End of Life Option Act Services Billing Examples: CMS-1500

Page updated: September 2020

Examples in this section are to assist providers in billing for end of life services on the CMS-1500 claim form. Refer to the *End of Life Option Act Services* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* 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 *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Attending/Consulting Physician Visits

Figure 1. Attending Physician Visit.

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

In this example, an attending physician is billing for end of life services delivered during a 30-minute visit. HCPCS code S0257 (counseling and discussion regarding advance directives or end of life care planning and decisions, with patient) is entered in the *Procedures, Services or Supplies* field (Box 24D).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21A). Code Z76.89 is not illustrated but indicated by D1D1D1D in the example. The secondary diagnosis represents the terminal disease (secondary diagnosis code placement is indicated by D2D2D2D in the example).

In this example, an ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind*. area of box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

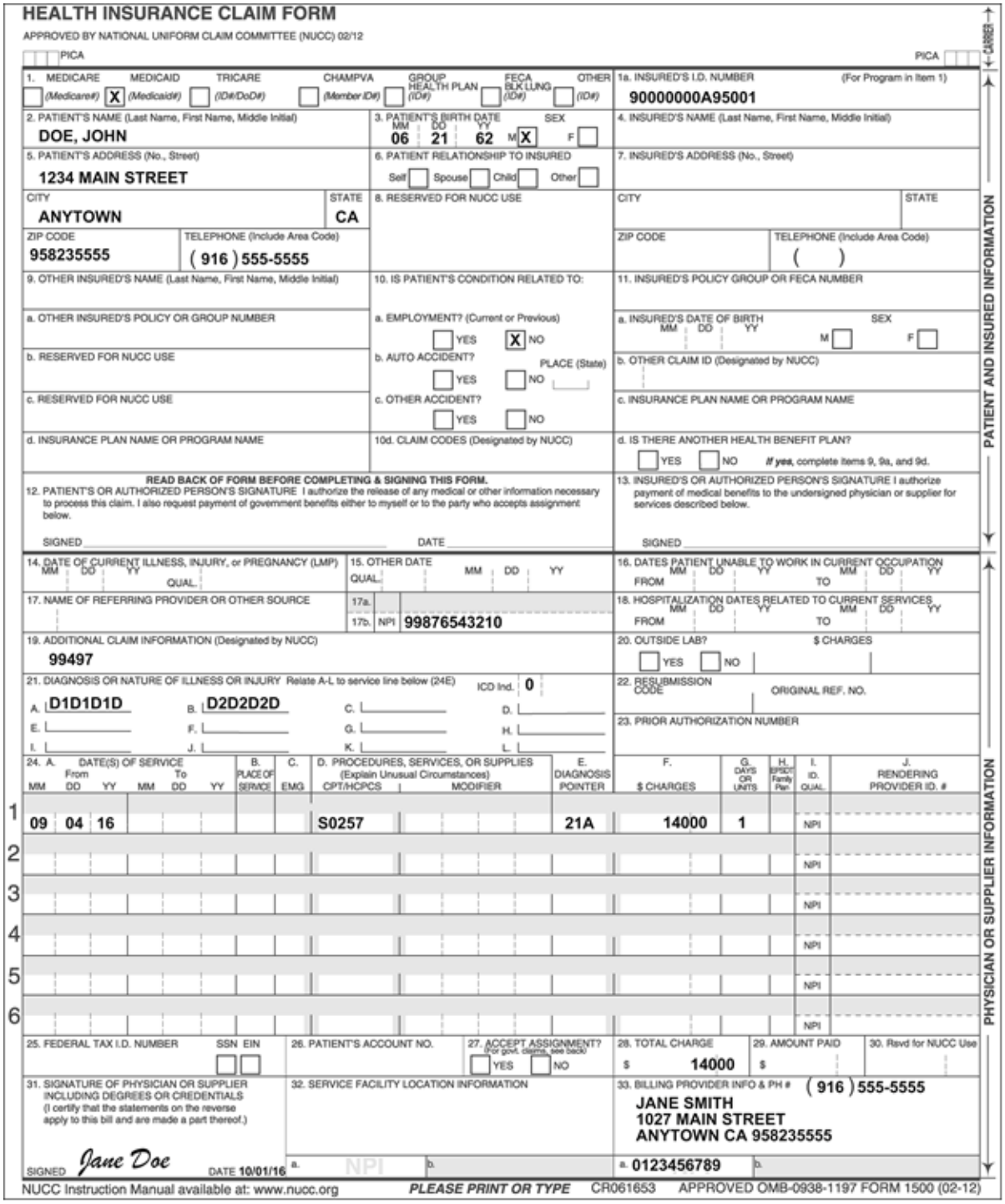
Attending Physician Visit

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) is entered in the *Additional Claim Information* field (Box 19). In this example, CPT code 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; each additional 30 minutes) is not applicable because the visit duration was limited to 30 minutes. If the visit duration was 60 minutes, then CPT code 99498 should be entered in Box 19 along with code 99497.

Consulting Physician Visit

‹‹Claims submitted for consulting physician services are billed the same as those for the attending physician visit, except an appropriate code from CPT range 99242 thru 99244 (office consultation for a new or established recipient) is entered in the *Additional Claim Information* field (Box 19), instead of codes 99497/99498.››

“21A” is entered in the *Diagnosis Pointer* field (Box 24E) to reference the applicable diagnosis code in Box 21A for both attending and consulting physician services claims.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE: 06 21 62 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN | STATE: CA

8. RESERVED FOR NUCC USE

CITY: | STATE:

ZIP CODE: 958235555 | TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 99876543210

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 99497

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 04 16				S0257		21A	14000	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 14000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Doe DATE 10/01/16

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1: Attending Physician Visit.

Psychiatrist Visit

Figure 2. Psychiatrist Visit.

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

In this example, the attending physician has referred the recipient to a psychiatrist for a mental health assessment. The psychiatrist is billing for end of life services.

ICD-10-CM diagnosis code Z01.89 (encounter for other specified special examinations) would be entered in the *Diagnosis or Nature of Illness* or Injury field (Box 21A). Code Z01.89 is not illustrated but is indicated by D1D1D1D in the example. The secondary diagnosis represents the mental health diagnosis, if one is diagnosed (secondary diagnosis code placement is indicated by D2D2D2D in the example).

In this example, an ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind*. area of box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

CPT code 90791 (psychiatric diagnostic evaluation) is required in the *Additional Claim Information* field (Box 19).

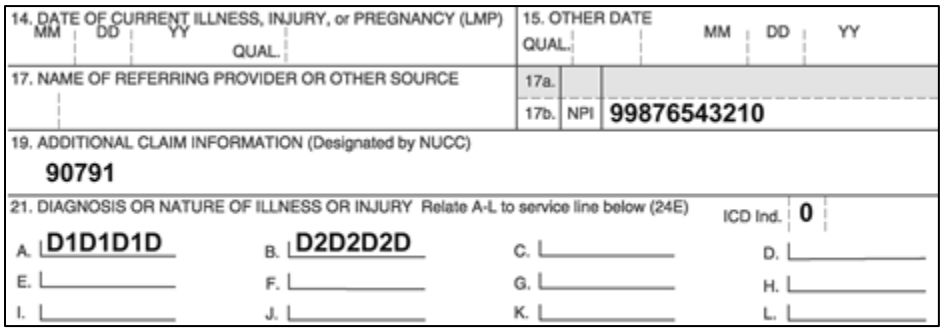


Figure 2: Psychiatrist Visit.

Non-Compounded Pharmacy Claim Submitted by Pharmacy or Attending Physician

Figure 3. Non-Compounded Pharmacy Claim.

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

All claims for aid-in-dying drugs submitted by pharmacies must be submitted on the CMS-1500 claim form. Claims submitted via the POS system, *Pharmacy Claim Form* (30-1) or *Compound Drug Pharmacy Claim Form* (30-4) will be denied. Attending physicians who normally bill for clinical services on the *CMS-1500* claim form must bill for aid-in-dying drugs on the *CMS-1500* 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 end of life drug is billed. HCPCS code J8499 (prescription drug, oral, non-chemotherapeutic, NOS) is entered in the *Procedures, Services or Supplies* field (Box 24D).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21A). Code Z76.89 is not illustrated but is indicated by D1D1D1D in the example.

In this example, an ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind*. area of box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

The product ID qualifier N4 and the National Drug Code (NDC) number are entered in the shaded area of Box 24A. In the shaded area of Box 24D, the two-character unit of measure qualifier is entered followed by the numeric quantity (a 10-digit number) administered to the patient. The 10 digits consist 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:

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

Enter the charge for this drug in the *Total Charges* field (Box 24F) on the claim line that pertains to the drug being claimed.

Enter “1” in the *Service Units* field (Box 24G) on the same claim line as code J8499 regardless of the quantity of the drug dispensed.

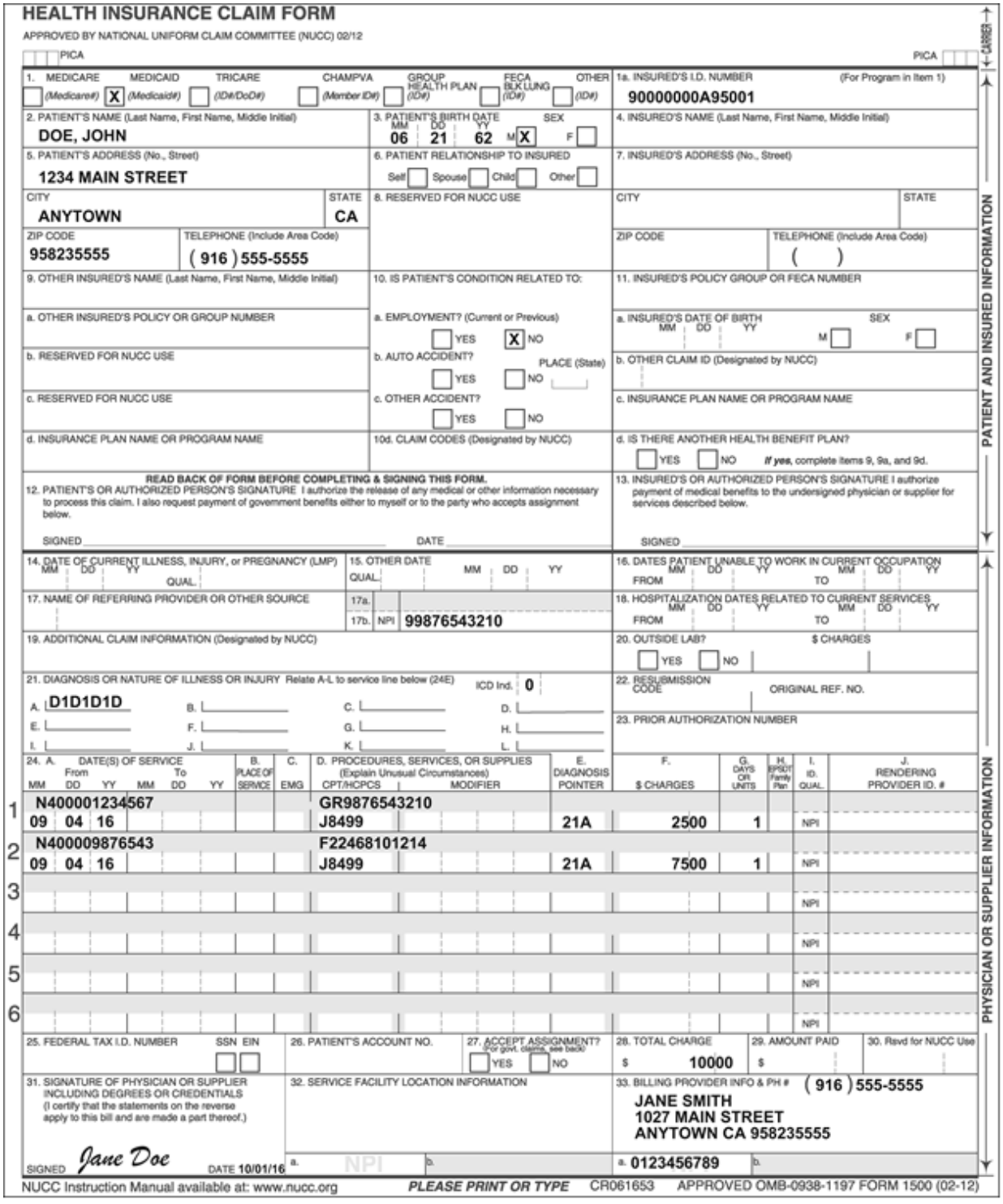
For each additional non-compounded aid-in-dying drug dispensed, repeat the above instructions on the next claim line.

Add up the charges for each drug claimed and enter this number in the *Total Charge* field (Box 28).

“21A” is entered in the *Diagnosis Pointer* field (Box 24E) to reference the applicable diagnosis code in Box 21A.

If the claim for aid-in-dying drugs is submitted by the attending physician, 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.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE: 06 21 62 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 99876543210

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N400001234567 09 04 16			GR9876543210 J8499		21A	2500	1		NPI	
2 N400009876543 09 04 16			F22468101214 J8499		21A	7500	1		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 10000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Doe DATE 10/01/16

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 3: Non-Compounded Pharmacy Claim.

Compounded Pharmacy Claim Submitted by Pharmacy or Attending Physician

Figure 4. Compounded Pharmacy Claim.

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

All claims for aid-in-dying drugs submitted by pharmacies must be submitted on the CMS-1500 claim form. Claims submitted via the POS system, *Pharmacy Claim Form* (30-1) or *Compound Drug Pharmacy Claim Form* (30-4) will be denied. Attending physicians who normally bill for clinical services on the *CMS-1500* claim form must bill for aid-in-dying drugs on the *CMS-1500* claim form. The ELOA only allows prescribing of drugs that can be ingested (oral or sublingual).

In this example, an end of life drug is billed. HCPCS code J7999 (compounded drug, not otherwise classified) is entered in the *Procedures, Services or Supplies* field (Box 24D).

ICD-10-CM diagnosis code Z76.89 (persons encountering health services in other specified circumstances) would be entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21A). Code Z76.89 is not illustrated but is indicated by D1D1D1D in the example.

In this example, an ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

The product ID qualifier N4 and the National Drug Code (NDC) number for the main ingredient are entered in the shaded area of Box 24A. In the shaded area of Box 24D, the two-character unit of measure qualifier is entered followed by the numeric quantity (a 10-digit number) administered to the patient. The 10 digits consist 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:

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

Enter the number “1” in the *Days or Units* field (Box 24G) regardless of the quantity of the drug dispensed.

“21A” is entered in the *Diagnosis Pointer* field (Box 24E) to reference the applicable diagnosis code in Box 21A.

If the claim for aid-in-dying drugs is submitted by the attending physician, an invoice documenting the cost of the drugs must be submitted as an attachment.

For compounded drugs, the main ingredient must be an FDA-approved drug to 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.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400001234567								GR9876543210							
09	04	16						J7999		21A	2500	1		NPI	
														NPI	

Figure 4: Compounded Pharmacy Claim.

Compounded Drug Attachment

Figure 5: Sample Compounded Drug Attachment

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

All compounded drug ingredients must be listed on an attachment to the claim (in addition to invoice or catalog page[s]) showing the NDC/UPC/HRI#, unit, quantity and charge.

End of Life Compounded Drug Attachment

Pharmacy Name: ABC Home Pharmacy
Provider Number: 0123456789
Prescription Number: 1234567
Date of Service: 09/04/2016

Compounded Drug Ingredients:

NDC/UPC/HRI #	Unit	Quantity	Charge
N400009876543	F2	3.00	300.00
N400001234567	GR	2.00	50.00
N400009876543	ML	1.00	25.00
Totals		6.00	375.00

2 – Compounded Drug Attachment Completion PROPubs

Figure 5: Sample Compounded Drug Attachment

‹‹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.