

# AMBULATORY SURGICAL CENTERS

Chapter Twenty-Nine of the Medicaid Services Manual

**Issued November 1, 2010** 

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

ISSUED: REPLACED:

10/10/12 11/01/10

**CHAPTER 29: AMBULATORY SURGICAL CENTERS** 

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#### AMBULATORY SURGICAL CENTERS

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ISSUED: 09/21/21 REPLACED: 11/01/10

**CHAPTER 29: AMBULATORY SURGICAL CENTERS** 

SECTION 29.0: OVERVIEW PAGE(S) 1

#### **OVERVIEW**

The Medicaid Ambulatory Surgery Program provides surgical services to eligible Medicaid beneficiaries not requiring hospitalization and which the expected duration of services would not exceed 24 hours following an admission. Services are provided at an ambulatory surgical center (ASC) which is a free-standing facility, separate from a hospital, which meets the needs of the eligible beneficiary for minor surgery.

The purpose of this chapter is to set forth the conditions and requirements an ASC must meet in order to qualify for reimbursement under the Louisiana Medicaid program. The manual is intended to make available to Medicaid providers of ASCs a ready reference for information and procedural material needed for the prompt and accurate filing of claims for services furnished to Medicaid beneficiaries. The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), Program Operations Section is responsible for assuring provider compliance with these regulations.

#### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

SECTION 29.1: COVERED SERVICES PAGE(S) 2

#### **COVERED SERVICES**

An ambulatory surgical center (ASC) is any distinct entity that operates exclusively for the purpose of providing surgical services to beneficiaries not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The services must be medically necessary, preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but is organized and operated to provide medical care to beneficiaries.

ASC services are items and services furnished by an outpatient ASC in connection with a covered surgical procedure. Covered services include, but are not limited to, the following:

- 1. Nursing, technician and related services;
- 2. Use of an ASC;
- 3. Laboratory and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;
- 4. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- 5. Administrative, record keeping, and housekeeping items and services;
- 6. Materials for anesthesia;
- 7. Intra-ocular lenses; and
- 8. Supervision of the services of an anesthetist by the operating surgeon.

#### **Exclusions**

Items and services for which payment may be made under other provisions are excluded from ASC services. The following are not included in ASC services:

- 1. Physician services;
- 2. Laboratory and x-ray not directly related to the surgical procedure;

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SECTION 29.1: COVERED SERVICES PAGE(S) 2

- 3. Diagnostic procedures (other than those directly related to performance of the surgical procedure);
- 4. Prosthetic devices (except intraocular lens implant);
- 5. Ambulance services;
- 6. Leg, arm, back, and neck braces;
- 7. Artificial limbs;
- 8. Durable medical equipment (DME) for use in the patient's home; and
- 9. Chronic pain management.

**NOTE:** Funds reimbursed for the purpose of chronic pain management, are subject to recoupment.

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SECTION 29.2: PROVIDER REQUIREMENTS PAGE(S) 1

#### PROVIDER REQUIREMENTS

Ambulatory surgical centers (ASCs) must have an agreement with the Centers for Medicare and Medicaid Services (CMS) and be enrolled as a Medicaid provider in order to participate in Medicare and/or Medicaid. Terms for this agreement can be found in 42 the Code of Federal Regulations (CFR) §416.30.

The ASC must have a system to transfer beneficiaries requiring emergency admittance or overnight care to a fully licensed and certified Title XIX hospital following any surgical procedure performed at the facility.

#### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

SECTION 29.3: REIMBURSEMENT PAGE(S) 2

#### REIMBURSEMENT

Reimbursement for surgical procedures performed in an ambulatory surgical center (ASC) is a flat fee per service in accordance with the 4 payment groups established for ambulatory surgery services specified on the Medicaid fee schedule. Reimbursement amounts can be found on the Professional Services Fee Schedule. (See Appendix A for information on how to obtain a copy of the fee schedule).

The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a medically necessary surgery including the following:

- 1. Admission;
- 2. Patient history and physical;
- 3. Laboratory tests;
- 4. Operating room staffing;
- 5. Recovery room charges; and
- 6. All supplies related to the surgical care of the beneficiary and discharge.

The flat fee excludes payments for the physician performing the surgery, the radiologist and the anesthesiologist when these professionals are not under contract with the ASC.

For those surgical procedures not included in the payment groupings on the Medicaid fee schedule, the reimbursement is the established flat fee for the service.

#### **Never Events**

Reimbursement will not be provided for "never events" or medical procedures performed in error that are preventable and have a serious, adverse impact to the health of the beneficiary.

Reimbursement will not be provided when the following occurs:

- 1. The wrong surgical procedure is performed on a beneficiary;
- 2. A surgical or invasive procedure is performed on the wrong body part; or
- 3. A surgical or invasive procedure is performed on the wrong beneficiary.

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SECTION 29.3: REIMBURSEMENT PAGE(S) 2

# **Billing**

ASC claims are completed on the Centers for Medicare and Medicaid (CMS) 1500 or 837P. There should only be one line item per claim form.

Only one procedure code may be reimbursed per outpatient surgical session.

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APPENDIX A: CONTACT INFORMATION PAGE(S) 1

# **CONTACT INFORMATION**

ASSISTANCE NEEDED	HOW TO OBTAIN
Comment	Available at <a href="https://www.lamedicaid.com">www.lamedicaid.com</a> under Type of Service (TOS) 08
Copy of the Professional Services Fee Schedule	"Evaluation and Management" and Laboratory Current Procedural Terminology (CPT) codes are excluded.
Billing Questions/Assistance	Gainwell Technologies Provider Relations P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040

#### **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING PAGE(S) 13

#### **CLAIMS FILING**

Hard copy billing of ambulatory surgical center services are billed on the paper Centers for Medicare and Medicaid (CMS)-1500 (02/12) claim form or electronically in the 837P transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

**Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

**Situational** information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies P.O. Box 91020 Baton Rouge, LA 70821

This appendix includes the following:

- 1. Instructions for completing the CMS-1500 claim form and a sample of a completed CMS-1500 claim form; and
- 2. Instructions for adjusting/voiding a claim and a sample of an adjusted CMS-1500 claim form.

**ISSUED:** 04/25/25 12/09/24 **REPLACED:** 

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APPENDIX B: CLAIMS FILING PAGE(S) 13

# CMS-1500 (02/12) INSTRUCTIONS FOR AMBULATORY SURGICAL **CENTERS**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's Identification (ID) Number	Required – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS or Recipient Eligibility Verification System (REVS).  NOTE: The beneficiaries' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) from the plastic ID card is NOT acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB)	Situational – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07).	
	Sex	Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
8	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If beneficiary has no other coverage, leave blank.  If there is other commercial insurance coverage, the state assigned 6-digit third-party liability (TPL) carrier code is <b>required</b> in this block. The carrier code is indicated on the MEVS) response as the Network Provider Identification Number.  Make sure the explanation of benefits (EOBs) from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered for commercial and Medicare Health Maintenance Organizations (HMOs) in this field.  DO NOT enter dashes, hyphens, or the word TPL in the field.  NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or Federal Employees Compensation Act (FECA) Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
11b	Employer's Name or School Name	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	If Patient Has Had Same or Similar Illness, Give First Date	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Optional.	
17a	Unlabeled	Leave Blank.	
17b	National Provider Identifier (NPI)	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Reserved for Local Use	Leave Blank.	
20	Outside Lab?	Optional.	

# **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

#	_	Instructions	Alerts
21	International Classification of Diseases (ICD) Ind.  Diagnosis or Nature of Illness or Injury	Required Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.  9 ICD-9-CM 0 ICD-10-CM  Required Enter the most current ICD diagnosis code.  NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable.  ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.  ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.  Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com).

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# **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

Locator #	Description	Instructions	Alerts
22	Resubmission Code	Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.  Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.  Appropriate reason codes follow:  Adjustments 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other  Voids 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).  To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization (PA) Number	Situational – Complete if appropriate or leave blank.  If the services being billed must be Prior Authorized, the PA number is required to be entered.	
24	Supplemental Information	Leave Blank.	
24A	Date(s) of Service	Required Enter the date of service for each procedure.  Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	Situational – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<b>Required</b> Enter the procedure code(s) for services rendered in the un-shaded area(s).	

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Locator #	Description	Alerts	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block.	
		More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	<b>Required</b> Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> Enter the number of units billed for the procedure code entered on the same line in 24D	
24Н	Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	ID Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID #	Leave Blank	
25	Federal Tax ID Number	Optional.	
26	Patient's Account Number	Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay.	
		If TPL does not apply to the claim, leave blank.  Do not report Medicare payments in this field.	
30	Reserved for NUCC use	Leave Blank.	

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Locator #	Description	Instructions	Alerts		
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional. – The practitioner or the practitioner's authorized representative's original signature is no longer required.			
	Date	Enter the date of form completion.			
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.			
32a	NPI	Optional.			
32b	Unlabeled	<b>Situational</b> – Complete if appropriate or leave blank.			
33	Billing Provider Info & Phone #	<b>Required</b> Enter the provider name, address including zip code and telephone number.			
33a	NPI	Required - Enter the billing provider's 10 digit NPI number.			
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number.	The 7-digit Medicaid Provider Number must appear on paper		
		<b>ID Qualifier - Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	claims.		

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APPENDIX B: CLAIMS FILING PAGE(S) 13

# Example of Billing for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12  PICA			PICA ITT
MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	1a. INSURED'S LD. NUMBER (For Program in	in Hom 1)
(Medicare #) × (Medicaid #) (ID#/DoD#) (Member	HEALTH PLAN BLK LUNG (ID#) (ID#) (ID#) (ID#)	1234567890123	1 10011 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	INSURED'S NAME (Last Name, First Name, Middle Initial)	
LOU, JANNIE	06 19 85 M FX		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other		
CITY	8. RESERVED FOR NUCC USE	CITY	TATE
ZIP CODE TELEPHONE (Indude Area Code)	-	ZIP CODE TELEPHONE (Include Area Co	ide)
( )		( )	
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)	a. INSURED'S DATE OF BIRTH SEX	
TPL Code if applicable b. RESERVED FOR NUCCUSE	YES NO	b. OTHER CLAIM ID (Designated by NUCC)	
	b. AUTO ACCIDENT? PLACE (State)	CONTEST COMMITTO (CHARGING BY NUCCO)	
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	$\overline{}$
	YES NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
FXΔ	MPLE OF	If yes, complete items 9, 9a and 9	d.
READ BACK OF FORM BEFORE COMPLETING  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   authorize the		<ol> <li>INJURGES OR AUTHORIZED PERSON'S SIGNATURE I au payment of medical benefits to the undersigned physician or signed.</li> </ol>	
to process this claim. I also request payment of government benefits either below.	to myself or to the party who accepts assignment	services described below.	,,
SIGNED	DATE	SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP	ATION
	JAL.	FROM TO MM DD	"
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVI	ÇŞ
718	. NPI	FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to s	ervice line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.	
A 78907 B 78321 C.I	78729 D 53081	CODE CHOINAL REP. NO.	
E F G.	н	23. PRIOR AUTHORIZATION NUMBER	
L J K	L		
From To PLACEOF (Ex	EDURES, SERVICES, OR SUPPLIES E. plain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS BYSOT ID. RENDE	RING
MM DD YY MM DD YY SERVICE EMG CPT/HC	PCS MODIFIER POINTER	\$ CHARGES UNITS Plan QUAL PROVIDE	R ID.#
1 12 15 14 12 15 14 24 4538	0   ABCD	900 00 1 NPI	
2			
		NPI	
3		, , , , , , , , , , , , , , , , , , , ,	
		NPI NPI	
4		!   NPI	
		i i i i i i i i i i i i i i i i i i i	
5		NPI NPI	RING ER ID. #
6		NPI	
	ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. datms, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALAI	
1234	YES NO	s 900 00 s s	900 00
INCLUDING DEGREES OR CREDENTIALS	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH# (225) 555-495	57
(i certify that the statements on the reverse apply to this bill and are made a part thereof.)		SURGI CENTER 123 MAIN ST	
		ANY TOWN, LA 70000	
SIGNED IMA BILLER DATE 1/7/15 a.	b.	a. 1234567891 b. 1234567	
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1	500 (02-12)

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APPENDIX B: CLAIMS FILING PAGE(S) 13

# Example of Billing for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EX-42			
EALTH INSURANCE			
PROVED BY NATIONAL UNIF	ORM CLAIM COMMITTEE (NUCC) 02/12		PICA T
MEDICARE MEDICAID  (Medicare #) X (Medicaid	Olivani i	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1) 1234567890123
PATIENT'S NAME (Last Name		3. PATIENTS BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OU, JANNIE		06   19   85 M FX	
PATIENT'S ADDRESS (No., S	treet)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
		Self Spouse Child Other	
TY	STATE	8. RESERVED FOR NUCC USE	CITY
PCODE	TELEPHONE (Indude Area Code)	-	ZIP CODE TELEPHONE (Include Area Code)
	( )		
OTHER INSURED'S NAME (U	ast Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
			a INSURED'S DATE OF BIRTH SEX
OTHER INSURED'S POUCY PL Code if applicable		a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
RESERVED FOR NUCCUSE	7	YES NO b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
		C A Bs A Did. F.	a comment and the second second and second
ESERVED FOR NUCC USE			c. INSURANCE PLAN NAME OR PROGRAM NAME
		YES NO	
SURANCE PLAN NAME OF	PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	EVAI	ADLE OF L	3. IN JR 9'S OR JULYO ZED PERSON'S SIGNATURE I authorize
READ ATIENTS OR AUTHORIZED	BACK OF FORM E FOR OM ON	re-das, of any means the in the day necessary	/ amount of meaning be affits to the undersigned physician or supplier for
o process this claim. I also req elow.	uest payment of government benefits either	to myself or to the party who accepts assignment	services described below.
SIGNED		DATE	SIGNED
ATE OF CURRENT ILLNES		OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY MM   DD   YY
	UAL QU VIDER OR OTHER SOURCE 17a		FROM TO
WHILE OF REPERRING PRO	VIDER OR OTHER SOURCE 17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
ADDITIONAL CLAIM INFOR!	MATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
	,		VES NO
DIAGNOSIS OR NATURE OF		rvice line below (24E) ICD Ind. 0	22. RESUBMISSION ORIGINAL REF. NO.
R 1084	B. R6 34 C. L	R 13 19 D K2 19	
	F G.	н	23. PRIOR AUTHORIZATION NUMBER
A. DATE(S) OF SERVICE	J. K. E. B. C. D.PROCI	EDURES, SERVICES, OR SUPPLIES E.	E   G   W   I
	O PLACEOF (Exp D YY SERVICE EMG CPT/HCI	olain Unusual Circumstances) CCS MODIFIER  DIAGNOSIS POINTER	F. G. H. L. J. DAYS OR Ferby S CHARGES UNITS   Ferby QUAL. PROVIDER ID. #
08 15   10   0	8   15   24   4538	0 ABCD	900 00 1 NPI
	5   15   24     4000	- I NOOD	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
			NPI
			NPI
			1   Net
			NPI NPI
	1 1 1		
			NPI
			NPI
FEDERAL TAX LD. NUMBER	SSN EIN 26 PATIENTS	ACCOUNT NO. 27 ACCEPT, ASSIGNMENT?	
FEDERAL TAXLD. NUMBER	SSN EN 20 PATIENTS 1234	ACCOUNT NO. 27, ACCEPT, ASSIGNMENT? (For gar, dates, seeback) (YES NO	NPI
SIGNATURE OF PHYSICIAN	1234 OR SUPPLIER 32 SERVICE F.	ACCOUNT NO. 27 ACCEPT ASSIGNMENT? YOU gat dams see basin NO.	NPI       28. TOTAL CHARGE   29. AMOUNT PAID   30. BALANCE DUE
SIGNATURE OF PHYSICIAN NOLUDING DEGREES OR O	1234 OR SUPPLIER REDENTIALS 11the reverse	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5 900   00 5 5 900   00 33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER
SIGNATURE OF PHYSICIAN NOLUDING DEGREES OR O	1234 OR SUPPLIER REDENTIALS 11the reverse	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5 900 00 \$ \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 \$ 900 00 00 \$ 900 00 00 00 00 00 00 00 00 00 00 00 00
	1234 OR SUPPLIER REDENTIALS 11the reverse	YES NO	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 5 900   00 5 5 900   00 33. BILLING PROVIDER INFO & PH# (225) 555-4957 SURGI CENTER

# **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING

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# Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

EALTH INSURANCE CLAIM FORM		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0	2/12	
PICA		PICA
	MPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (IDIN) (IDIN) (IDIN)	1a. INSURED'S LD. NUMBER (For Program in Item 1)
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OU, JANNIE	06 19 85 M FX	
PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
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ITY ST/	ATE 8. RESERVED FOR NUCC USE	CITY
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( )		( )
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
OTHER INSURED'S POLICY OR GROUP NUMBER	a FMDI OVMENTO/Common or Depute and	a. INSURED'S DATE OF BIRTH SEX
PL Code if applicable	a. EMPLOYMENT? (Current or Previous)  YES NO	a. INSUREDS DATE OF BIRTH SEX
RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE	c. CD. MOLD N	c. INSURANCE PLAN NAME OR PROGRAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES NO 10d. RESERVED FOR LOCAL LISE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
EV	VIVIDIE UE	If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE SOMEL	TING & SIGNING THIS FORM	3. Ned ALD S OR AS HORIZED PERSON'S SIGNATURE I authorize
to process this claim. I also request payment of government benefits of	te the release of any medical or other information necessary lither to myself or to the party who accepts assignment	y payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED	DATE	SIGNED
LOATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	AS OTHER DATE	
MM DO YY QUAL	QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  WM DD YY  FROM TO MM DD YY  TO MM DD YY
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	71b. NPI	FROM TO
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO
I. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	to service line below (24E) ICD Ind. 9	22. RESUBMISSION ORIGINAL REF. NO.
A. [78907 B. [78321	c. [78729 D. [53081	A 02 4361134567800
E F	G H	23. PRIOR AUTHORIZATION NUMBER
J	K. L. L. L. POCEDURES, SERVICES, OR SUPPLIES   E.	F G H I J
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	NTS ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. dalms, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
1234 I. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVI	YES NO CE FACILITY LOCATION INFORMATION	s 900 00 s s 900 00 33. BILLING PROVIDER INFO & PH# (225) 555-4957
INCLUDING DEGREES OR CREDENTIALS (i) certify that the statements on the reverse	The second secon	SURGI CENTER
apply to this bill and are made a part thereof.)		123 MAIN ST
		ANY TOWN, LA 70000
IGNED IMA BILLER DATE 1/7/15 a.	b.	a. 1234567891 b. 1234567
UCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM CMS-1500 (02:

# **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING

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# Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)

EALTH IN																		
PROVED BY NA	TIONAL	NIFORM	CLAIM	COMMI	TTEE (N	UCC) 02/12												PICA
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OU, JANN						(	06   1	9   8	35 M		F X							
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TY								pouse FOR NU			Other	CITY						STATE
CODE		TE	LEPHO	NE (Indu	ide Area	Code)						ZIP CODE			TELEP	HONE (I	nclude Art	a Code)
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OTHER INSUR	ED'S NAM	E (Last I	Name, F	irst Nam	e, Middle	Initial) 10.	IS PATIE	NT'S CO	NDITIO	N RELA	TED TO:	11. INSURED'S	POLICY	GROUF	P OR FEO	CA NUMI	BER	
OTHER INSUR	ED'S POL	CY OR	GROUP	NUMBE	R	a. E/	MPLOYM	ENT?(C	urrent o	r Previou	us)	a. INSURED'S	DATE	OF BIRT	TH .		SEX	
L Code if	applica	able						YES		NO	,	MM	DO	YY		M		F
ESERVED FO	R NUCC	JSE				b. Al	ЈТО АОО			P	LACE (State)	b. OTHER CLAI	MID (De	signate	d by NUC	(C)		
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# **CHAPTER 29: AMBULATORY SURGICAL CENTERS**

APPENDIX B: CLAIMS FILING

PAGE(S) 13

# **Example of Blank Form**

回帰回 でなる 回転車 HEALTH INSURANCE CLAIM FORM			CARRIER
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			3
PICA		PICA	<b>□</b> Y
1. MEDICARE MEDICAID TRICARE CHAMPVA (Medicare#) (Medicare#) (Medicare#) (Member £9#)	GROUP FECA OTHER HEALTH PLAN BLK LUNG (IDW)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	^
	PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	-11
	PATIENT RELATIONSHIP TO INSURED	T INCHIDED ADDRESS (No. Physia)	_
S. PATIENT S AUDIESS (No., Street)	Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)	
CITY STATE 8.	RESERVED FOR NUCC USE	CITY	3
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)	Ē
( )		( )	N. C.
8. 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	N. N.
a. OTHER INSURED'S POLICY OR GROUP NUMBER a.	EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
S. S	YES NO	a. INSURED'S DATE OF BIRTH  MM DO WY  M F	PATIENT AND INSURED INFORMATION
b. RESERVED FOR NUCC USE b.	AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	9
c. RESERVED FOR NUCC USE c.	OTHER ACCIDENT?	© INSURANCE PLAN NAME OR PROGRAM NAME	_3
W. REGERVED FOR ROOD OSE	YES NO	E INSCIDENCE PERVIOUSE OF PROGRAM IN ME	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10	od. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	A
DEAD RADY OF FORM DEPOSE SAME PERSON		YES NO # yes, complete items 9, 9a, and 9d.	_1
READ BACK OF FORM BEFORE COMPLETING & 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the relat to process this dailm. I also request payment of government benefits either to melow.	accurate This Pores. ase of any medical or other information necessary nyself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>	ě
SIGNED	DATE	SIGNED	+
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
		YES NO	
21. DIAGNOSIS OF NATURE OF ILLNESS OF INJURY Relate A-L to service I	line below (24E) ICD Ind.	22. RESUBMISSION ORIGINAL REF. NO.	
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INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	ITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )	
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