End of Life Option Act Services Billing Examples: UB-04

Page updated: August 2020

Examples in this section are to assist providers in billing for end of life services on the *UB-04* claim form. Refer to the *End of Life Option Act Services* section of this manual for detailed policy information. Refer to the *UB-04 Completion: Outpatient Services Billing Example* 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 diagnosis 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.

Attending/Consulting Physician and Psychiatrist/ Psychological Visit: FQHC or RHC

Figure 1. Attending Physician Visit: FQHC or RHC.

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

In this example, an attending physician working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) is billing for end of life services. Revenue code 0521 is entered in the *Revenue Code* field (Box 42). HCPCS code S0257 is entered in the *HCPCS/Rate* field (Box 44).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in Box 67 for attending and consulting physicians. Code Z76.89 is not illustrated but indicated by D1D1D1D in the example. The secondary diagnosis representing the terminal disease would be entered in Box 67A (secondary diagnosis code placement is indicated by D2D2D2D in the example).

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

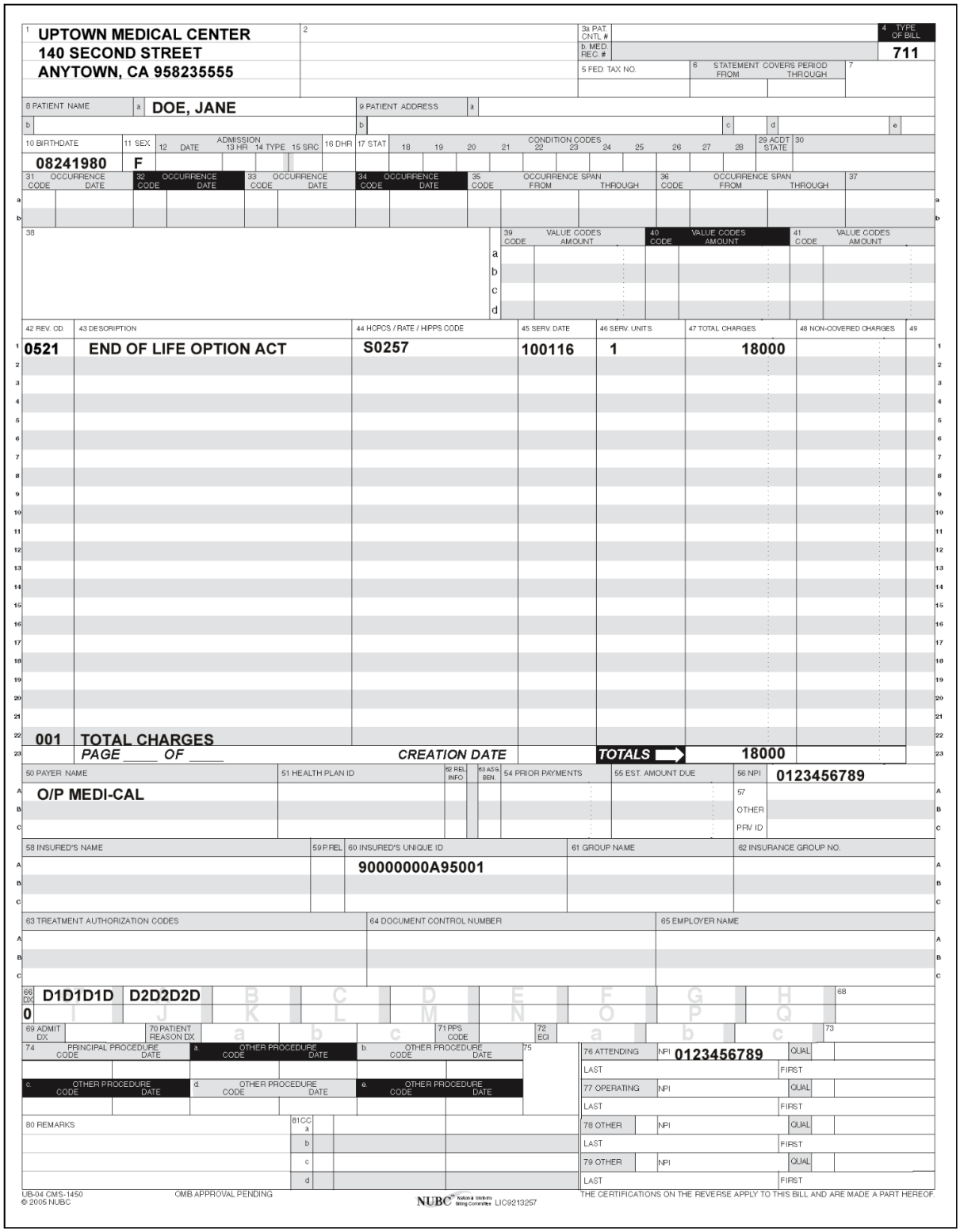
Consulting Physician Visit

Claims submitted for consulting physician services are billed the same as for attending physicians.

Psychiatrist/Psychologist Visit

Revenue code 0521 is entered in the *Revenue Code* field (Box 42). HCPCS code S0257 is entered in the *HCPCS/Rate* field (Box 44). ICD-10-CM diagnosis code Z01.89 (encounter for other specified special examination) would be entered in Box 67. A mental health diagnosis (if there is one) would be entered in Box 67A.

Note: Use revenue code 0520 for services billed for IHS-MOA Clinic providers.



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN, CA 958235555

4 TYPE OF BILL: 711

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 08241980 | 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
0521	END OF LIFE OPTION ACT	S0257	100116	1	18000	
001	TOTAL CHARGES				18000	

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: O/P MEDI-CAL

56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D D2D2D2D

76 ATTENDING NPI: 0123456789

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC National Uniform Billing Committee LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 1. Attending Physician Visit: FQHC or RHC

Attending/Consulting Physician and Psychiatrist/ Psychologist Visit: Outpatient Clinic

Figure 2. Attending Physician Visit: Outpatient Clinic.

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

In this example, an attending physician in an outpatient clinic (not an RHC, FQHC or IHS/MOA) is billing for end of life services. HCPCS code S0257 (counseling and discussion regarding advance directives or end of life care planning and decisions, with patient) is entered in the *HCPCS/Rate* field (Box 44).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in Box 67. Code Z76.89 is not illustrated but indicated by D1D1D1D in the example. The secondary diagnosis representing the terminal disease would be entered in Box 67A (secondary diagnosis code placement is indicated by D2D2D2D in the example).

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

CPT® code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is entered in the *Remarks* field (Box 80). In this example, CPT code 99498 (…each additional 30 minutes) is not applicable.

Consulting Physician Visit

‹‹HCPCS code S0257 would be entered in the *HCPCS/Rate* field (Box 44). ICD-10-CM diagnosis code Z76.89 would be entered in Box 67 and the secondary diagnosis representing the terminal disease would be entered in Box 67A. An appropriate code from CPT range 99242 thru 99244 would be entered in the *Remarks* field (Box 80).››

Psychiatrist/Psychologist Visit

HCPCS code S0257 would be entered in the *HCPCS/Rate* field (Box 44). ICD-10-CM diagnosis code Z01.89 (encounter for other specified special examination) would be entered in Box 67 and a mental health diagnosis (if there is one) would be entered in Box 67A. CPT code 90791 would be entered in the *Remarks* field (Box 80).

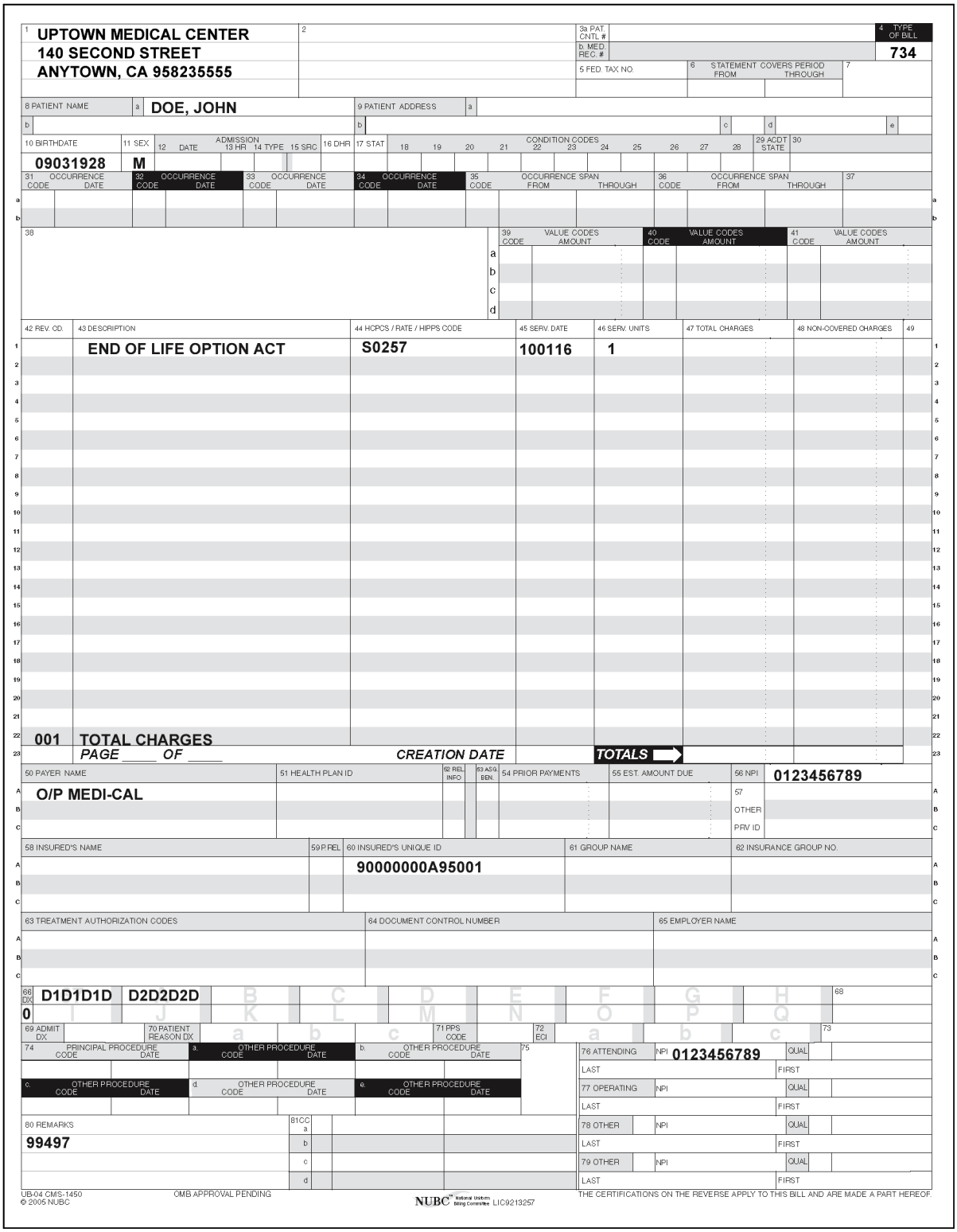


Figure 2. Attending Physician Visit: Outpatient Clinic

Non-Compounded Pharmacy Claim Submitted by Attending Physician at An Outpatient Clinic

Figure 3. Non-Compounded Pharmacy Claim: Outpatient Clinic.

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

Attending physicians who normally bill for clinical services on the UB-04 claim form must bill for aid-in-dying drugs on the *UB-04* claim form. The End of Life Option Act (ELOA) only allows prescribing of drugs that can be ingested (oral or sublingual).

In this example, an aid-in-dying drug is billed. HCPCS code J8499 (prescription drug, oral, non-chemotherapeutic, NOS) is in the *HCPCS/Rate* field (Box 44).

Enter the appropriate two-digit facility type code (for example “79” [clinic – other]) and one-character frequency code “1” as “791” in the *Type of Bill* field (Box 4).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in Box 67. Code Z76.89 is not illustrated but is indicated by D1D1D1D in the example.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Both a product qualifier (N4) and National Drug Code (NDC) are required on the claim. Providers enter the product qualifier and NDC number immediately followed by the two-digit unit of measure and 10-digit numeric quantity for the drug in the *Description* field (Box 43). The 10-digit numeric quantity consists of seven digits for the whole number, followed by three decimal places. Omit the decimal point when entering the number on the claim. Valid unit of measure qualifiers are as follows:

‹‹**Product Qualifier and Unit of Measure Use for Claims Table**››

Qualifier	**Unit of Measure**
F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

Enter “1” in the *Service Units* field (Box 46) on the same claim line as code J8499 regardless of the quantity of the drug dispensed.

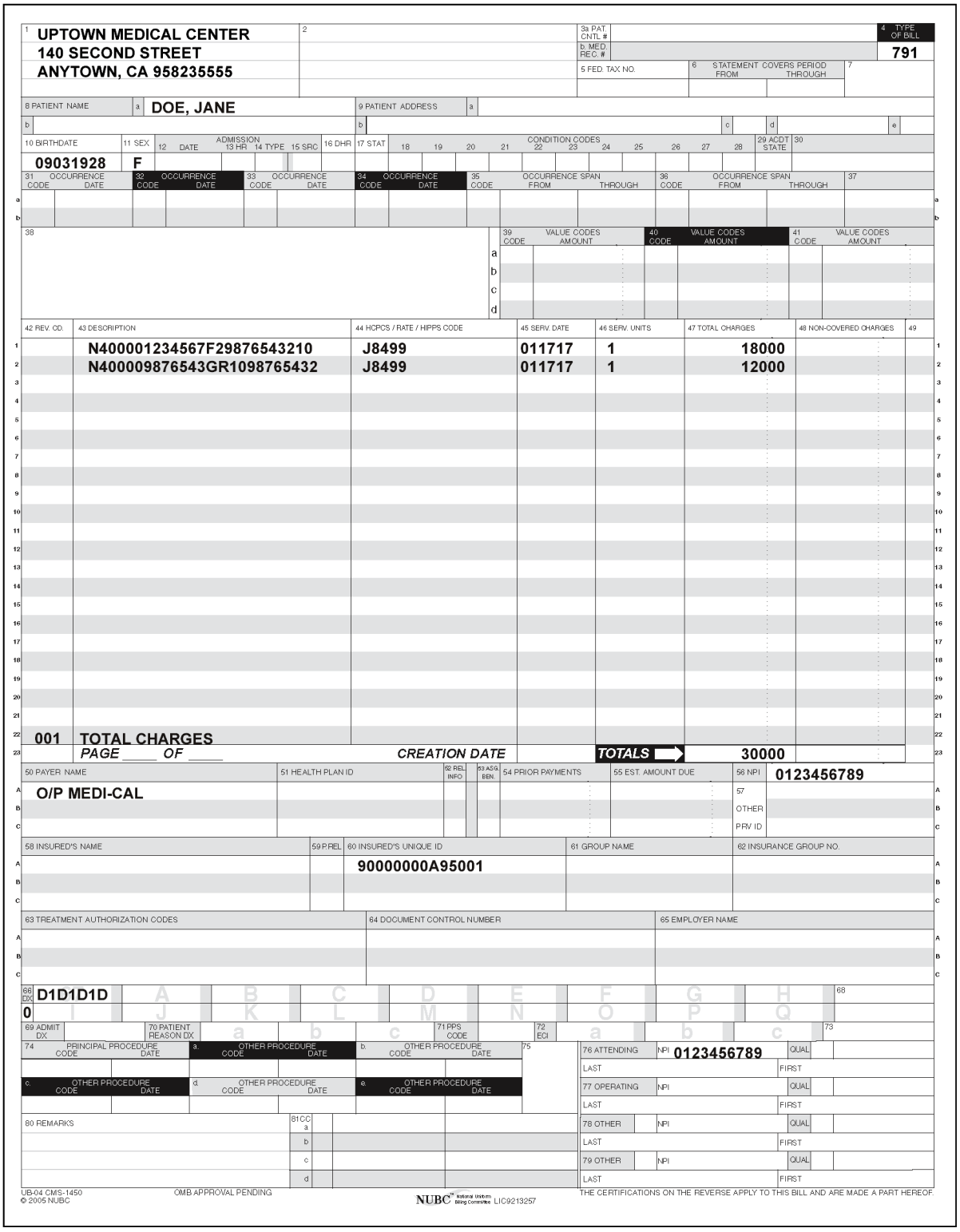
For each additional non-compounded aid-in-dying drug dispensed, repeat the above instructions on the next claim line.

Enter the invoice price for this drug in the *Total Charges* field (Box 47) on the claim line that pertains to the drug being claimed.

Add up the charges for each drug claimed and enter this number in the *Total Charges* field (Box 47, line 23).

An invoice documenting the cost of the drugs must be submitted as an attachment.

Only United States Food and Drug Administration (FDA) approved drugs may be reimbursed by Medi-Cal. Unapproved drugs, including foreign-made versions of FDA-approved drugs that have not been manufactured pursuant to FDA approval, will not be reimbursed.



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN, CA 958235555

4 TYPE OF BILL: 791

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 09031928 | 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
	N400001234567F29876543210	J8499	011717	1	18000	
	N400009876543GR1098765432	J8499	011717	1	12000	
001	TOTAL CHARGES					
	PAGE ____ OF ____	CREATION DATE		TOTALS	30000	

50 PAYER NAME: O/P MEDI-CAL

56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 0123456789

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 3. Non-Compounded Pharmacy Claim: Outpatient Clinic

Compounded Pharmacy Claim Submitted by Attending Physician at An Outpatient Clinic

Figure 4. Compounded Pharmacy Claim: Outpatient Clinic.

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

Attending physicians who normally bill for clinical services on the *UB-04* claim form must bill for aid-in-dying drugs on the *UB-04* claim form. The ELOA only allows prescribing of drugs that can be ingested (oral or sublingual).

In this example, an aid-in-dying drug is billed. *HCPCS* code J7999 (compounded drug, not otherwise classified) is in the *HCPCS/Rate* field (Box 44).

Enter the appropriate two-digit facility type code (for example “79” [clinic – other]) and one-character frequency code “1” as “791” in the *Type of Bill* field (Box 4).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in Box 67. Code Z76.89 is not illustrated but is indicated by D1D1D1D in the example.

Because this claim is submitted with a diagnosis code, an ICD indicator is required in the *DX* field (Box 66). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Both a product qualifier (N4) and National Drug Code (NDC) for the main ingredient are required on the claim. Providers enter the product qualifier and NDC number for the main ingredient immediately followed by the two-digit unit of measure and 10-digit numeric quantity for the drug in the *Description* field (Box 43). The 10-digit numeric quantity consists of seven digits for the whole number, followed by three decimal places. Omit the decimal point when entering the number on the claim. Valid unit of measure qualifiers are as follows:

‹‹**Product Qualifier and Unit of Measure Use for Claims Table**››

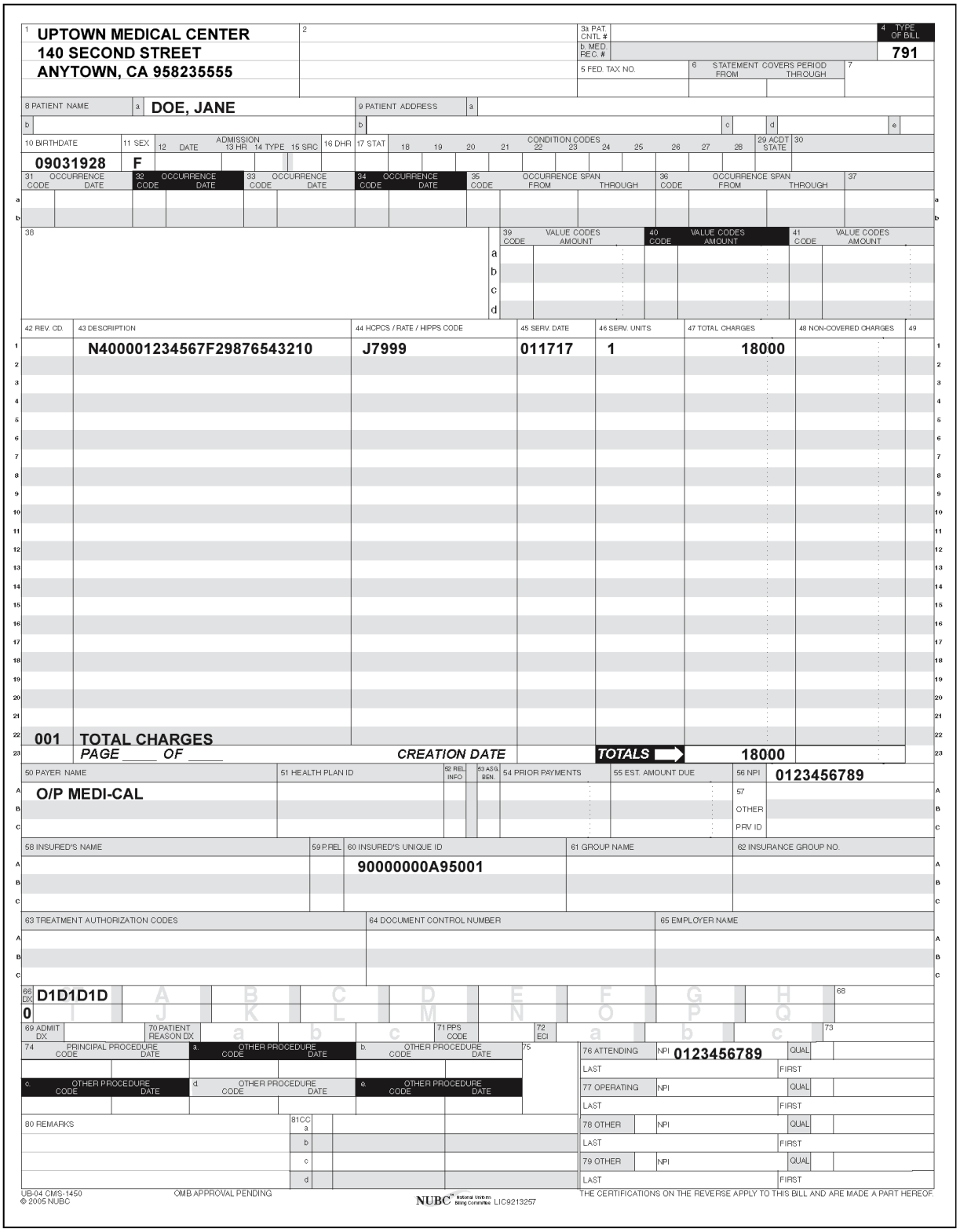
Qualifier	**Unit of Measure**
F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

Enter “1” in the *Service Units* field (Box 46) on the same claim line as code J7999 regardless of the quantity of the drug dispensed.

Enter the invoice price for this drug in the *Total Charges* field (Box 47).

An invoice documenting the cost of the compounded drug must be submitted as an attachment.

Only United States Food and Drug Administration (FDA) approved drugs may be reimbursed by Medi-Cal. Unapproved drugs, including foreign-made versions of FDA-approved drugs that have not been manufactured pursuant to FDA approval, will not be reimbursed.



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN, CA 958235555

4 TYPE OF BILL: 791

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 09031928 | 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
	N400001234567F29876543210	J7999	011717	1	18000	
001	TOTAL CHARGES					
	PAGE ____ OF ____	CREATION DATE		TOTALS	18000	

50 PAYER NAME: O/P MEDI-CAL

56 NPI: 0123456789

58 INSURED'S NAME | 60 INSURED'S UNIQUE ID: 90000000A95001 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

66 DX: D1D1D1D
0

76 ATTENDING NPI: 0123456789

UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC National Uniform Billing Committee LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 4. Compounded Pharmacy Claim: Outpatient Clinic

‹‹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.