AMBULATORY SURGICAL CENTERS PROVIDER MANUAL

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
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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.
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 ambulatory surgical center 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 ambulatory surgical center;
3. Lab 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. Lab and x-ray not directly related to the surgical procedure;
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 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.
PROVIDER REQUIREMENTS

Ambulatory surgical centers (ASC) 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 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.
REIMBURSEMENT

Reimbursement for surgical procedures performed in an ambulatory surgical center (ASC) is a flat fee per service in accordance with the four 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 ambulatory surgery center.

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.
Billing

Ambulatory surgical center claims are completed on the CMS 1500 or 837P. There should only be one (1) line item per claim form.

Only one (1) procedure code may be reimbursed per outpatient surgical session.
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>ASSISTANCE NEEDED</th>
<th>HOW TO OBTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copy of the Professional Services Fee Schedule</td>
<td>Available at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under Type of Service (TOS) 08</td>
</tr>
<tr>
<td></td>
<td>“Evaluation and Management” and Laboratory CPT codes are excluded.</td>
</tr>
<tr>
<td>Billing questions/assistance</td>
<td>Gainwell Technologies</td>
</tr>
<tr>
<td></td>
<td>Provider Relations</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 91024</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td></td>
<td>1-800-473-2783 or (225) 924-5040</td>
</tr>
</tbody>
</table>
CLAIMS FILING

Hard copy billing of ambulatory surgical center services are billed on the paper 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.
CMS 1500 (02/12) INSTRUCTIONS FOR AMBULATORY SURGICAL CENTERS

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung</td>
<td><strong>Required</strong> -- Enter an “X” in the box marked Medicaid (Medicaid #).</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. Number</td>
<td><strong>Required</strong> – Enter the beneficiary’s 13-digit Medicaid I.D. number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS or REV.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NOTE:</strong> The beneficiaries’ 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <strong>NOT</strong> acceptable. The ID number must match the beneficiary’s name in Block 2.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td><strong>Required</strong> – Enter the beneficiary’s last name, first name, middle initial.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td><strong>Situational</strong> – Enter the beneficiary’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an “X” in the appropriate box to show the sex of the beneficiary.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td><strong>Situational</strong> – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td><strong>Optional</strong> – Print the beneficiary’s permanent address.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td><strong>Situational</strong> – If beneficiary has no other coverage, leave blank.</td>
<td>ONLY the 6-digit code should be entered for commercial and Medicare 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</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is Patient’s Condition Related To:</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth Sex</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>Employer’s Name or School Name</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature (Release of Records)</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Patient's or Authorized Person's Signature (Payment)</td>
<td><strong>Situational</strong> – Obtain signature if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness / Injury / Pregnancy</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>If Patient Has Had Same or Similar Illness, Give First Date</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Unlabeled</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Reserved for Local Use</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21</td>
<td>ICD Ind.</td>
<td><strong>Required</strong> -- 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.</td>
<td>The most specific diagnosis codes must be used. General codes are not acceptable.</td>
</tr>
<tr>
<td></td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td><strong>Required</strong> -- Enter the most current ICD diagnosis code.</td>
<td>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTE: The ICD-9-CM &quot;E&quot; and &quot;M&quot; series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</td>
<td>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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 (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>).</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission Code</td>
<td><strong>Situational.</strong> 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.</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appropriate reason codes follow:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Adjustments</strong></td>
<td></td>
</tr>
</tbody>
</table>
|          |                                          | 01 = Third Party Liability 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                                                                                                   |                                                                                                                                                                                                      |
<table>
<thead>
<tr>
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<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is <strong>required</strong> to be entered.</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td><strong>Leave Blank.</strong></td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td><strong>Required</strong> -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td>
<td></td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td><strong>Required</strong> -- Enter the appropriate place of service code for the services rendered.</td>
<td></td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td><strong>Required</strong> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</td>
<td></td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td><strong>Required</strong> -- 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.</td>
<td></td>
</tr>
<tr>
<td>24F</td>
<td>$Charges</td>
<td><strong>Required</strong> -- Enter usual and customary charges for the service rendered.</td>
<td></td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td><strong>Required</strong> -- Enter the number of units billed for the procedure code entered on the same line in 24D</td>
<td></td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT Family Plan</td>
<td><strong>Situational</strong> -- Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.</td>
<td></td>
</tr>
<tr>
<td>24I</td>
<td>I.D. Qual.</td>
<td><strong>Optional.</strong> If possible, leave blank for Louisiana Medicaid billing.</td>
<td></td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider I.D. #</td>
<td><strong>Leave Blank</strong></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>Patient's Account No.</td>
<td><strong>Situational</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment?</td>
<td><strong>Optional.</strong> Claim filing acknowledges acceptance of Medicaid assignment.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td><strong>Required</strong> – Enter the total of all charges listed on the claim.</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td><strong>Situational</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Rsvd for NUCC use</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials Date</td>
<td><strong>Optional.</strong> – The practitioner or the practitioner’s authorized representative’s original signature is no longer required. Enter the date of form completion.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td><strong>Situational</strong> – Complete as appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td><strong>Optional.</strong></td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Unlabelled</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Ph #</td>
<td><strong>Required</strong> -- Enter the provider name, address including zip code and telephone number.</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td><strong>Required</strong> - Enter the billing provider’s 10 digit NPI number.</td>
<td>The 7-digit Medicaid Provider Number must appear on paper claims.</td>
</tr>
<tr>
<td>33b</td>
<td>Unlabelled</td>
<td><strong>Required</strong> – Enter the billing provider’s 7-digit Medicaid ID number. ID Qualifier - <strong>Optional.</strong> If possible, leave blank for Louisiana Medicaid billing.</td>
<td></td>
</tr>
</tbody>
</table>
Example of Billing for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

HEALTH INSURANCE CLAIM FORM

Example of ICD-9

Claims Filing Page 8 of 12 Appendix B
Example of Billing for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)
Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

**Example of ICD-9**

```
<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73907</td>
<td>Example of Diagnosis Code</td>
</tr>
<tr>
<td>78321</td>
<td>Example of Diagnosis Code</td>
</tr>
<tr>
<td>78729</td>
<td>Example of Diagnosis Code</td>
</tr>
<tr>
<td>53081</td>
<td>Example of Diagnosis Code</td>
</tr>
</tbody>
</table>
```

**Example of Billing Adjustment**

```
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45380</td>
<td>Example of Procedure Code</td>
</tr>
</tbody>
</table>
```

**Example of Claim Form**

```
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>LOU JANNIE</td>
</tr>
<tr>
<td>Date of Service</td>
<td>12/15/14</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>45380</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>73907</td>
</tr>
</tbody>
</table>
```

**Example of Provider Information**

```
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>SURGI CENTER</td>
</tr>
<tr>
<td>Address</td>
<td>123 MAIN ST</td>
</tr>
</tbody>
</table>
```

**Example of Claim Filing**

```
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>SURGI CENTER</td>
</tr>
<tr>
<td>Address</td>
<td>123 MAIN ST</td>
</tr>
<tr>
<td>Phone Number</td>
<td>(225) 566-4957</td>
</tr>
</tbody>
</table>
```
Example of Billing Adjustment for Ambulatory Surgical Centers with ICD-10 Diagnosis Code (Dates ON OR AFTER 10/1/15)
Example of Blank Form