180000	

50 PAYER NAME: O/P MEDI-CAL

55 EST. AMOUNT DUE: 180000

56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

63 TREATMENT AUTHORIZATION CODES: 01234567890

66 DX: 0 | C9201 Y

76 ATTENDING NPI: 1234567890

77 OPERATING NPI: 2345678901

80 REMARKS: SEE ATTACHED INVOICE

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Figure 2. Bone Marrow Procurement. Outpatient Claim Required. DRG-Reimbursed Hospital.

‹‹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.