Billing Units for Provider-Administered Drugs

Provider guidance for prior authorization requests and medical-benefit claims

APPLIES TO	Prior authorization and reauthorization | Professional and outpatient facility claims

Accurate Healthcare Common Procedure Coding System (HCPCS) billing units help Curative review prior authorization requests and process claims without avoidable delays. Use this guidance for provider-administered drugs and biological products billed under the medical benefit, including J-codes, drug-related Q-codes, and applicable unclassified or not otherwise classified (NOC) codes.

KEY POINT	**One billing unit is the amount stated in the HCPCS code description. One unit does not necessarily mean one vial, one dose, one visit, or one administration.**

How to calculate billing units

Submit the HCPCS code and number of units that accurately represent the requested dose for authorization or the administered dose for a claim.

1. Confirm the HCPCS code and review the code description.
2. Identify the amount represented by one HCPCS billing unit.
3. Divide the clinical dose by the amount represented by one HCPCS unit.

BILLING UNIT FORMULA
Clinical dose / amount represented by one HCPCS unit = billing units *Illustrative example: 300 mg dose / 10 mg per unit = 30 billing units.*

Always verify the HCPCS code description before submitting the request or claim.

What to include with a prior authorization request

Required information	What to submit
Drug identification	Drug name and HCPCS code
Dose and units	Dose per administration and correct HCPCS units per administration
Treatment schedule	Frequency and number of planned administrations
Authorization period	Requested treatment period
Quantity format	Clearly state either units per administration plus total administrations, or total units for the entire authorization period
Dose phases	List loading and maintenance doses separately when they require different unit quantities
FOR CLAIMS	**Report the HCPCS code and number of billing units that accurately represent the dose administered.**

Weight- or body-size-based dosing

When dosing is based on weight or body size, identify the applicable dosing method, such as actual body weight, ideal body weight, adjusted body weight, or body surface area. Include the units of measurement and the date the height or weight was obtained. The height and/or weight used should be sufficiently current to support accurate dosing and reasonably reflect the member's clinical status. More recent measurements may be required when clinically indicated.

Common submission issues

Common submission issue	How to correct it
Submitting one unit by default when the dose requires multiple units	Calculate units from the amount in the HCPCS code description.
Submitting units that do not match the clinical dose	Recheck the code description and the unit calculation.
Using an HCPCS code that does not match the requested drug	Select and submit the correct HCPCS code.
Entering vials, visits, or doses instead of HCPCS units	Enter the number of HCPCS billing units.
Not identifying whether units are per administration or total	Clearly label the submitted quantity.
Submitting conflicting dose or unit information	Correct the inconsistency before resubmitting.
Using a NOC code without the drug name, dose, and required details	Include the identifying and dosing information needed for review.

How Curative handles unclear or inconsistent information

Curative may independently validate mathematical and clinical consistency. When the submitted HCPCS code, dose, and quantity are sufficiently clear, Curative may update the billing units to correct a calculation or unit-conversion error.

Curative will not otherwise alter, infer, assume, or correct the provider's intended HCPCS code, dose, or quantity. Curative will not assume that the provider intended to add a zero, move a decimal point, select another code, or request a different quantity.

If information is unclear or inconsistent, Curative may request clarification or a corrected submission. A request may be administratively closed or denied as incomplete. Clinical review will begin or resume after corrected information is received. **An incorrect, incomplete, or internally inconsistent request or claim may delay review or payment.** It may be adjusted or administratively denied, as permitted by applicable requirements.

Provider submission checklist

- [ ] Select the correct HCPCS code and review the code description.
- [ ] Calculate the correct number of billing units.
- [ ] Confirm that the clinical dose and billing units agree.
- [ ] Identify whether the quantity is per administration or total for the authorization period.
- [ ] List loading and maintenance doses separately when unit quantities differ.
- [ ] Include weight- or body-size-based dosing details when relevant.

Use this guide to support complete and consistent submissions for provider-administered drugs.