AHCCCS
Arizona Health Care Cost Containment System

11/13/14

TABLE OF CONTENTS

ASC Technical Assistance Document

Section 1:

Introduction

Overview

This manual provides Technical guidance for billing ASC Claims through the internet, paper, or the 837 format.

Ambulatory Surgical Center (ASC)

Effective 04/01/2011 all Indian Health Services facilities and Tribally-Operated 638 Health Programs (IHS/638) outpatient surgeries performed at their facilities must bill with the ASC procedure codes on the CMS 1500 (08-05) form type. The facilities will be reimbursed the ASC Fee Schedule rate and not the All Inclusive Rate (AIR).

UP to three CMS 1500 (08-05) claim form can be billed, the ASC Facility, the Surgeon fee, and the Anesthesiologists fee.

RATES – As you know, AHCCCS has historically used an ASC Grouper system for pricing, which is no longer supported by Medicare. Therefore the new AHCCCS ASC fee schedule will not group rates, but will assign a rate to each allowable code. This structure is very similar to the new Medicare ASC structure, but rates will be AHCCCS specific. Unlike Medicare's ASC fee schedule, AHCCCS will not bundle procedure codes with implants.

CODES – This change will also expand access to procedures in the ASC setting by providing payment for approximately 2,000 additional procedure codes formerly not eligible for billing in a Freestanding ASC.

PROCESSING – The new ASC reimbursement system may have fee schedule amounts of zero for codes which are allowable in the ASC, but are included in the fees associated with surgical procedures. Unlike other AHCCCS fee schedules, if the fee for the procedure is $0.00 for the claim date of service the allowed amount for that procedure should be $0.00. The new reimbursement system will also follow Facility (OPFS) Correct Coding Initiatives (CCI). We believe the new payment system will promote a better alignment of procedures and their payments and will open many appropriate codes for ASC utilization.

Ambulatory Surgical Center (ASC) FFS Rates & Codes - Link

http://www.azahcccs.gov/commercial/ProviderBilling/rates/ASCrates.aspx

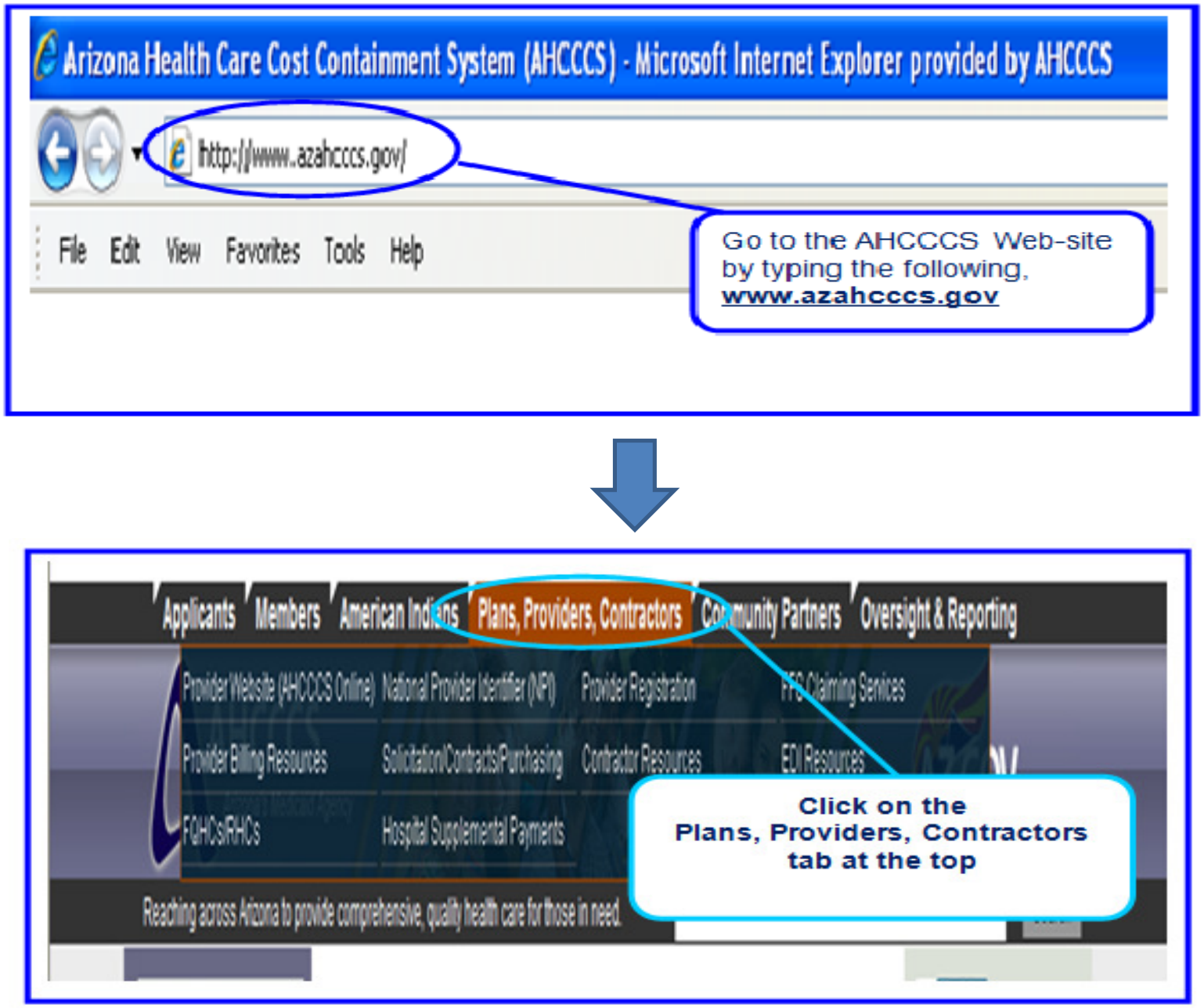
Physician/Anesthesia Fee Schedules Codes and Rates

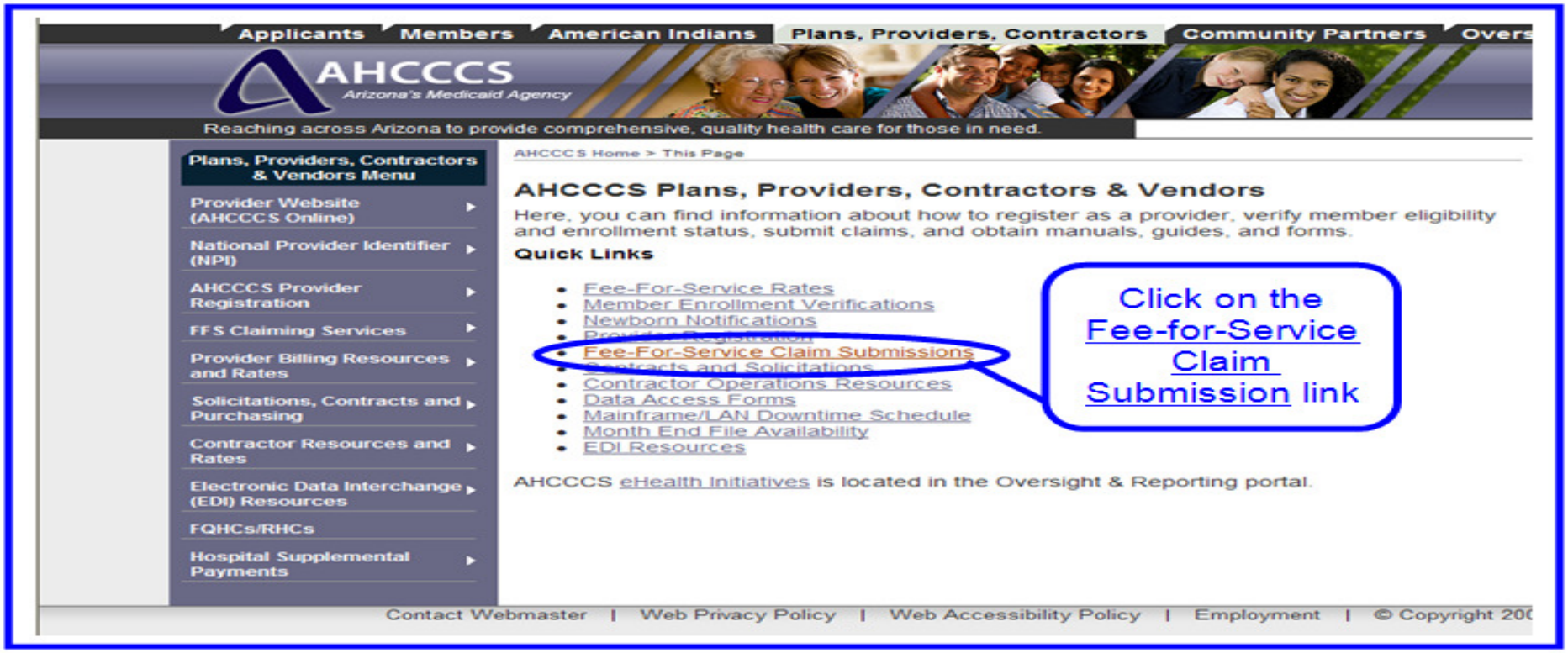
http://www.azahcccs.gov/commercial/ProviderBilling/rates/Physicianrates/Physicianrates.aspx

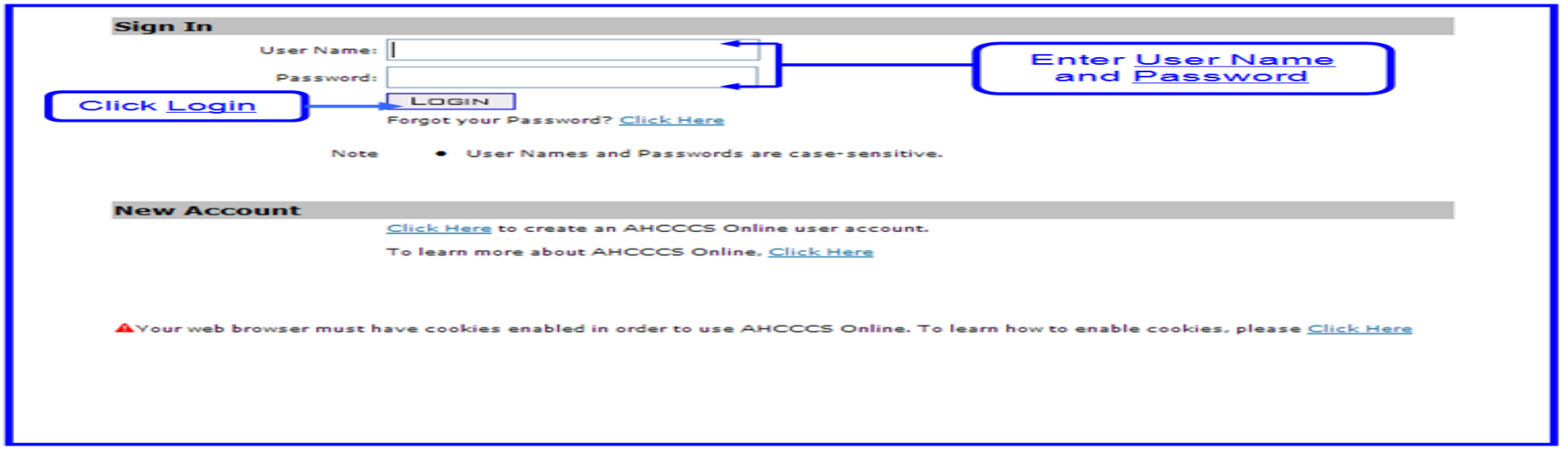
ASC Technical Assistance Document

Section 2:

Sign On


Arizona Health Care Cost Containment System (AHCCCS) - Microsoft Internet Explorer provided by AHCCCS
http://www.azahcccs.gov/
File Edit View Favorites Tools Help
Go to the AHCCCS Web-site by typing the following, www.azahcccs.gov
Applicants
Members
American Indians
Plans, Providers, Contractors
Community Partners
Oversight & Reporting
Provider Website (AHCCCS Online)
National Provider Identifier (NPI)
Provider Registration
Provider Billing Resources
Solicitation/Contracts/Purchasing
Contractor Resources
EDI Resources
FQHCs/RHCs
Hospital Supplemental Payments
Reaching across Arizona to provide comprehensive, quality health care for those in need.
Click on the Plans, Providers, Contractors tab at the top


Applicants
Members
American Indians
Plans, Providers, Contractors
Community Partners
AHCCCS
Arizona's Medicaid Agency
Reaching across Arizona to provide comprehensive, quality health care for those in need.
Plans, Providers, Contractors & Vendors Menu
Provider Website (AHCCCS Online)
National Provider Identifier (NPI)
AHCCCS Provider Registration
FFS Claiming Services
Provider Billing Resources and Rates
Solicitations, Contracts and Purchasing
Contractor Resources and Rates
Electronic Data Interchange (EDI) Resources
FQHCs/RHCs
Hospital Supplemental Payments
AHCCCS Home > This Page
AHCCCS Plans, Providers, Contractors & Vendors
Here, you can find information about how to register as a provider, verify member eligibility and enrollment status, submit claims, and obtain manuals, guides, and forms.
Quick Links
Fee-For-Service Rates
Member Enrollment Verifications
Newborn Notifications
Fee-For-Service Claim Submissions
Contractor Operations Resources
Data Access Forms
Mainframe/LAN Downtime Schedule
Month End File Availability
EDI Resources
AHCCCS eHealth Initiatives is located in the Oversight & Reporting portal.
Click on the Fee-for-Service Claim Submission link
Contact Webmaster | Web Privacy Policy | Web Accessibility Policy | Employment | © Copyright 200


Sign In
User Name:
Password:
LOGIN
Forgot your Password? Click Here
Note • User Names and Passwords are case-sensitive.
Click Login
Enter User Name and Password
New Account
Click Here to create an AHCCCS Online user account.
To learn more about AHCCCS Online, Click Here
Your web browser must have cookies enabled in order to use AHCCCS Online. To learn how to enable cookies, please Click Here

ASC Technical

Assistance Document

Section 3:

On-Line Claim Submission

:: FAQ :: User Manuals :: LogOut ::

Main Menu

- Eligibility And Enrollment Status
- Provider Information
- Prior Authorization Inquiry
- Newborn Notification
- Provider Verification
- Prior Authorization Submission
- Provider Verification_New
- Claims Submission 5010
- Eligibility And Enrollment 4010
- Claim Status 5010
- Claim Submission
- Claim Status

Support and Manuals

- AHCCCS Online User Manuals

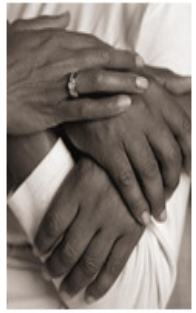
Account Information

- User Name: Test05
- User ID: 0116631
- Type: Master
- IP: 170.68.81.245
- AHCCCS Provider ID: 231725
- Admin

⚠For security purposes, your session will be logged out after 15 minutes of inactivity.⚠

Claim Status allows providers to check the status of **Fee-For-Service** claims. If the recipient is enrolled in a capitated Health Plan, please contact the Health Plan for claim inquiries. For a listing of the Health Plan contact information, please click on Health Plan Listing.

Claim Submission allows providers to submit **Fee-For-Service** claims to AHCCCS for nightly processing. Professional, Institutional and Dental claims will be accepted.



Prior Authorization Inquiry will allow providers to verify the status of previously submitted Prior Authorization requests.

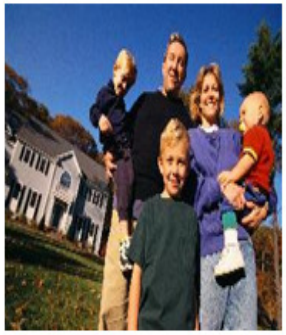
Member Eligibility Verification allows providers to verify an AHCCCS recipient's eligibility and their enrollment in a Health Plan. Providers also can obtain Medicare and other third party coverage information for a recipient.

Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available.

HealthPlan Address Changes allows health plans to send address changes from members via the web.

Prior Authorization Submission allows providers to submit prior authorizations via the web.

Provider Verification allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses, Group Affiliations and Authorized Signatures. For further information, please click on AHCCCS Provider Registration.



The AHCCCS mainframe systems will have scheduled downtimes that occur on a weekly basis. During these downtimes (usually weekends), the web site will be unavailable. During system downtimes, please contact the AHCCCS COM Center at **602-417-7000** for immediate assistance regarding eligibility/enrollment. The Interactive Voice Response (IVR) System is also available for eligibility inquiries at **602-417-7200**. For claim inquiries, please contact the AHCCCS Claims Customer Service at **602-417-7670**. For a full list of contacts, please click on AHCCCS Contacts

ASC Technical

Assistance Document

Section 3:

On-Line Claim Submission

Billing for the ASC Facility

Claim Submission

Claims submitted to AHCC… 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing c… a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also… erage at the time the service is rendered. Claims will be processed under the following Identification Number (Non…

Payer/Receiver Electronic…

NOTE: You cannot view the processing status of claims submitted by other users.

Make sure that the word Professional is showing in the box

Enter New Claim

Type of Claim: Professional ▾ Go...

Click on go

View Claim Processing Status

Submission Date(s): - Go...

A screen with 8 tabs will appear

Professional Claim Submission

Help

* Indicates a required field.

Submitter | Providers | Patient/Subscriber | Ambulance | Other Payer | Attachments | Claim Information | Service Lines

Submitter

Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information Contact Telephone Number: 602-417-4562

Click on the Providers tab

Submit Cancel

This is where you will enter the provider or group billing information

Enter the biller or group tax ID here

Click on

SSN = (Social Security Number)

Or

EIN = (Employee Identification Number)

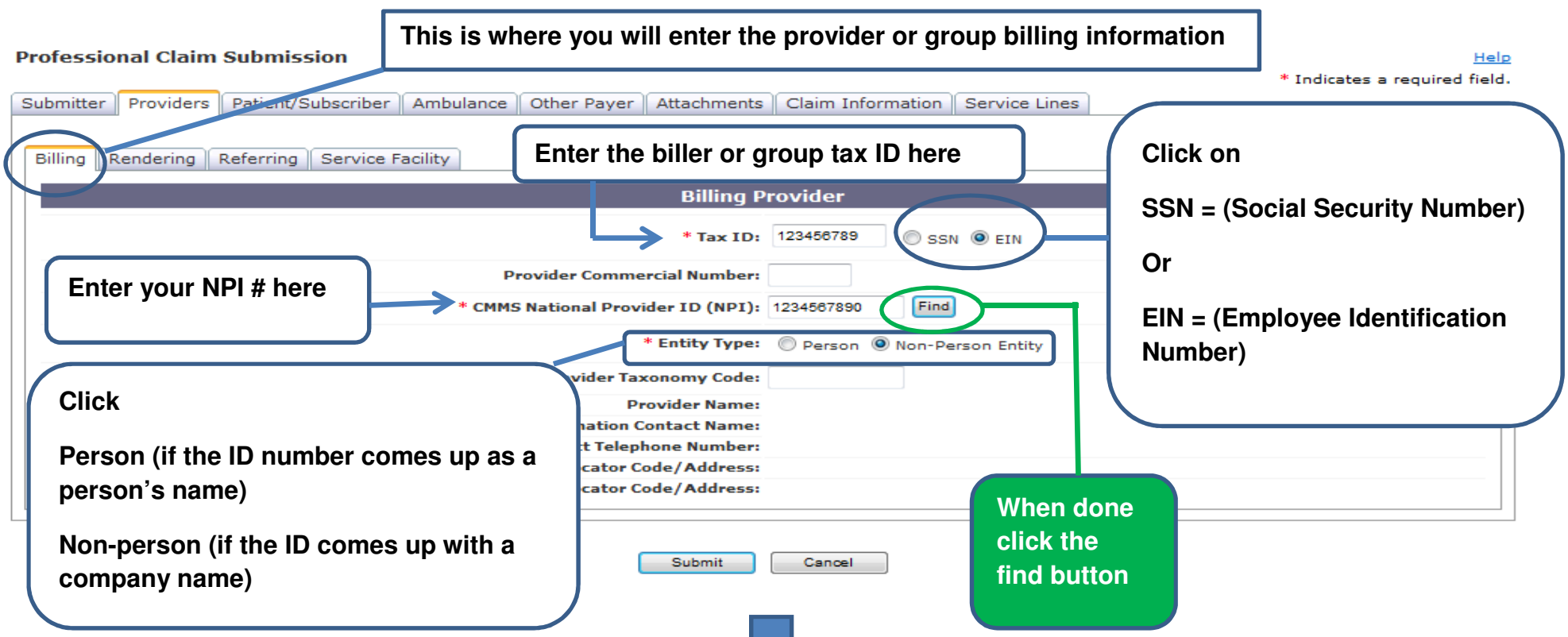
Enter your NPI # here

Click

Person (if the ID number comes up as a person's name)

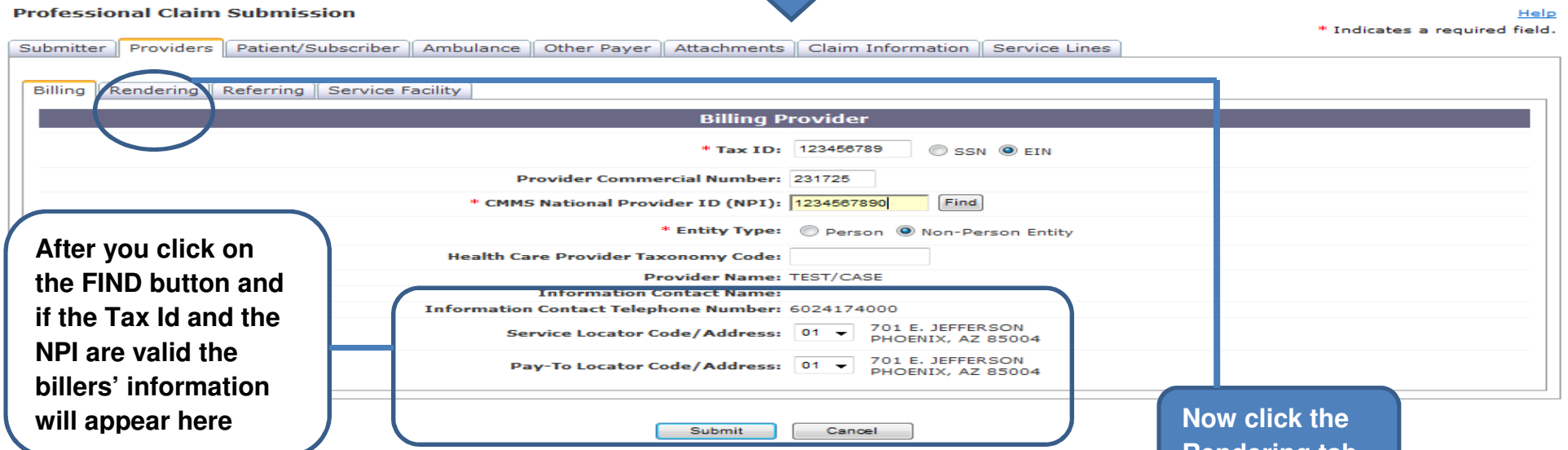
Non-person (if the ID comes up with a company name)

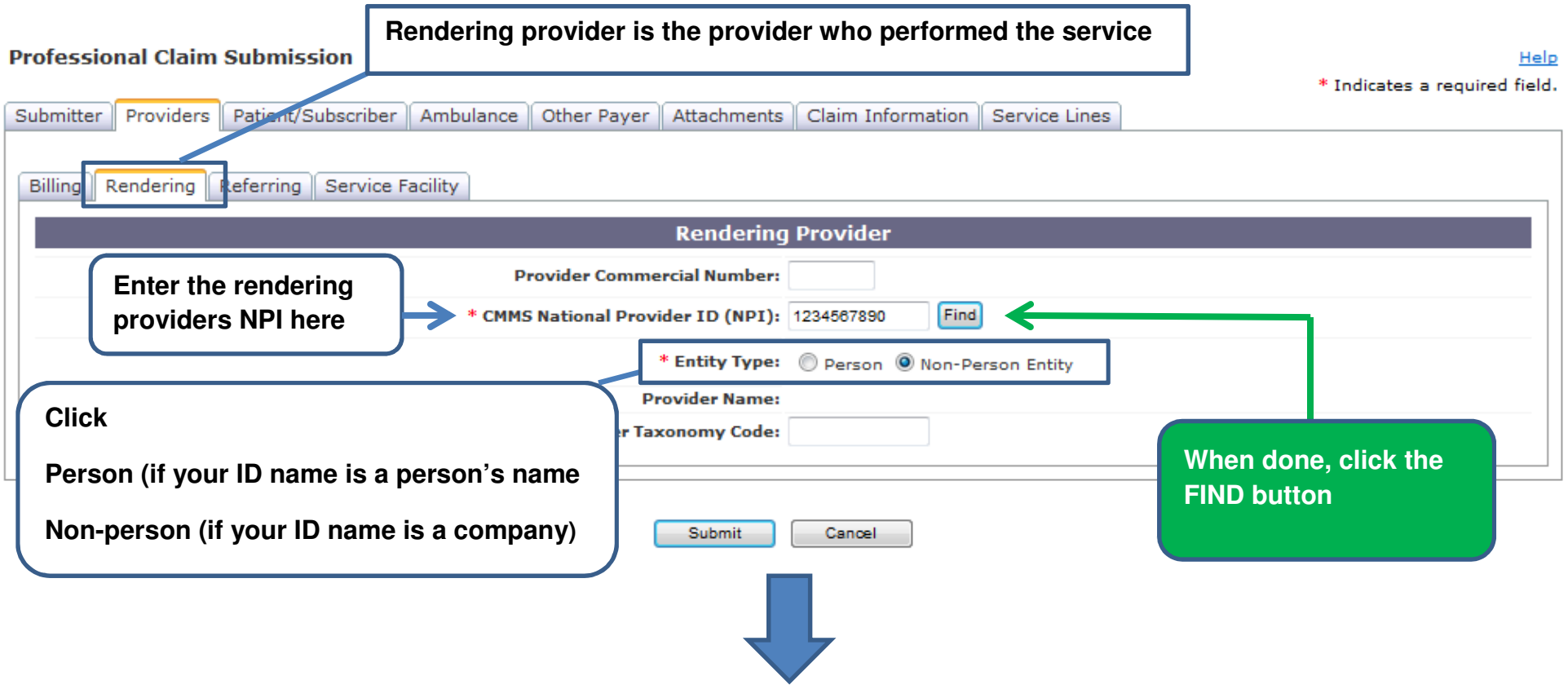
When done click the find button

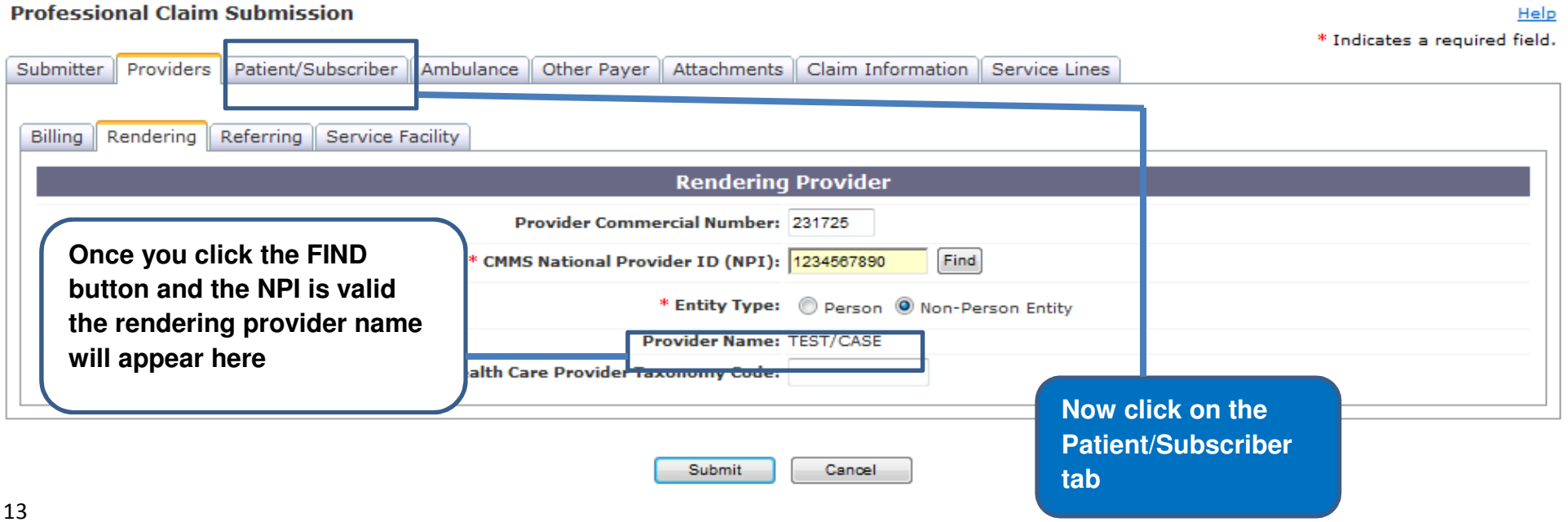


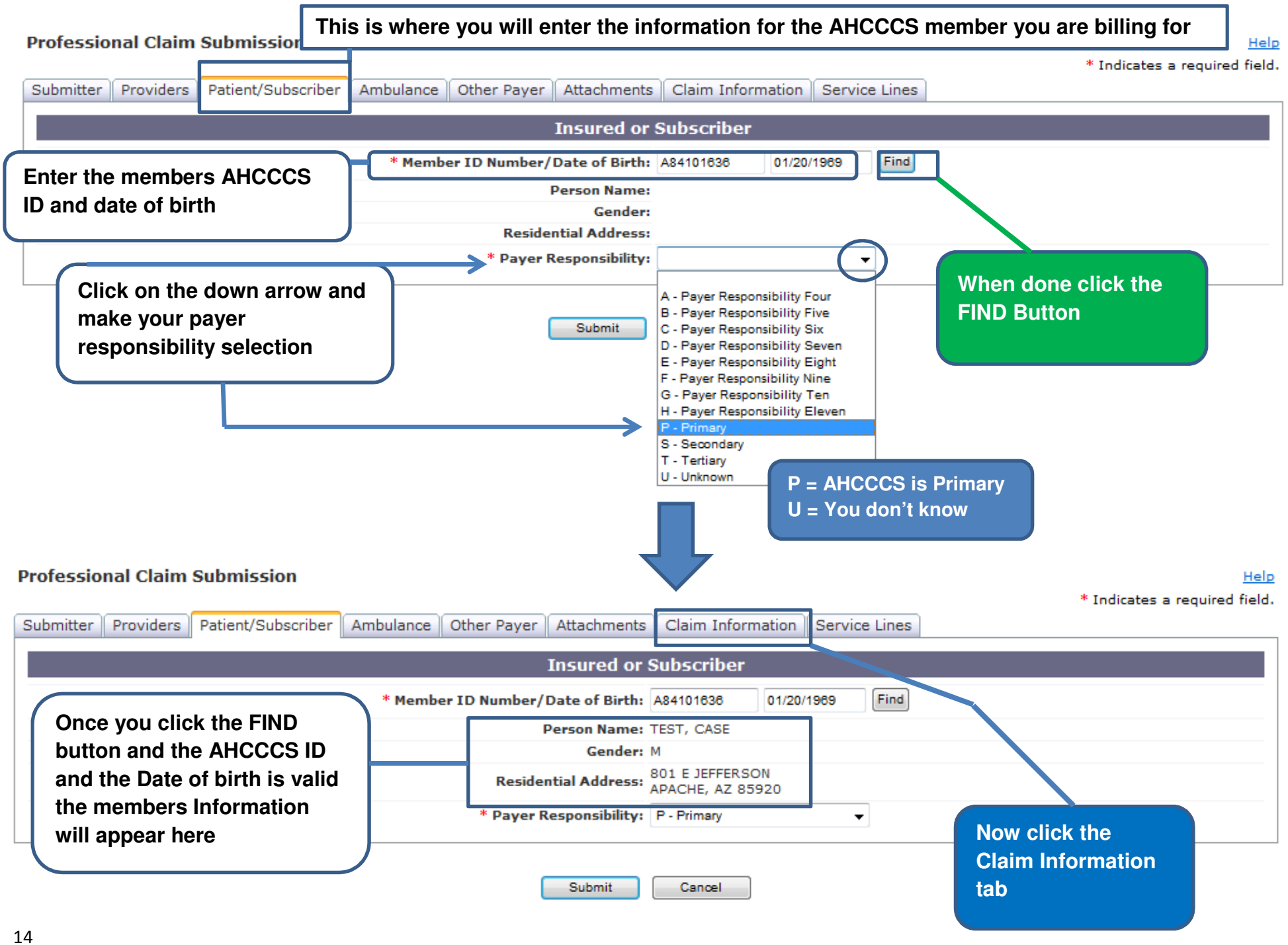
After you click on the FIND button and if the Tax Id and the NPI are valid the billers' information will appear here

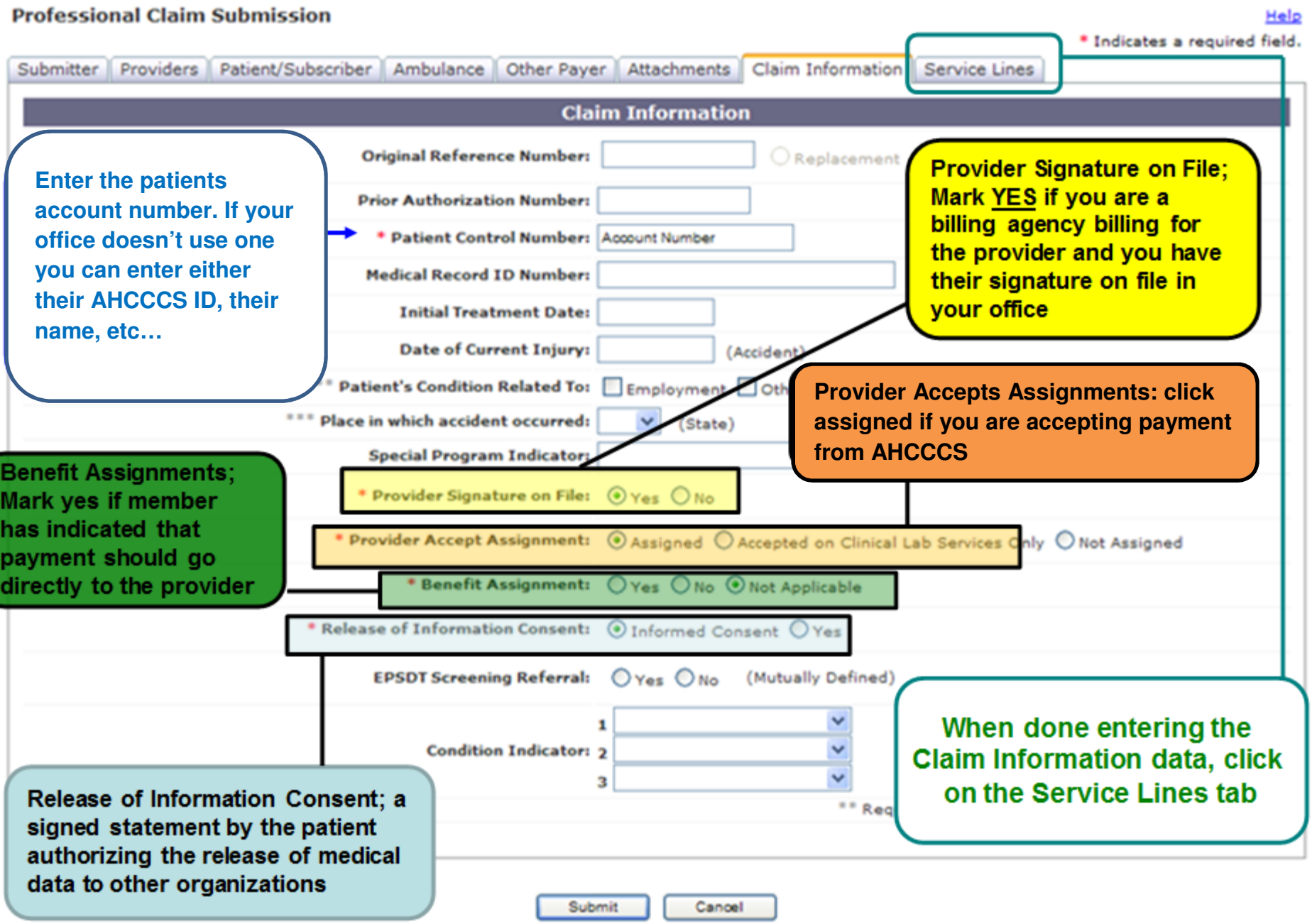
Now click the Rendering tab

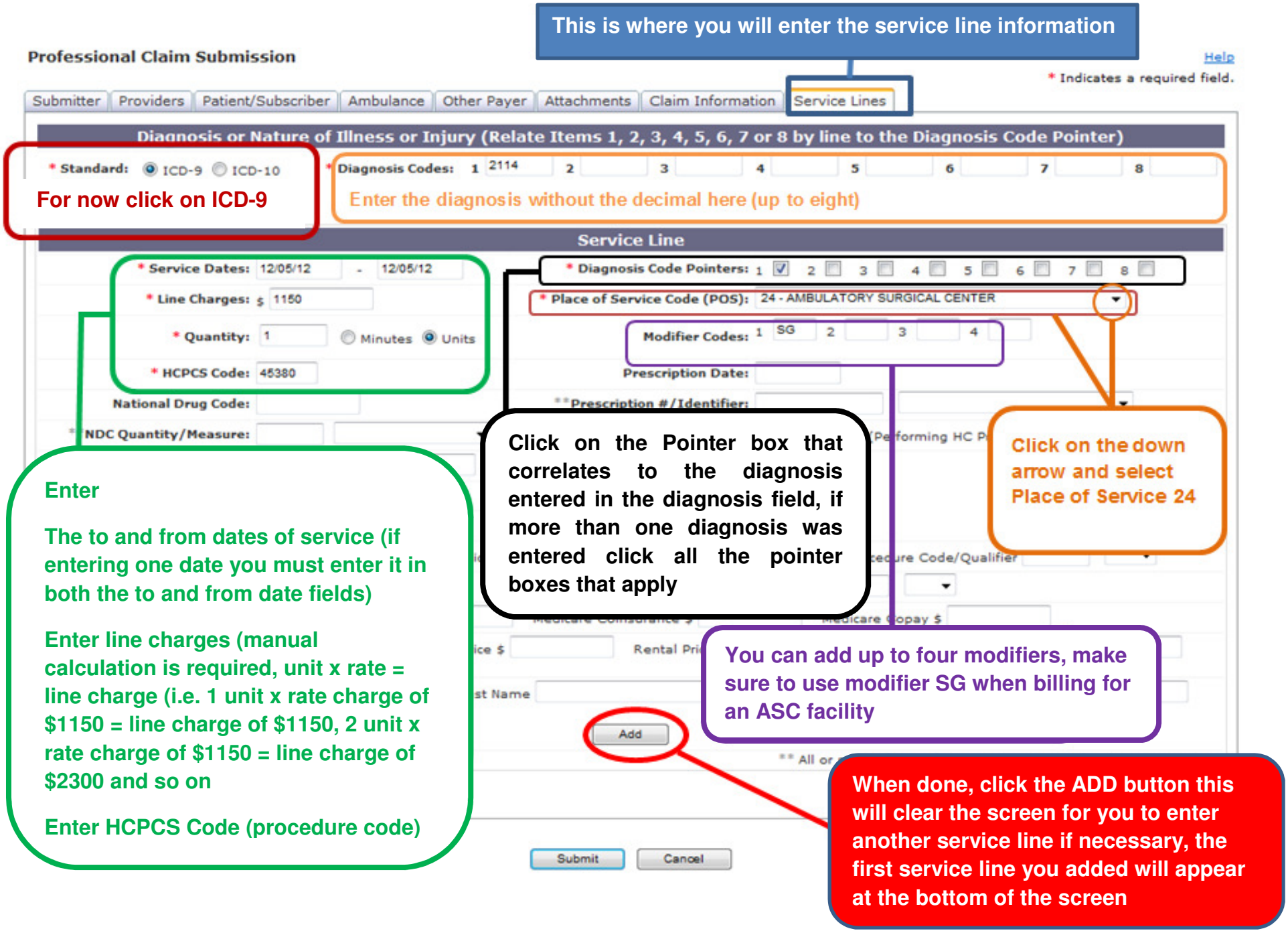


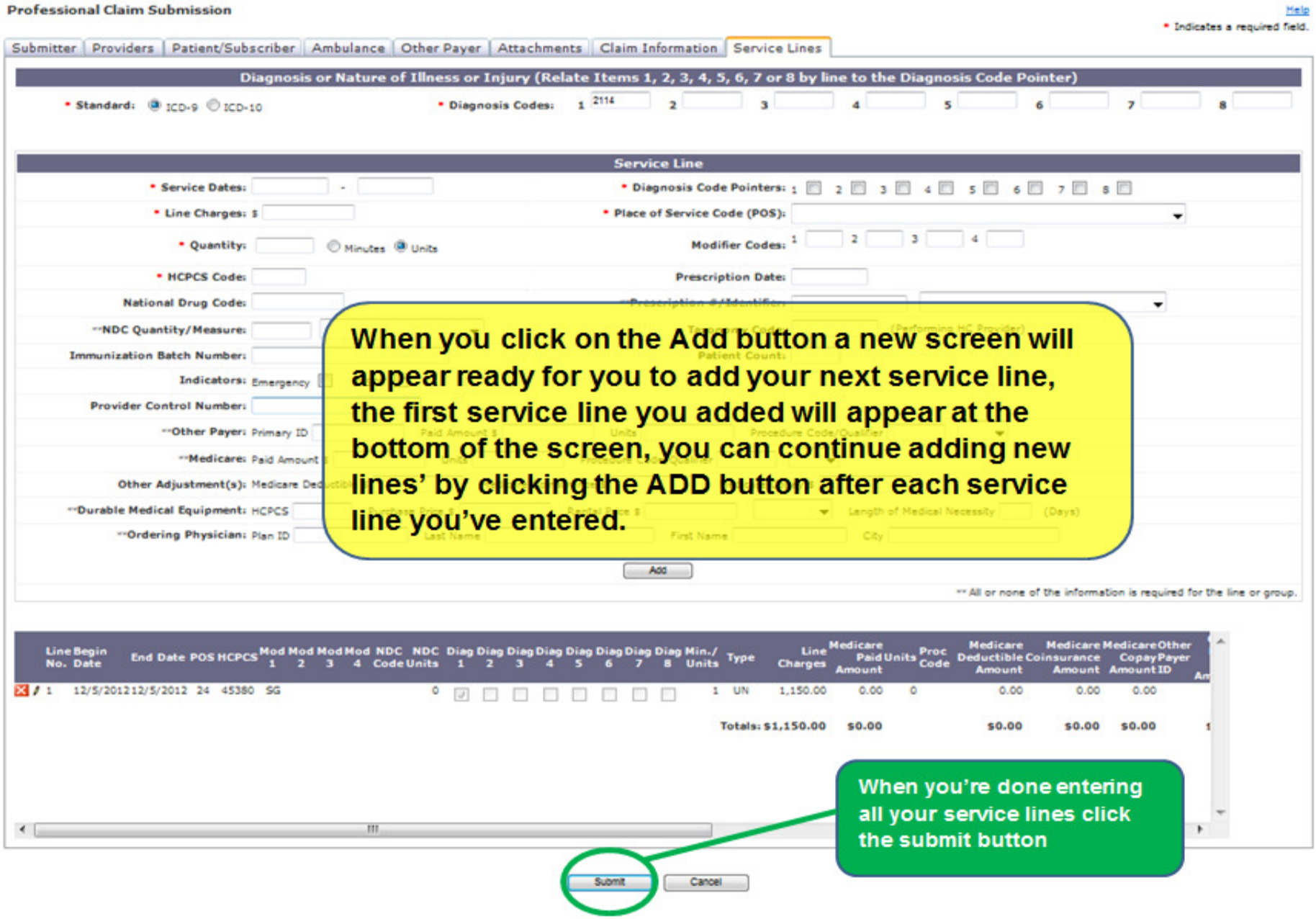

Rendering provider is the provider who performed the service
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Provider Commercial Number:
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Taxonomy Code:
Enter the rendering providers NPI here
Click
Person (if your ID name is a person's name
Non-person (if your ID name is a company)
When done, click the FIND button
Submit
Cancel

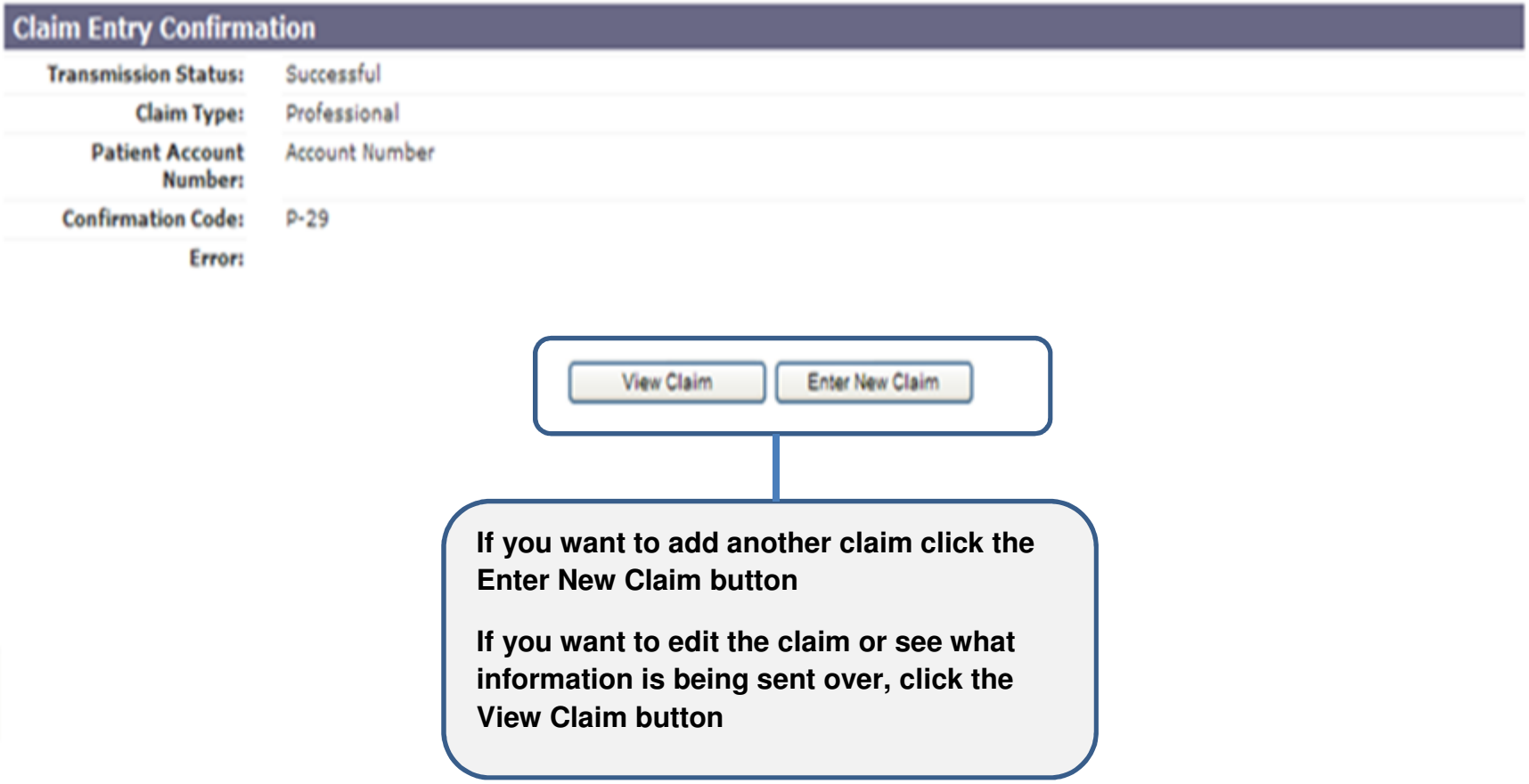

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Provider Commercial Number:
231725
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
TEST/CASE
Once you click the FIND button and the NPI is valid the rendering provider name will appear here
Now click on the Patient/Subscriber tab
Submit
Cancel


This is where you will enter the information for the AHCCCS member you are billing for
Professional Claim Submissior
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Enter the members AHCCCS ID and date of birth
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
Gender:
Residential Address:
* Payer Responsibility:
When done click the FIND Button
Click on the down arrow and make your payer responsibility selection
A - Payer Responsibility Four
B - Payer Responsibility Five
C - Payer Responsibility Six
D - Payer Responsibility Seven
E - Payer Responsibility Eight
F - Payer Responsibility Nine
G - Payer Responsibility Ten
H - Payer Responsibility Eleven
P - Primary
S - Secondary
T - Tertiary
U - Unknown
Submit
P = AHCCCS is Primary
U = You don't know
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Once you click the FIND button and the AHCCCS ID and the Date of birth is valid the members Information will appear here
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
TEST, CASE
Gender:
M
Residential Address:
801 E JEFFERSON
APACHE, AZ 85920
* Payer Responsibility:
P - Primary
Now click the Claim Information tab
Submit
Cancel


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Original Reference Number:
Replacement
Prior Authorization Number:
* Patient Control Number:
Account Number
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
* Patient's Condition Related To:
Employment
*** Place in which accident occurred:
(State)
Special Program Indicator:
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
** Req
Submit
Cancel
Enter the patients account number. If your office doesn't use one you can enter either their AHCCCS ID, their name, etc…
Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office
Provider Accepts Assignments: click assigned if you are accepting payment from AHCCCS
Benefit Assignments; Mark yes if member has indicated that payment should go directly to the provider
Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations
When done entering the Claim Information data, click on the Service Lines tab


This is where you will enter the service line information
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
For now click on ICD-9
* Diagnosis Codes: 1 2114 2 3 4 5 6 7 8
Enter the diagnosis without the decimal here (up to eight)
Service Line
* Service Dates: 12/05/12 - 12/05/12
* Line Charges: $ 1150
* Quantity: 1 Minutes Units
* HCPCS Code: 46380
National Drug Code:
NDC Quantity/Measure:
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Place of Service Code (POS): 24 - AMBULATORY SURGICAL CENTER
Modifier Codes: 1 SG 2 3 4
Prescription Date:
**Prescription #/Identifier:
Click on the down arrow and select Place of Service 24
Enter
The to and from dates of service (if entering one date you must enter it in both the to and from date fields)
Enter line charges (manual calculation is required, unit x rate = line charge (i.e. 1 unit x rate charge of $1150 = line charge of $1150, 2 unit x rate charge of $1150 = line charge of $2300 and so on
Enter HCPCS Code (procedure code)
Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the pointer boxes that apply
You can add up to four modifiers, make sure to use modifier SG when billing for an ASC facility
Add
When done, click the ADD button this will clear the screen for you to enter another service line if necessary, the first service line you added will appear at the bottom of the screen
Submit
Cancel


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 2114 2 3 4 5 6 7 8
Service Line
* Service Dates:
* Line Charges: $
* Quantity: Minutes Units
* HCPCS Code:
National Drug Code:
**NDC Quantity/Measure:
Immunization Batch Number:
Indicators: Emergency
Provider Control Number:
**Other Payer: Primary ID
**Medicare: Paid Amount
Other Adjustment(s): Medicare Ded
**Durable Medical Equipment: HCPCS
**Ordering Physician: Plan ID
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Place of Service Code (POS):
Modifier Codes: 1 2 3 4
Prescription Date:
Patient Count:
Last Name
First Name
City
Add
** All or none of the information is required for the line or group.
When you click on the Add button a new screen will appear ready for you to add your next service line, the first service line you added will appear at the bottom of the screen, you can continue adding new lines' by clicking the ADD button after each service line you've entered.
Line No. Begin Date End Date POS HCPCS Mod 1 Mod 2 Mod 3 Mod 4 NDC Code NDC Units Diag 1 Diag 2 Diag 3 Diag 4 Diag 5 Diag 6 Diag 7 Diag 8 Min./ Units Type Line Charges Medicare Paid Amount Units Proc Code Medicare Deductible Amount Medicare Coinsurance Amount Medicare Copay Amount Other Payer ID
1 12/5/2012 12/5/2012 24 45380 SG 0 1 UN 1,150.00 0.00 0 0.00 0.00 0.00
Totals: $1,150.00 $0.00 $0.00 $0.00 $0.00
When you're done entering all your service lines click the submit button
Submit
Cancel


Claim Entry Confirmation
Transmission Status: Successful
Claim Type: Professional
Patient Account Number: Account Number
Confirmation Code: P-29
Error:
View Claim
Enter New Claim
If you want to add another claim click the Enter New Claim button
If you want to edit the claim or see what information is being sent over, click the View Claim button

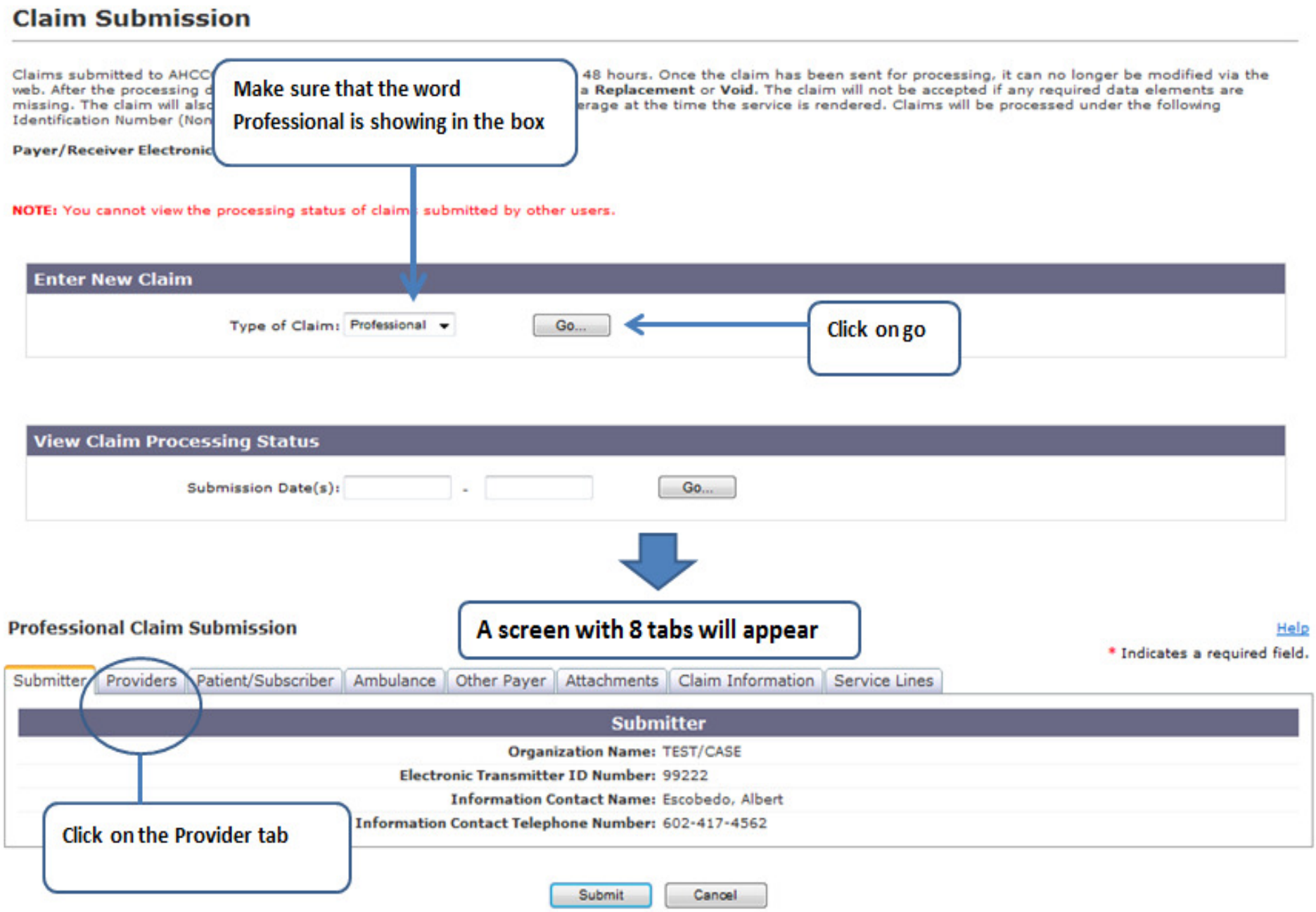
ASC Technical

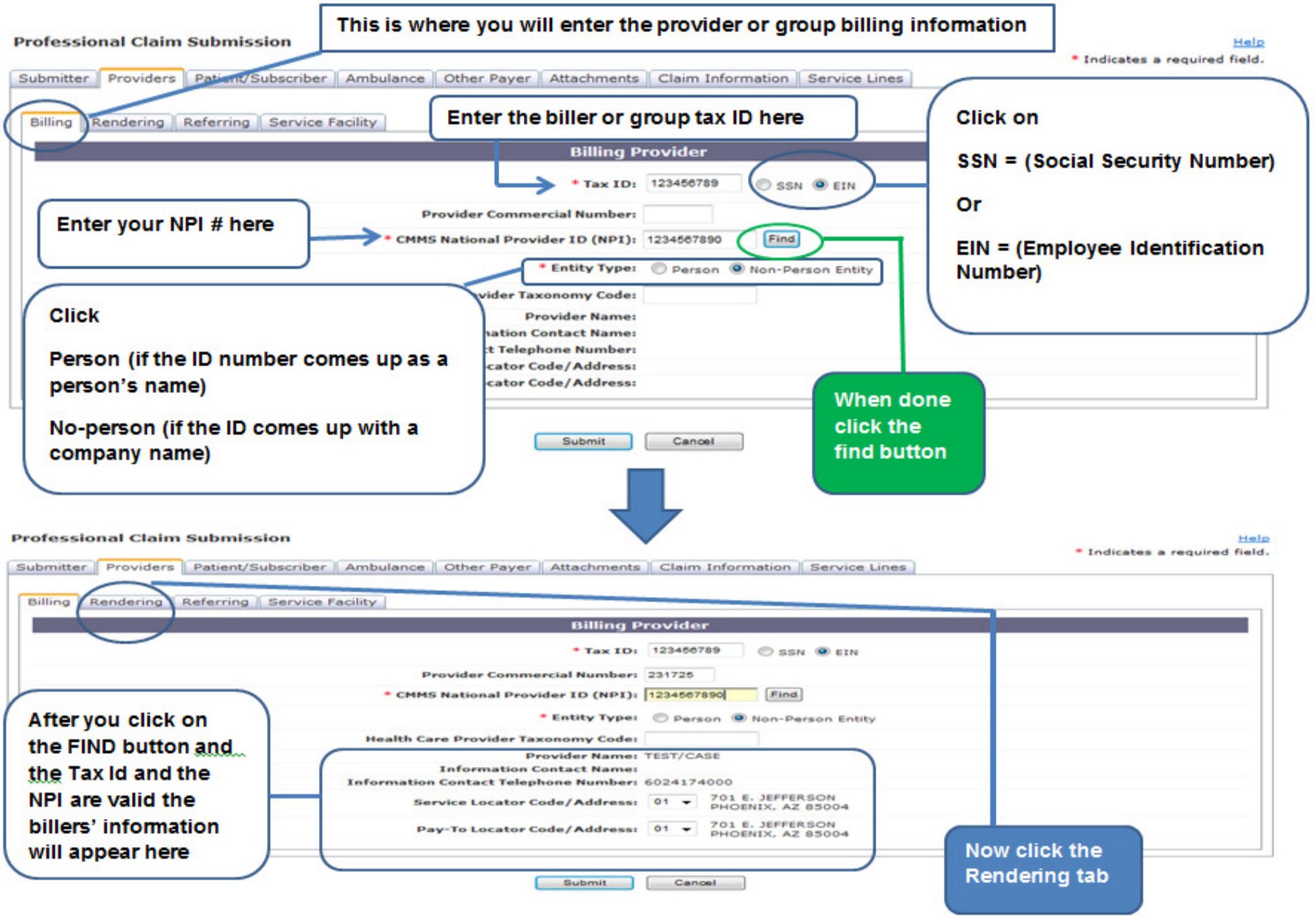
Assistance Document

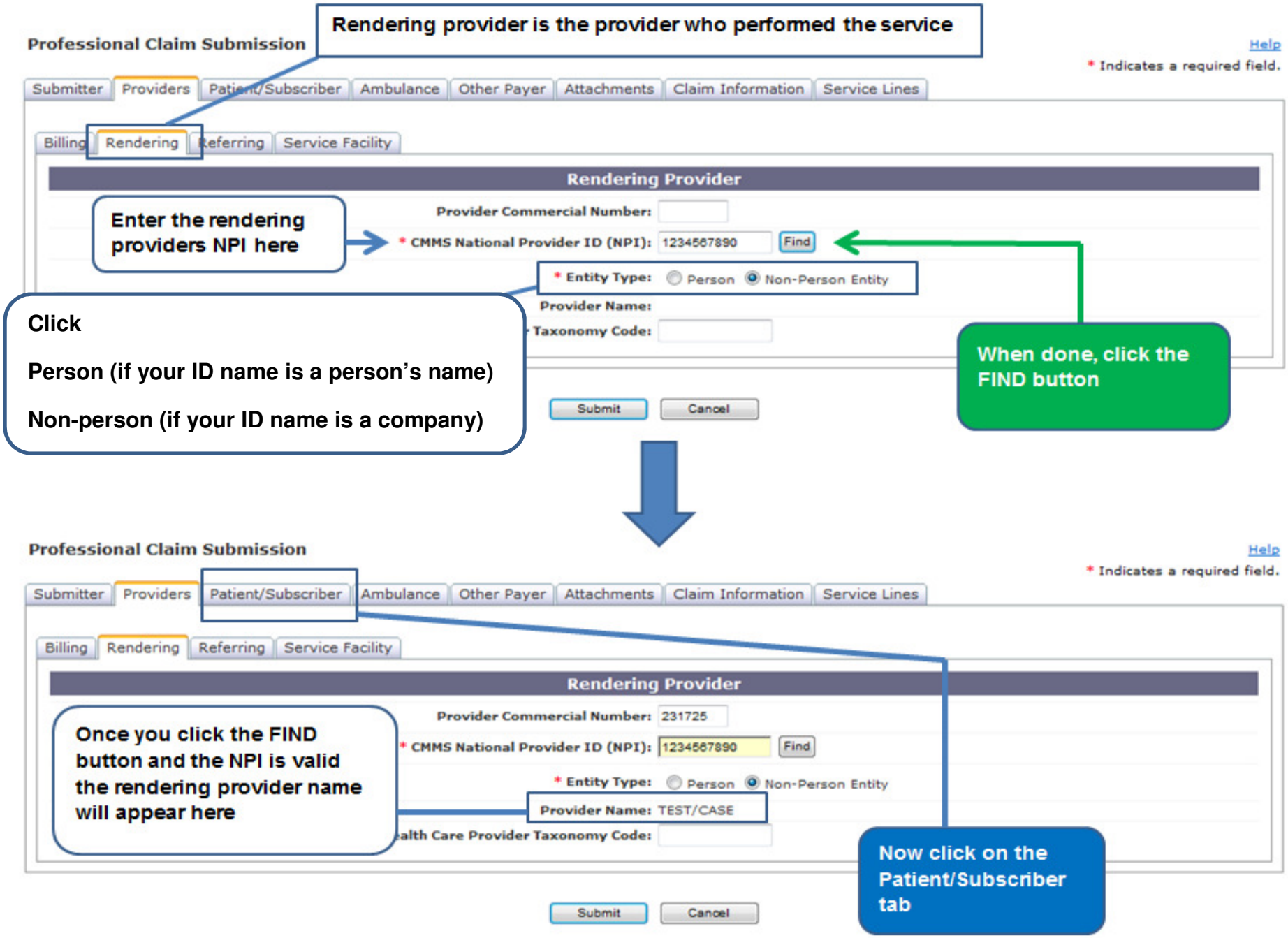
Section 3:

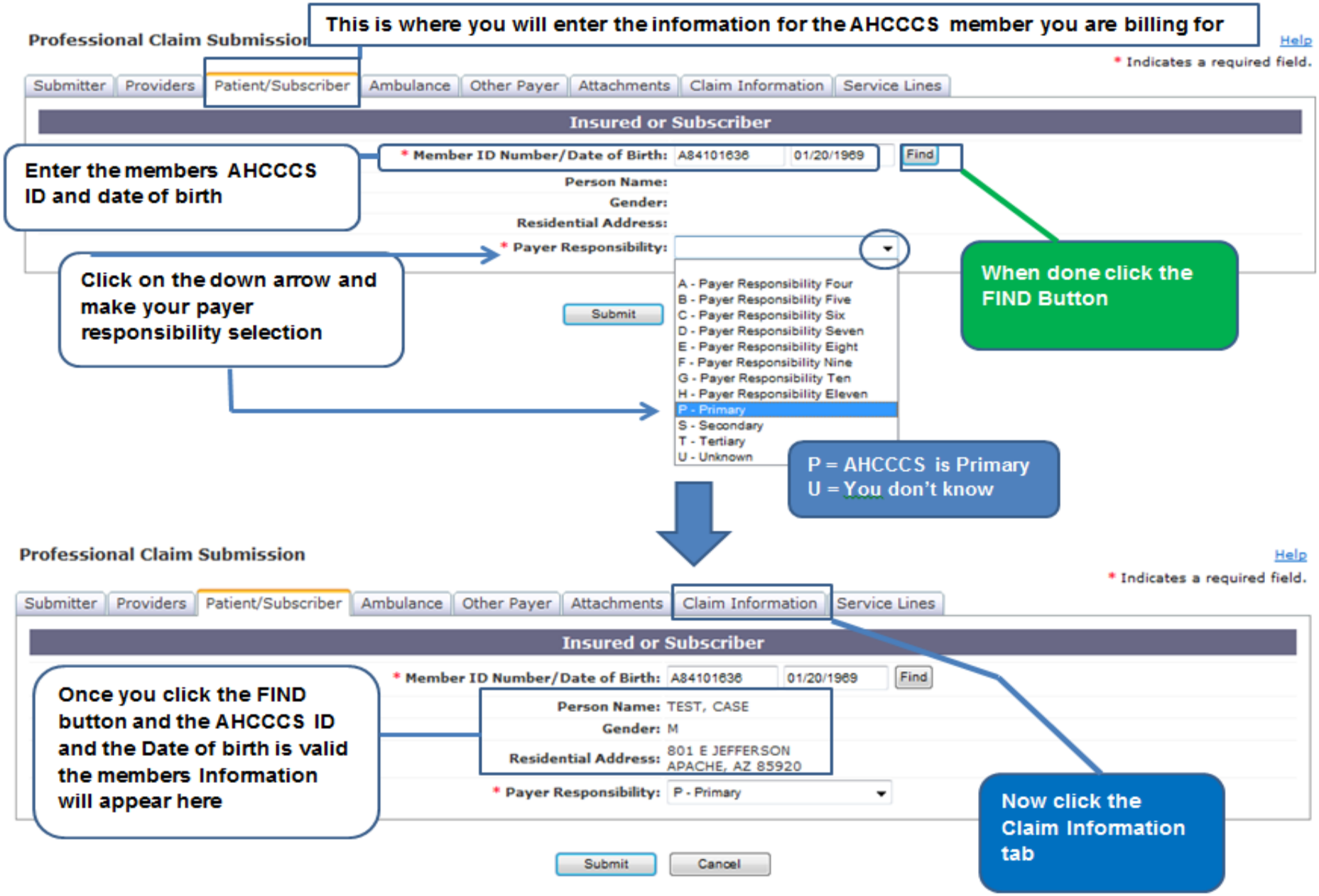
On-Line Claim Submission

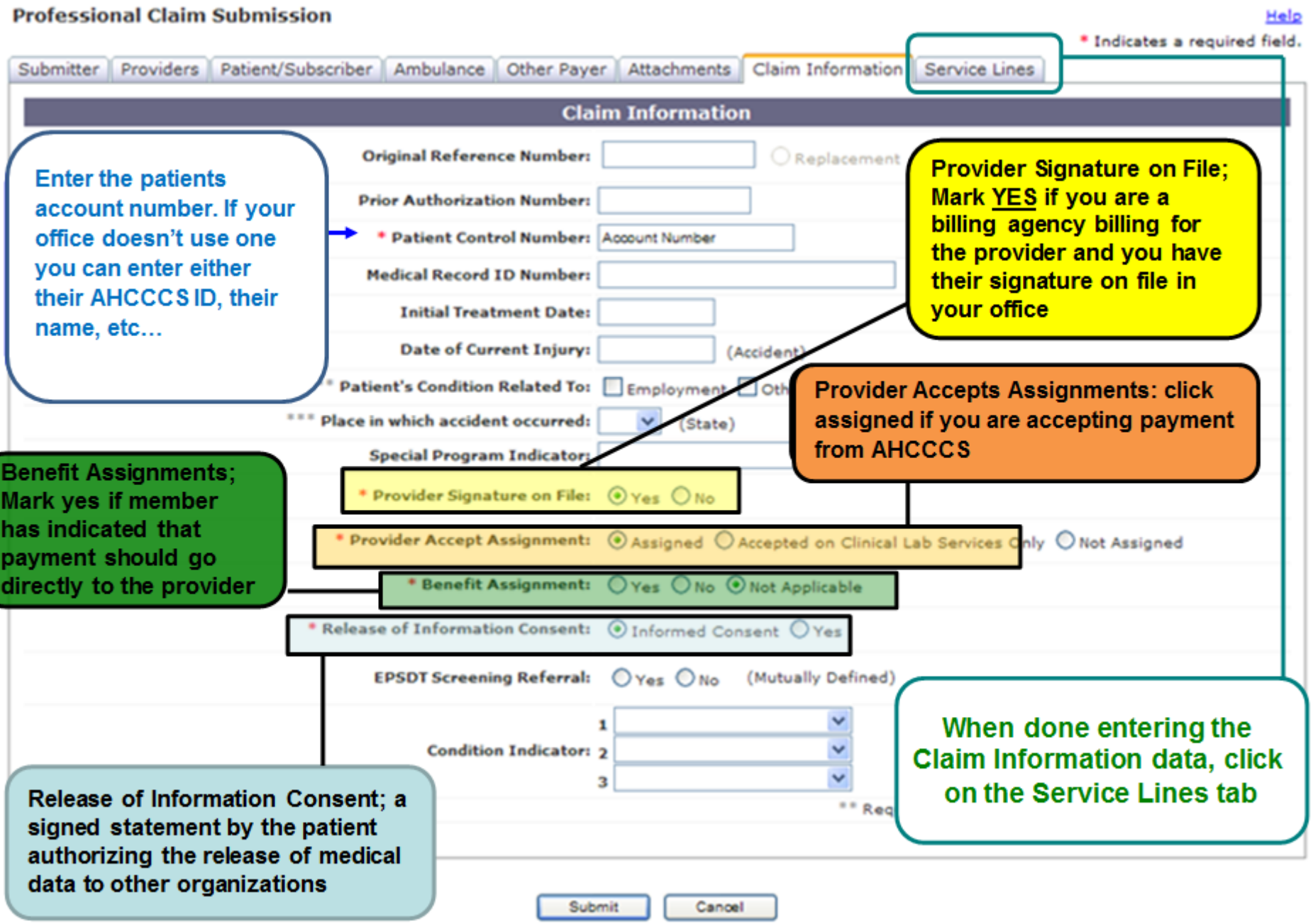
Billing for the Professional Fees'

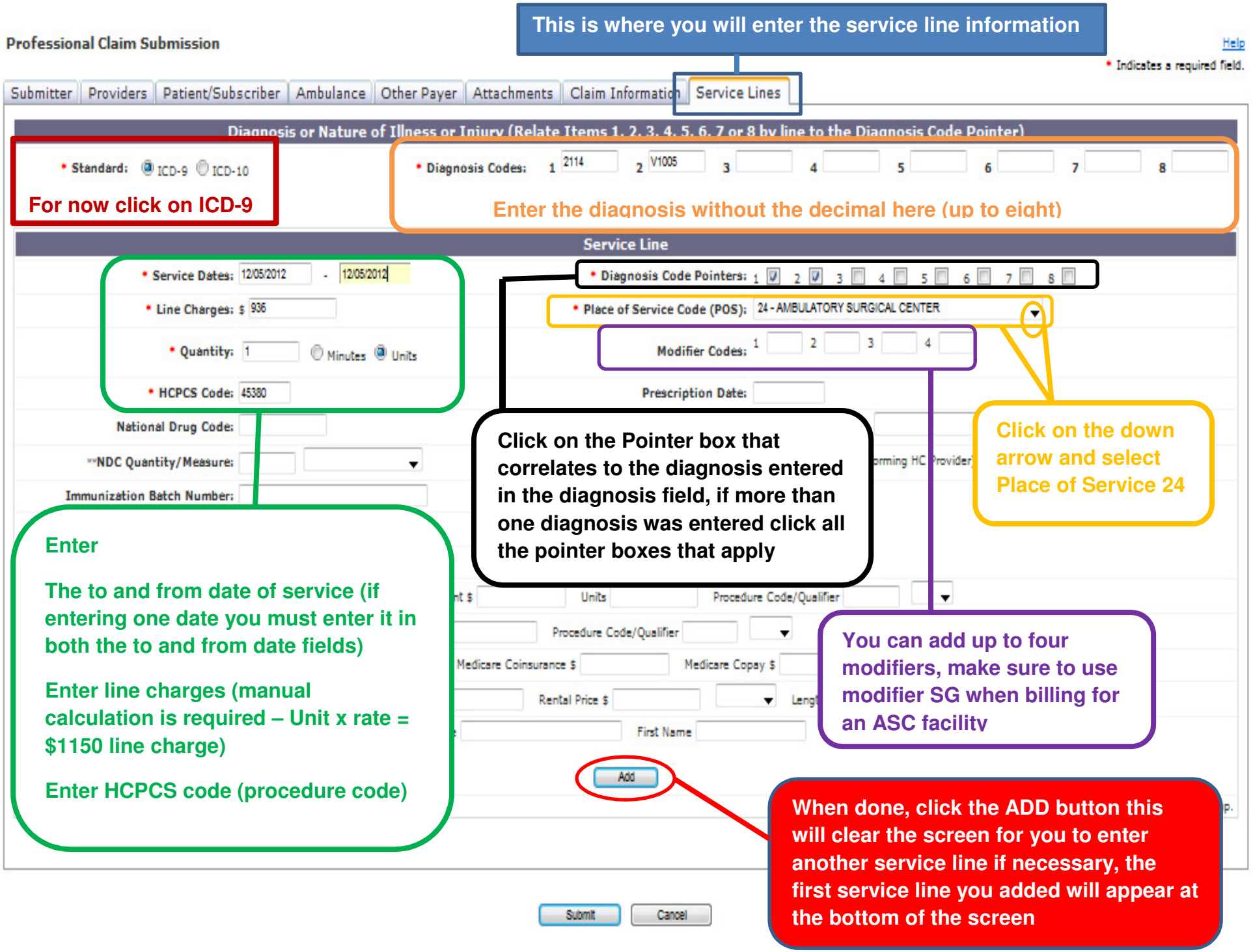

Claim Submission
Make sure that the word Professional is showing in the box
48 hours. Once the claim has been sent for processing, it can no longer be modified via the
a Replacement or Void. The claim will not be accepted if any required data elements are
erage at the time the service is rendered. Claims will be processed under the following
Payer/Receiver Electronic
NOTE: You cannot view the processing status of claim submitted by other users.
Enter New Claim
Type of Claim: Professional
Go...
Click on go
View Claim Processing Status
Submission Date(s):
Go...
A screen with 8 tabs will appear
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Submitter
Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information Contact Telephone Number: 602-417-4562
Click on the Provider tab
Submit
Cancel


This is where you will enter the provider or group billing information
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Enter the biller or group tax ID here
Billing Provider
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number:
* CMMS National Provider ID (NPI): 1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Submit
Cancel
Click on
SSN = (Social Security Number)
Or
EIN = (Employee Identification Number)
Enter your NPI # here
Click
Person (if the ID number comes up as a person's name)
No-person (if the ID comes up with a company name)
When done click the find button
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Billing Provider
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number: 231725
* CMMS National Provider ID (NPI): 1234567890
Find
* Entity Type:
Person
Non-Person Entity
Health Care Provider Taxonomy Code:
Provider Name: TEST/CASE
Information Contact Name:
Information Contact Telephone Number: 6024174000
Service Locator Code/Address: 01 701 E. JEFFERSON PHOENIX, AZ 85004
Pay-To Locator Code/Address: 01 701 E. JEFFERSON PHOENIX, AZ 85004
Submit
Cancel
After you click on the FIND button and the Tax Id and the NPI are valid the billers' information will appear here
Now click the Rendering tab


Rendering provider is the provider who performed the service
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Enter the rendering providers NPI here
Provider Commercial Number:
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Taxonomy Code:
When done, click the FIND button
Click
Person (if your ID name is a person's name)
Non-person (if your ID name is a company)
Submit
Cancel
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Once you click the FIND button and the NPI is valid the rendering provider name will appear here
Provider Commercial Number:
231725
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
TEST/CASE
alth Care Provider Taxonomy Code:
Now click on the Patient/Subscriber tab
Submit
Cancel


This is where you will enter the information for the AHCCCS member you are billing for
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Enter the members AHCCCS ID and date of birth
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
Gender:
Residential Address:
* Payer Responsibility:
When done click the FIND Button
Click on the down arrow and make your payer responsibility selection
Submit
A - Payer Responsibility Four
B - Payer Responsibility Five
C - Payer Responsibility Six
D - Payer Responsibility Seven
E - Payer Responsibility Eight
F - Payer Responsibility Nine
G - Payer Responsibility Ten
H - Payer Responsibility Eleven
P - Primary
S - Secondary
T - Tertiary
U - Unknown
P = AHCCCS is Primary
U = You don't know
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Once you click the FIND button and the AHCCCS ID and the Date of birth is valid the members Information will appear here
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
TEST, CASE
Gender:
M
Residential Address:
801 E JEFFERSON
APACHE, AZ 85920
* Payer Responsibility:
P - Primary
Now click the Claim Information tab
Submit
Cancel


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Enter the patients account number. If your office doesn't use one you can enter either their AHCCCS ID, their name, etc…
Original Reference Number:
Replacement
Prior Authorization Number:
* Patient Control Number:
Account Number
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
* Patient's Condition Related To:
Employment
*** Place in which accident occurred:
(State)
Special Program Indicator:
Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office
Provider Accepts Assignments: click assigned if you are accepting payment from AHCCCS
Benefit Assignments; Mark yes if member has indicated that payment should go directly to the provider
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
** Req
When done entering the Claim Information data, click on the Service Lines tab
Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations
Submit
Cancel


This is where you will enter the service line information
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
For now click on ICD-9
* Diagnosis Codes: 1 2114 2 V1005 3 4 5 6 7 8
Enter the diagnosis without the decimal here (up to eight)
Service Line
* Service Dates: 12/05/2012 - 12/05/2012
* Line Charges: $ 936
* Quantity: 1 Minutes Units
* HCPCS Code: 45380
National Drug Code:
**NDC Quantity/Measure:
Immunization Batch Number:
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Place of Service Code (POS): 24 - AMBULATORY SURGICAL CENTER
Modifier Codes: 1 2 3 4
Prescription Date:
Click on the down arrow and select Place of Service 24
Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the pointer boxes that apply
Enter
The to and from date of service (if entering one date you must enter it in both the to and from date fields)
Enter line charges (manual calculation is required – Unit x rate = $1150 line charge)
Enter HCPCS code (procedure code)
Units
Procedure Code/Qualifier
Procedure Code/Qualifier
Medicare Coinsurance $
Medicare Copay $
Rental Price $
First Name
You can add up to four modifiers, make sure to use modifier SG when billing for an ASC facility
Add
When done, click the ADD button this will clear the screen for you to enter another service line if necessary, the first service line you added will appear at the bottom of the screen
Submit
Cancel

Professional Claim Submission

Help

* Indicates a required field.

Submitter | Providers | Patient/Subscriber | Ambulance | Other Payer | Attachments | Claim Information | Service Lines

Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)

* Standard: ICD-9 ICD-10 * Diagnosis Codes: 1 V1005 2 2114 3 4 5 6 7 8

Service Line

* Service Dates: - * Diagnosis Code Pointers: 1 2 3 4 5 6 7 8

* Line Charges: $ * Place of Service Code (POS):

* Quantity: Minutes Units Modifier Codes: 1 2 3 4

* HCPCS Code: Prescription Date:

National Drug Code: **Prescription #/Identifier:

**NDC Quantity/Measure: Taxonomy Code: (Performing HC Provider)

Immunization Batch Number: Patient Count:

Indicators: Emergency EPSDT

Provider Control Number:

**Other Payer: Primary ID Paid Amount $ Units Procedure Code/Qualifier

**Medicare: Paid Amount $ Units Service Line Count

Other Adjustment(s): Medicare Deductible $ Medicare Coinsurance $ Medicare Copay $

**Durable Medical Equipment: HCPCS Purchase Price $ Rental Price $ Length of Medical Necessity (Days)

**Ordering Physician: Plan ID Last Name First Name City

Add

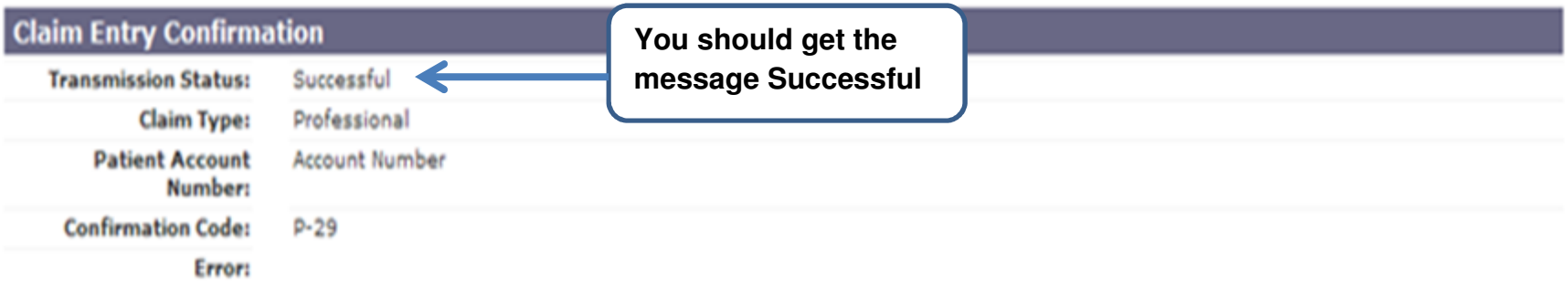
** All or none of the information is required for the line or group.

When you click on the Add button a new screen will appear ready for you to add your next service line and the first service line you added will appear at the bottom of the screen, you can continue adding new lines by clicking the add button after each service line you've entered

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Min./ Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer ID
1	12/5/2012	12/5/2012	25	45380						0	✓	✓							1	UN	936.00	0.00	0		0.00	0.00	0.00	
																				Totals:	$936.00	$0.00			$0.00	$0.00	$0.00	

When you're done entering all your service lines, click the Submit button

Submit Cancel



If you want to add another claim click the Enter New Claim button

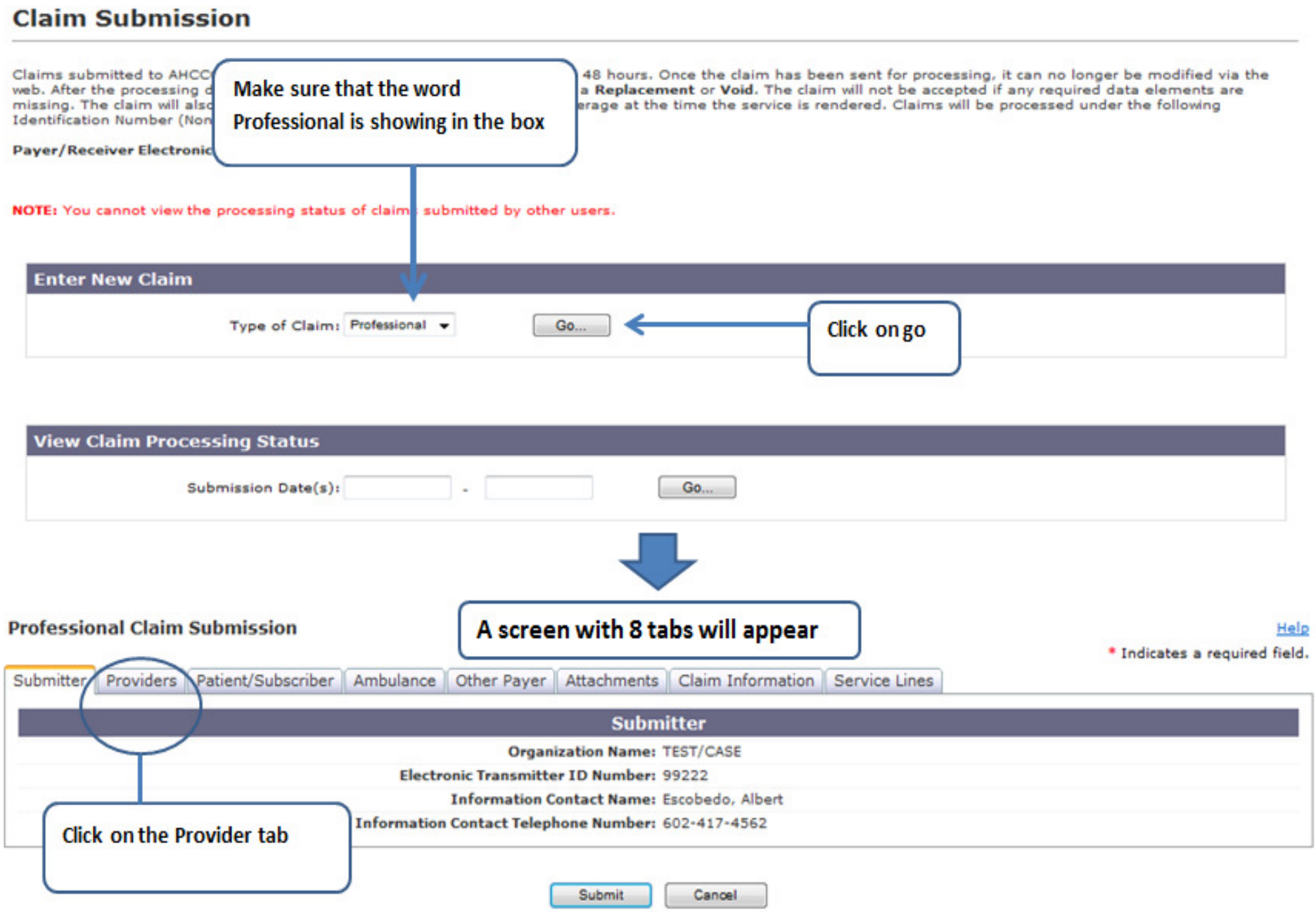
If you want to edit the claim or see what information is being sent over, click the View Claim button

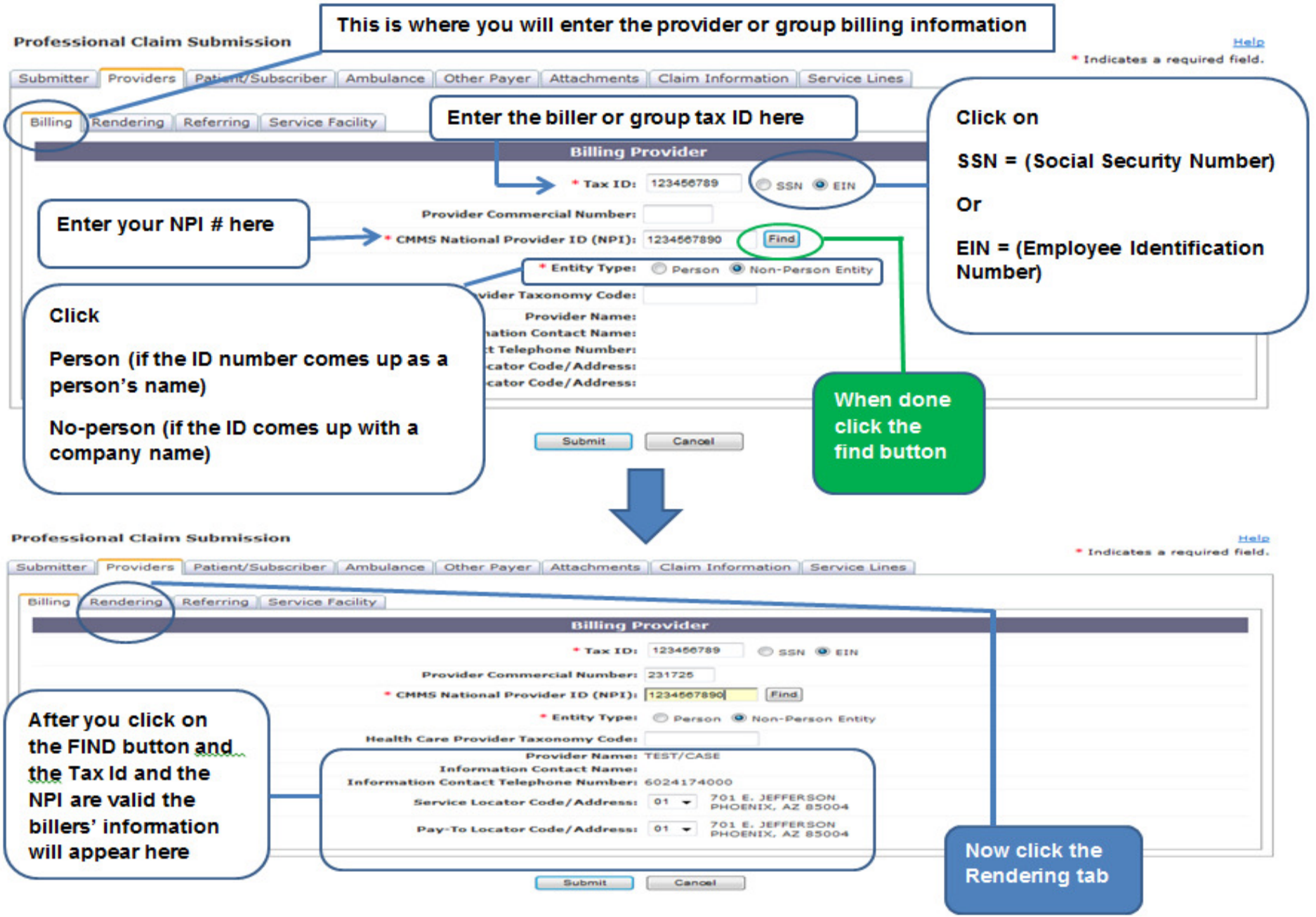
ASC Technical Assistance Document

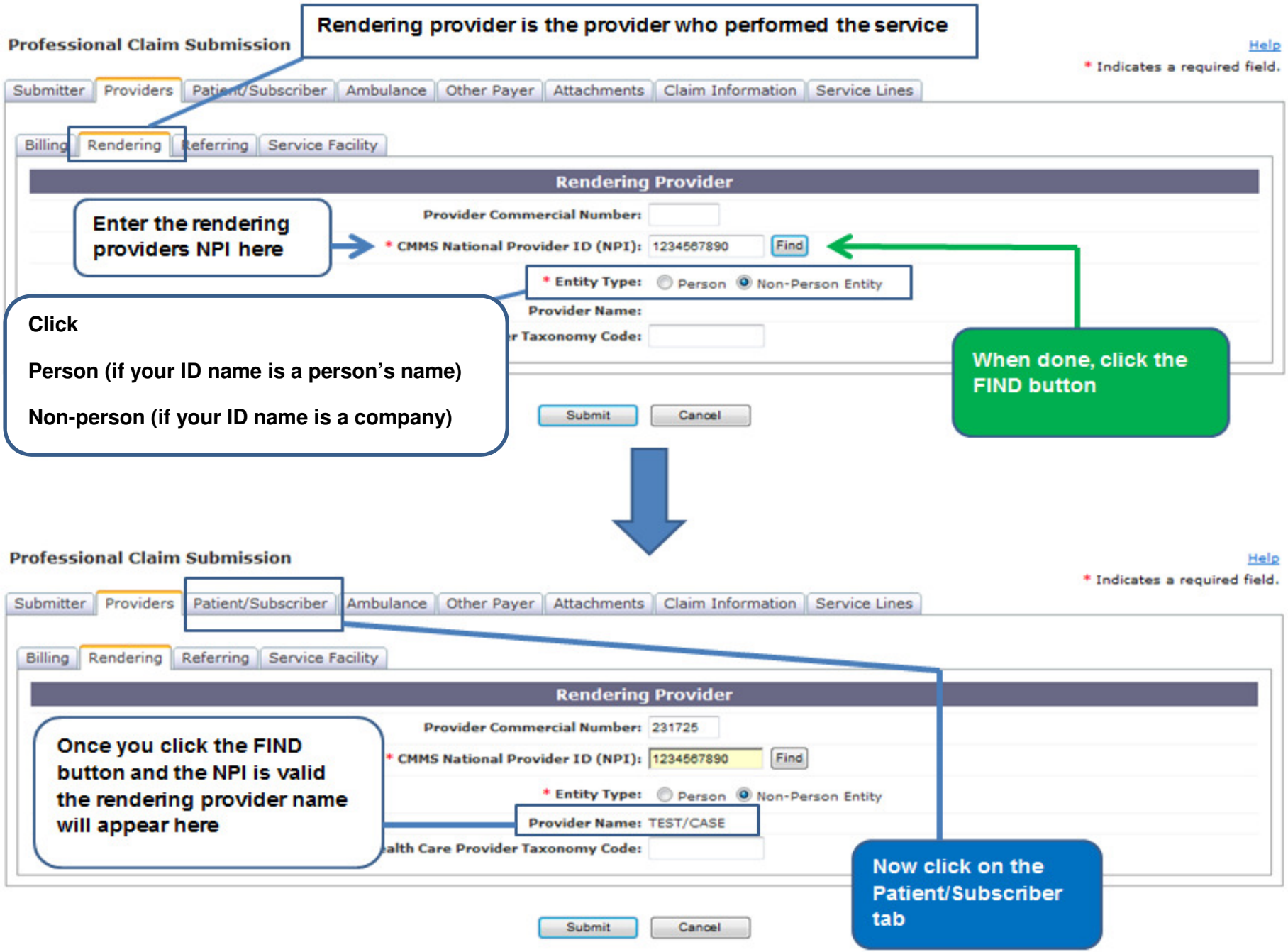
Section 3:

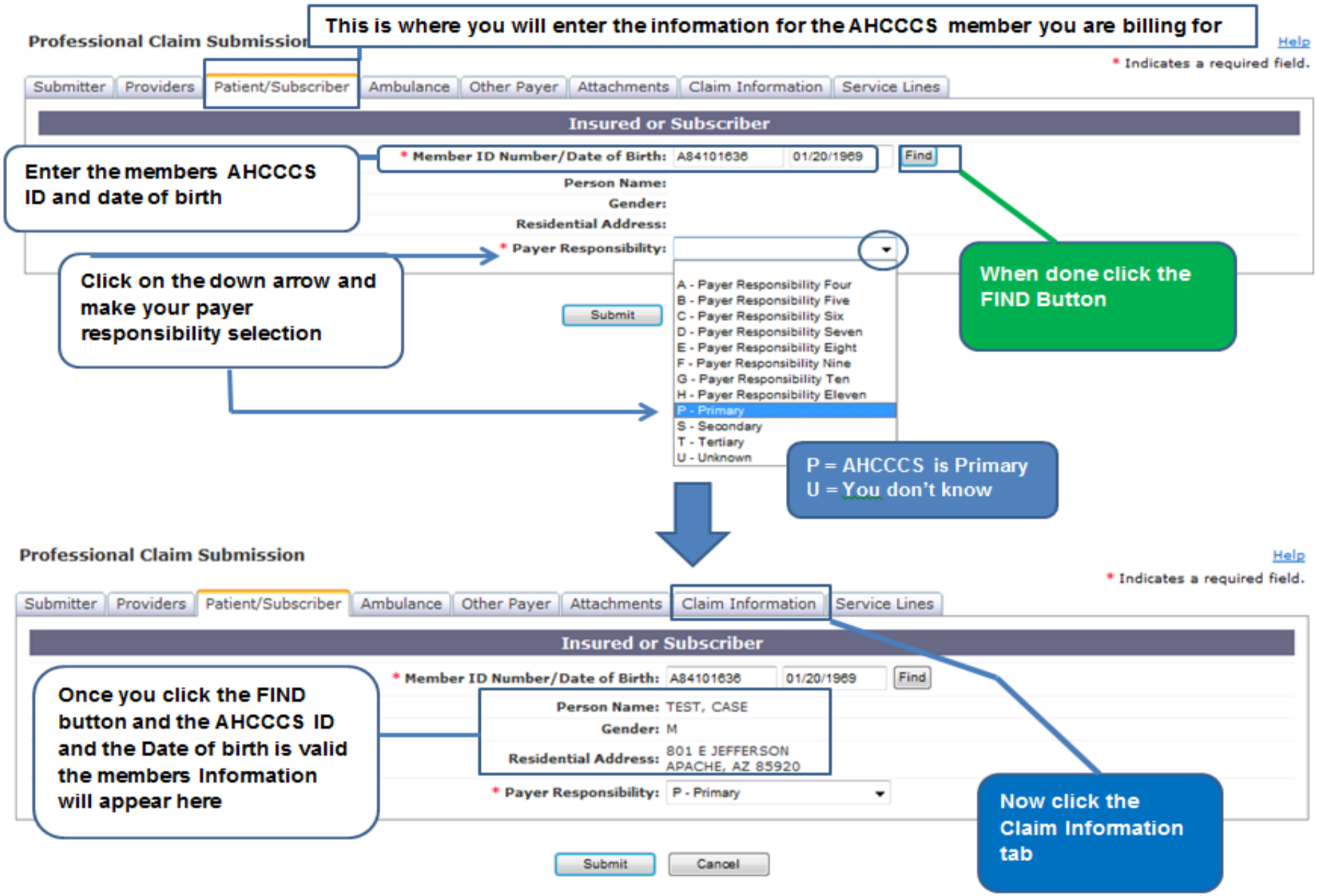
On-Line Claim Submission

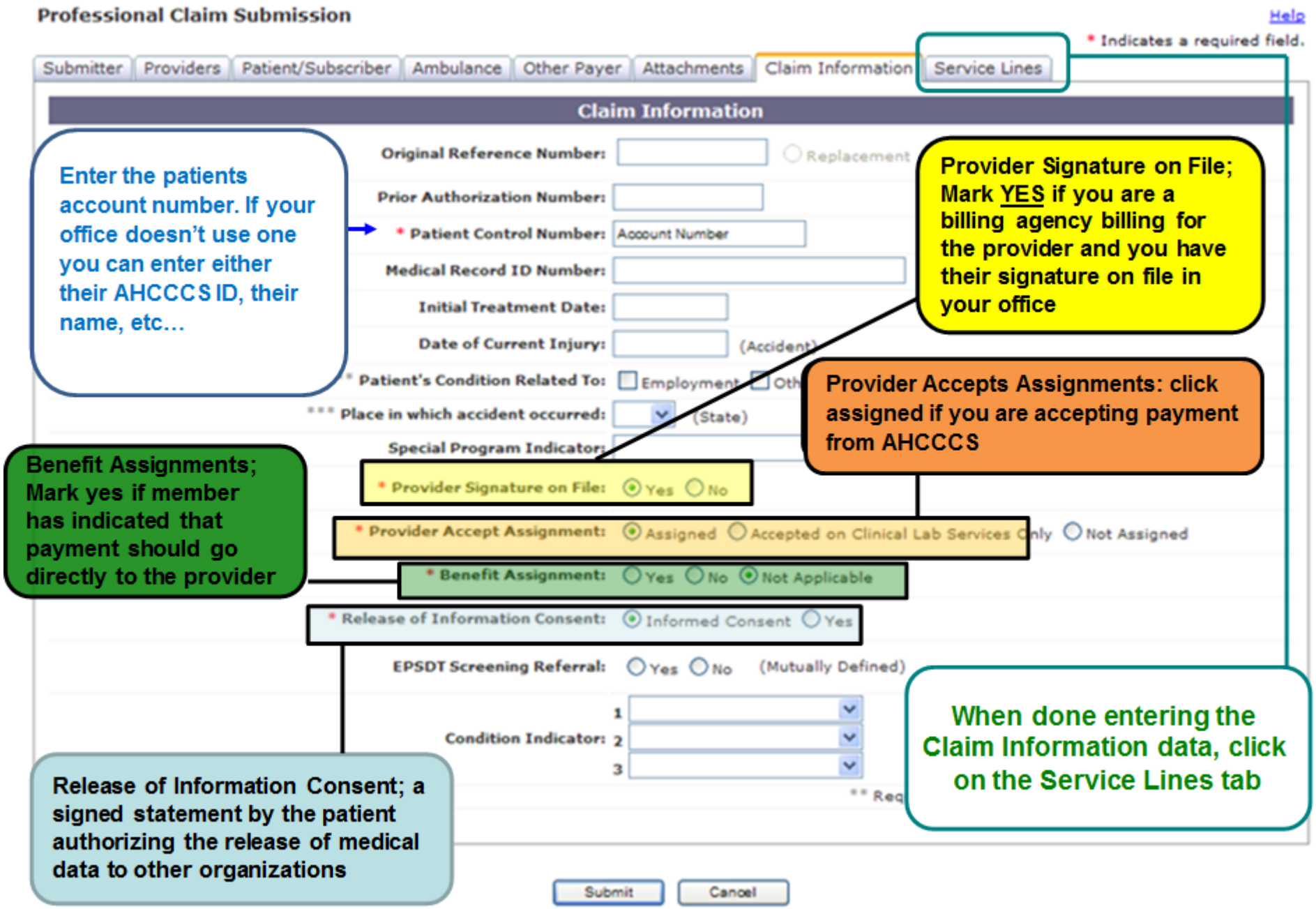
Billing for the Anesthesia

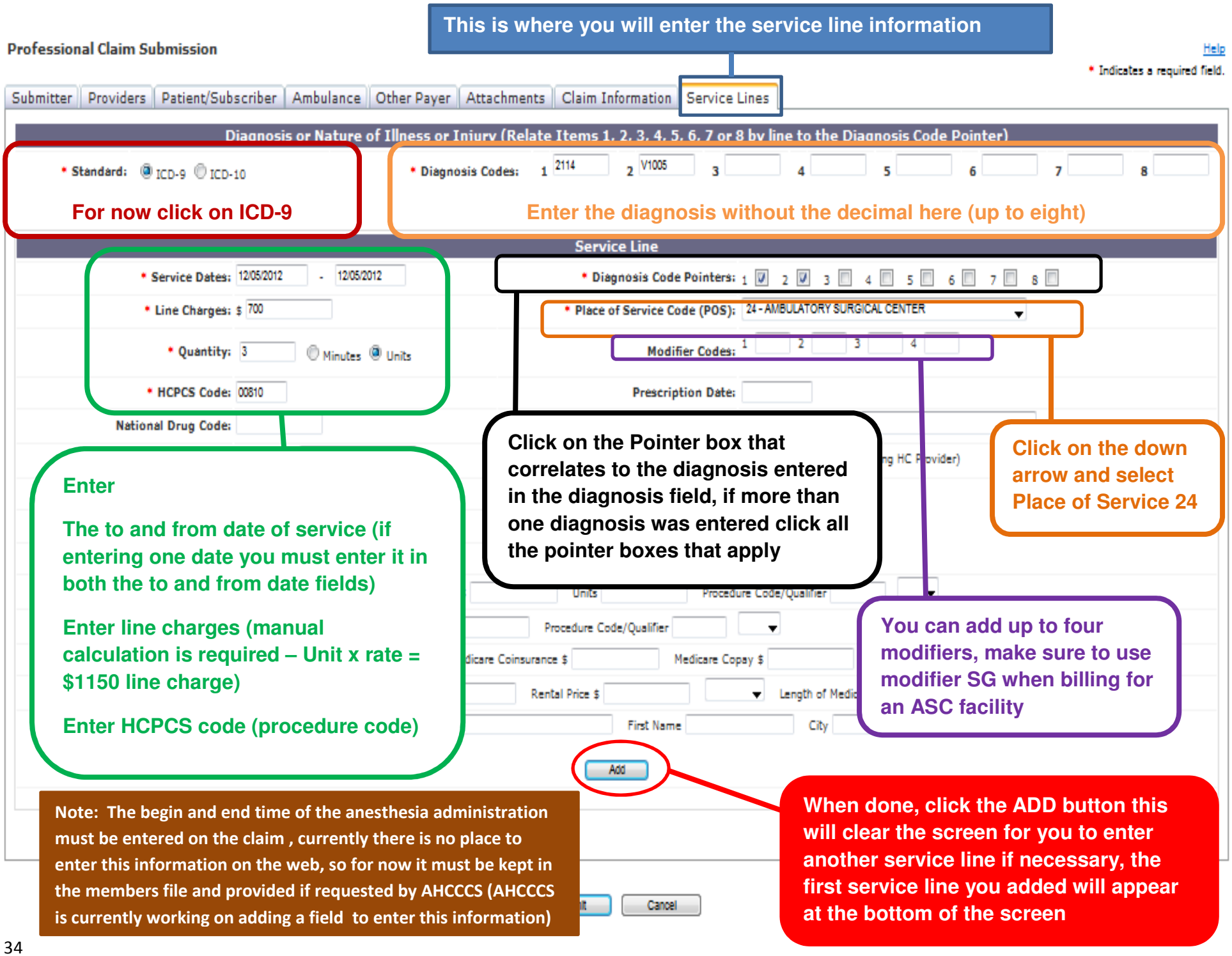

Claim Submission
Make sure that the word Professional is showing in the box
48 hours. Once the claim has been sent for processing, it can no longer be modified via the
a Replacement or Void. The claim will not be accepted if any required data elements are
erage at the time the service is rendered. Claims will be processed under the following
NOTE: You cannot view the processing status of claim submitted by other users.
Enter New Claim
Type of Claim: Professional
Go...
Click on go
View Claim Processing Status
Submission Date(s):
Go...
A screen with 8 tabs will appear
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Submitter
Organization Name: TEST/CASE
Electronic Transmitter ID Number: 99222
Information Contact Name: Escobedo, Albert
Information Contact Telephone Number: 602-417-4562
Click on the Provider tab
Submit
Cancel

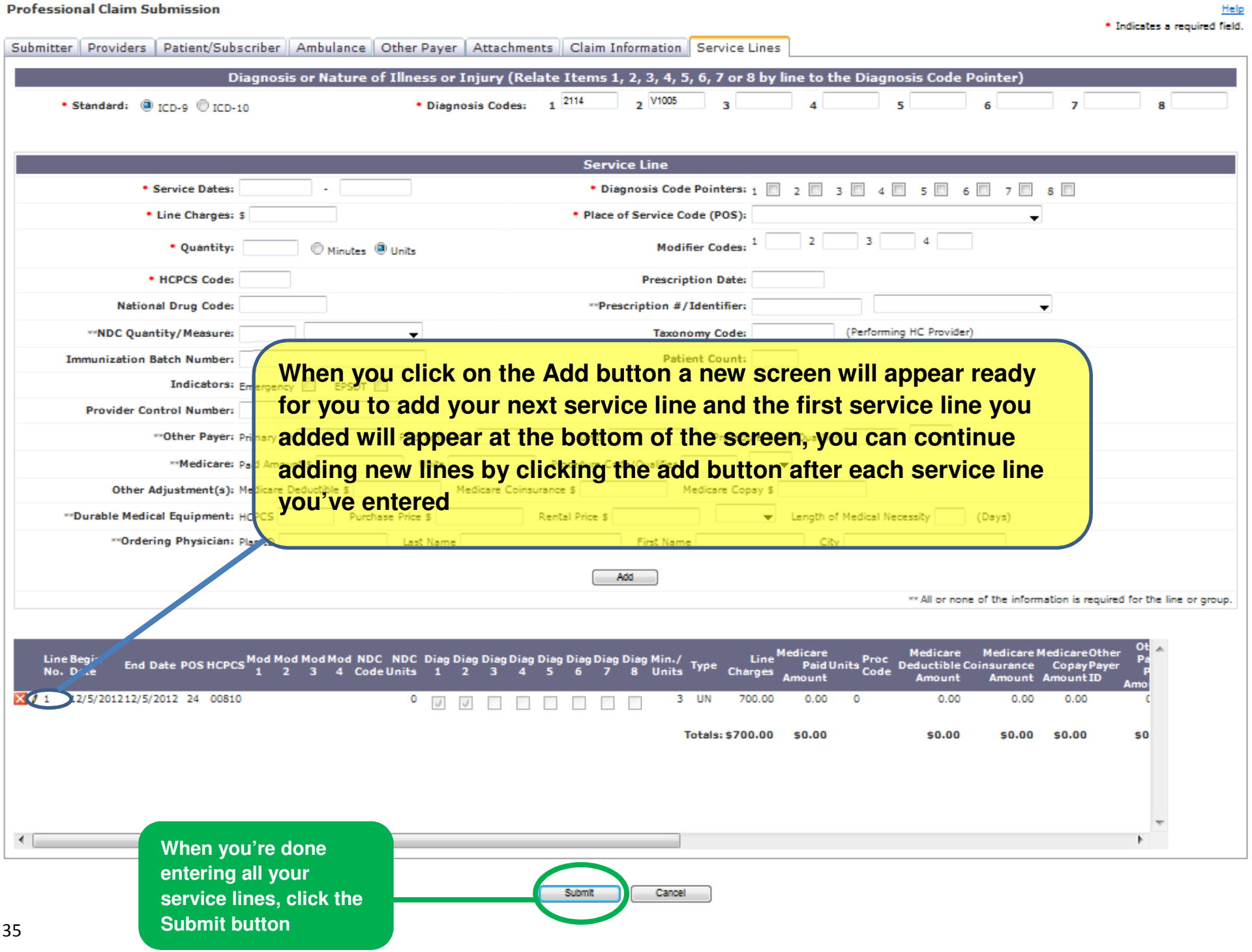

This is where you will enter the provider or group billing information
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Enter the biller or group tax ID here
Billing Provider
* Tax ID: 123456789
SSN
EIN
Click on
SSN = (Social Security Number)
Or
EIN = (Employee Identification Number)
Enter your NPI # here
Provider Commercial Number:
* CMMS National Provider ID (NPI): 1234567890
Find
* Entity Type:
Person
Non-Person Entity
Click
Person (if the ID number comes up as a person's name)
No-person (if the ID comes up with a company name)
When done click the find button
Submit
Cancel
Professional Claim Submission
Help
* Indicates a required field.
Billing
Rendering
Referring
Service Facility
Billing Provider
* Tax ID: 123456789
SSN
EIN
Provider Commercial Number: 231725
* CMMS National Provider ID (NPI): 1234567890
Find
* Entity Type:
Person
Non-Person Entity
Health Care Provider Taxonomy Code:
Provider Name: TEST/CASE
Information Contact Name:
Information Contact Telephone Number: 6024174000
Service Locator Code/Address: 01
701 E. JEFFERSON PHOENIX, AZ 85004
Pay-To Locator Code/Address: 01
701 E. JEFFERSON PHOENIX, AZ 85004
After you click on the FIND button and the Tax Id and the NPI are valid the billers' information will appear here
Now click the Rendering tab
Submit
Cancel

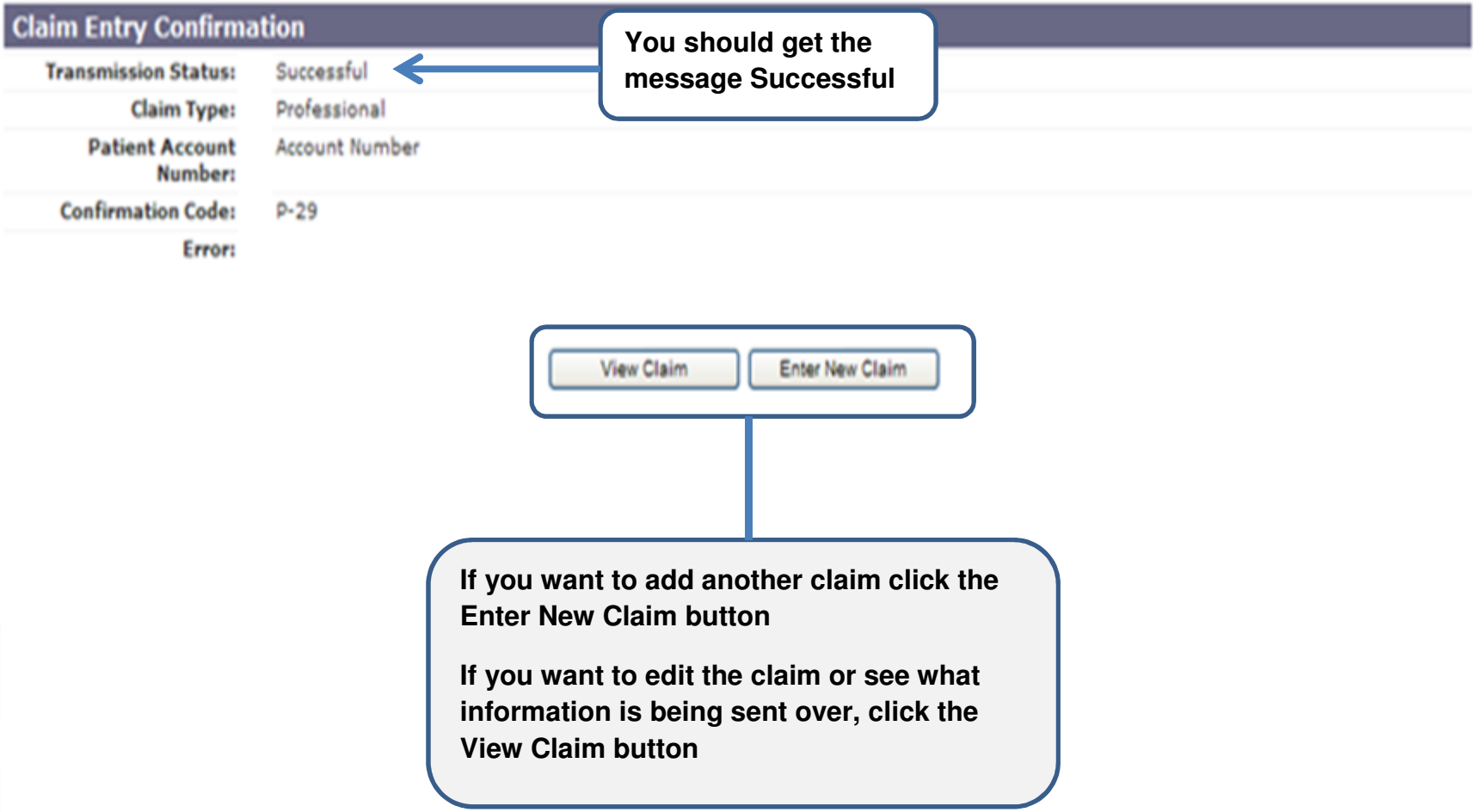

Rendering provider is the provider who performed the service
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Enter the rendering providers NPI here
Provider Commercial Number:
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
Taxonomy Code:
Click
Person (if your ID name is a person's name)
Non-person (if your ID name is a company)
When done, click the FIND button
Submit
Cancel
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Billing
Rendering
Referring
Service Facility
Rendering Provider
Once you click the FIND button and the NPI is valid the rendering provider name will appear here
Provider Commercial Number:
231725
* CMMS National Provider ID (NPI):
1234567890
Find
* Entity Type:
Person
Non-Person Entity
Provider Name:
TEST/CASE
alth Care Provider Taxonomy Code:
Now click on the Patient/Subscriber tab
Submit
Cancel


This is where you will enter the information for the AHCCCS member you are billing for
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Enter the members AHCCCS ID and date of birth
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
Gender:
Residential Address:
* Payer Responsibility:
When done click the FIND Button
Click on the down arrow and make your payer responsibility selection
A - Payer Responsibility Four
B - Payer Responsibility Five
C - Payer Responsibility Six
D - Payer Responsibility Seven
E - Payer Responsibility Eight
F - Payer Responsibility Nine
G - Payer Responsibility Ten
H - Payer Responsibility Eleven
P - Primary
S - Secondary
T - Tertiary
U - Unknown
Submit
P = AHCCCS is Primary
U = You don't know
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Insured or Subscriber
Once you click the FIND button and the AHCCCS ID and the Date of birth is valid the members Information will appear here
* Member ID Number/Date of Birth:
A84101636
01/20/1969
Find
Person Name:
TEST, CASE
Gender:
M
Residential Address:
801 E JEFFERSON
APACHE, AZ 85920
* Payer Responsibility:
P - Primary
Now click the Claim Information tab
Submit
Cancel


Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Claim Information
Enter the patients account number. If your office doesn't use one you can enter either their AHCCCS ID, their name, etc…
Original Reference Number:
Replacement
Prior Authorization Number:
* Patient Control Number:
Account Number
Medical Record ID Number:
Initial Treatment Date:
Date of Current Injury:
(Accident)
* Patient's Condition Related To:
Employment
*** Place in which accident occurred:
(State)
Special Program Indicator:
Provider Signature on File; Mark YES if you are a billing agency billing for the provider and you have their signature on file in your office
Provider Accepts Assignments: click assigned if you are accepting payment from AHCCCS
Benefit Assignments; Mark yes if member has indicated that payment should go directly to the provider
* Provider Signature on File:
Yes
No
* Provider Accept Assignment:
Assigned
Accepted on Clinical Lab Services Only
Not Assigned
* Benefit Assignment:
Yes
No
Not Applicable
* Release of Information Consent:
Informed Consent
Yes
EPSDT Screening Referral:
Yes
No
(Mutually Defined)
Condition Indicator:
1
2
3
** Req
When done entering the Claim Information data, click on the Service Lines tab
Release of Information Consent; a signed statement by the patient authorizing the release of medical data to other organizations
Submit
Cancel


This is where you will enter the service line information
Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
For now click on ICD-9
* Diagnosis Codes: 1 2114 2 V1005 3 4 5 6 7 8
Enter the diagnosis without the decimal here (up to eight)
Service Line
* Service Dates: 12/05/2012 - 12/05/2012
* Line Charges: $ 700
* Quantity: 3 Minutes Units
* HCPCS Code: 00810
National Drug Code:
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Place of Service Code (POS): 24 - AMBULATORY SURGICAL CENTER
Modifier Codes: 1 2 3 4
Prescription Date:
Enter
The to and from date of service (if entering one date you must enter it in both the to and from date fields)
Enter line charges (manual calculation is required – Unit x rate = $1150 line charge)
Enter HCPCS code (procedure code)
Click on the Pointer box that correlates to the diagnosis entered in the diagnosis field, if more than one diagnosis was entered click all the pointer boxes that apply
Click on the down arrow and select Place of Service 24
You can add up to four modifiers, make sure to use modifier SG when billing for an ASC facility
Units
Procedure Code/Qualifier
Procedure Code/Qualifier
Medicare Coinsurance $
Medicare Copay $
Rental Price $
First Name
City
Add
When done, click the ADD button this will clear the screen for you to enter another service line if necessary, the first service line you added will appear at the bottom of the screen
Note: The begin and end time of the anesthesia administration must be entered on the claim , currently there is no place to enter this information on the web, so for now it must be kept in the members file and provided if requested by AHCCCS (AHCCCS is currently working on adding a field to enter this information)
Cancel

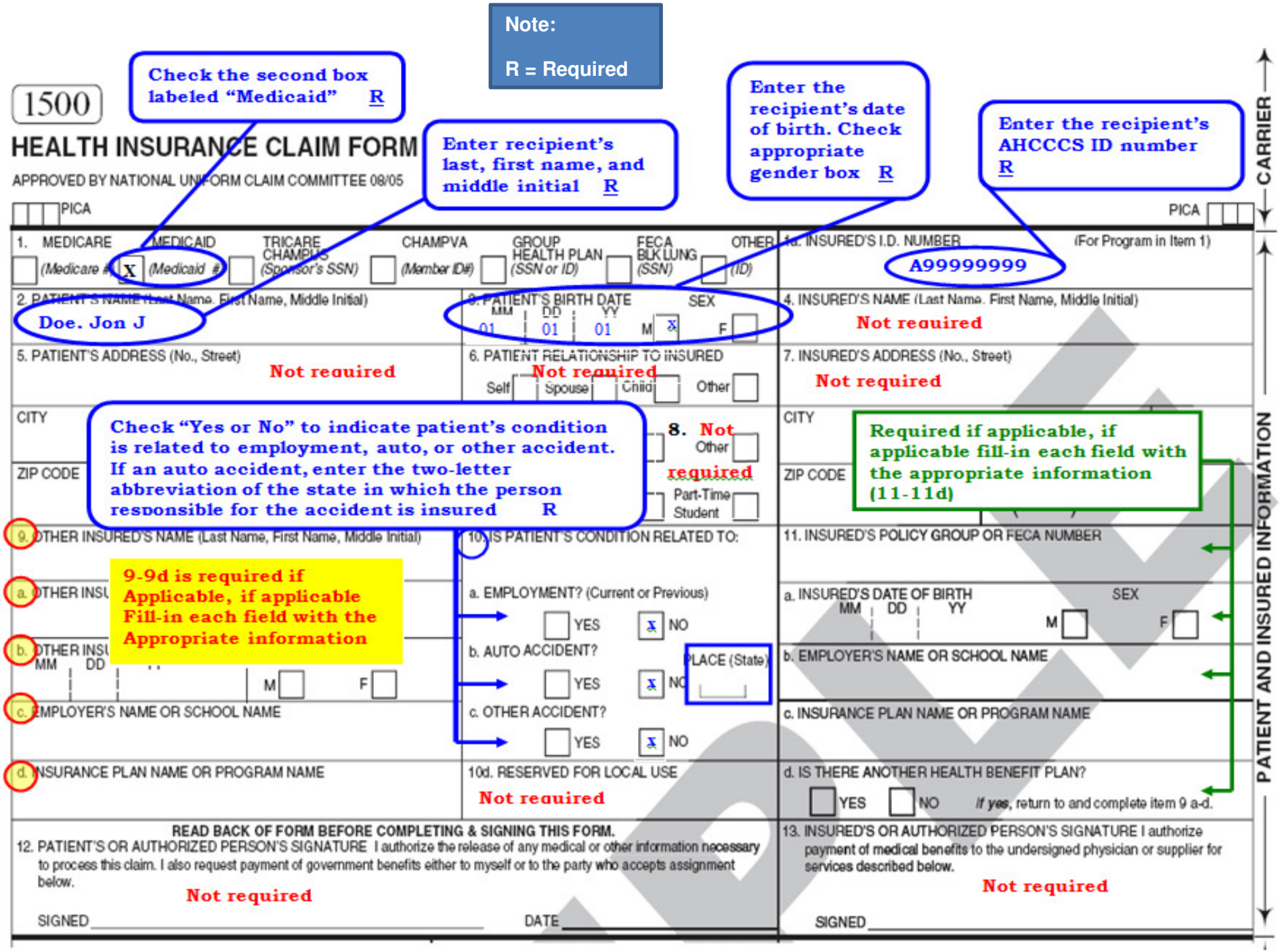

Professional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, 4, 5, 6, 7 or 8 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 2114 2 V1005 3 4 5 6 7 8
Service Line
* Service Dates:
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8
* Line Charges: $
* Place of Service Code (POS):
* Quantity: Minutes Units
Modifier Codes: 1 2 3 4
* HCPCS Code:
Prescription Date:
National Drug Code:
**Prescription #/Identifier:
**NDC Quantity/Measure:
Taxonomy Code: (Performing HC Provider)
Immunization Batch Number:
Patient Count:
Indicators: Emergency EPSDT
Provider Control Number:
**Other Payer:
**Medicare:
Other Adjustment(s):
Medicare Coinsurance $
Medicare Copay $
**Durable Medical Equipment:
Purchase Price $
Rental Price $
Length of Medical Necessity (Days)
**Ordering Physician:
Last Name
First Name
City
Add
** All or none of the information is required for the line or group.
When you click on the Add button a new screen will appear ready for you to add your next service line and the first service line you added will appear at the bottom of the screen, you can continue adding new lines by clicking the add button after each service line you've entered
Line No.
End Date
POS
HCPCS
Mod 1
Mod 2
Mod 3
Mod 4
NDC Code
NDC Units
Diag 1
Diag 2
Diag 3
Diag 4
Diag 5
Diag 6
Diag 7
Diag 8
Min./ Units
Type
Line Charges
Medicare Paid Amount
Units
Proc Code
Medicare Deductible Amount
Medicare Coinsurance Amount
Medicare Copay Amount
Other Payer ID
1 12/5/2012 12/5/2012 24 00810 0 3 UN 700.00 0.00 0 0.00 0.00 0.00
Totals: $700.00 $0.00 $0.00 $0.00 $0.00
When you're done entering all your service lines, click the Submit button
Submit
Cancel

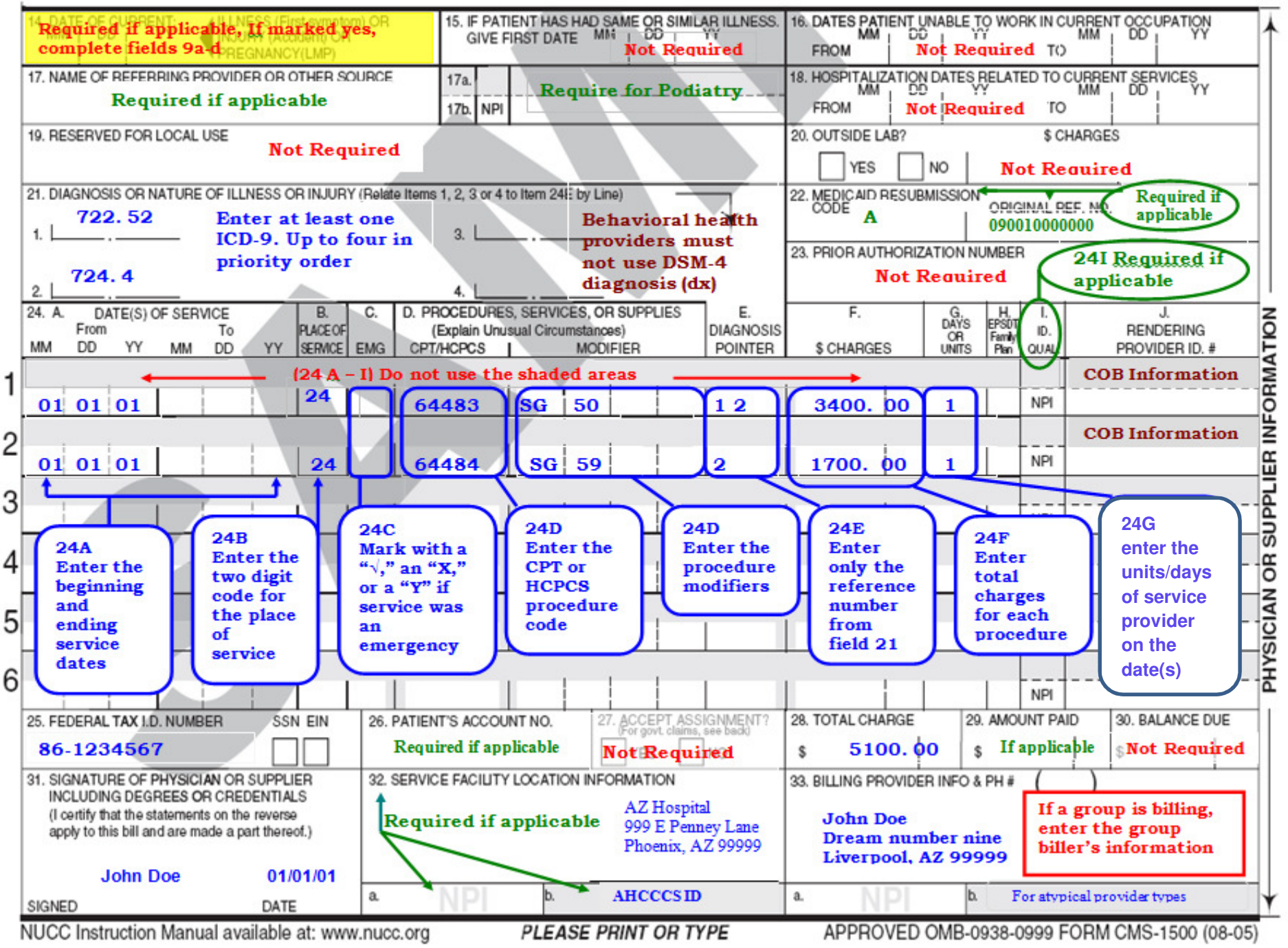

Claim Entry Confirmation
Transmission Status: Successful
Claim Type: Professional
Patient Account Number: Account Number
Confirmation Code: P-29
Error:
You should get the message Successful
View Claim
Enter New Claim
If you want to add another claim click the Enter New Claim button
If you want to edit the claim or see what information is being sent over, click the View Claim button

ASC Technical Assistance Document

Section 4:

Completing the CMS-1500 Paper Form (08-05)


Note:
R = Required
1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
Check the second box labeled "Medicaid" R
Enter recipient's last, first name, and middle initial R
Enter the recipient's date of birth. Check appropriate gender box R
Enter the recipient's AHCCCS ID number R
PICA
1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) X (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
A99999999
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe. Jon J
3. PATIENT'S BIRTH DATE SEX
MM DD YY
01 01 01 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Not required
5. PATIENT'S ADDRESS (No., Street)
Not required
6. PATIENT RELATIONSHIP TO INSURED
Not required
Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
Not required
CITY
ZIP CODE
Check "Yes or No" to indicate patient's condition is related to employment, auto, or other accident. If an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured R
8. Not
Other
required
Part-Time Student
CITY
ZIP CODE
Required if applicable, if applicable fill-in each field with the appropriate information (11-11d)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
9-9d is required if Applicable, if applicable Fill-in each field with the Appropriate information
a. OTHER INSU
b. OTHER INSU
MM DD
M F
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous)
YES X NO
b. AUTO ACCIDENT?
PLACE (State)
YES X NO
c. OTHER ACCIDENT?
YES X NO
10d. RESERVED FOR LOCAL USE
Not required
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH SEX
MM DD YY
M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO If yes, return to and complete item 9 a-d.
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.
Not required
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.
Not required
SIGNED
CARRIER
PATIENT AND INSURED INFORMATION


Required if applicable, If marked yes, complete fields 9a-d
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
Not Required
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Not Required
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
Required if applicable
Require for Podiatry
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Not Required
19. RESERVED FOR LOCAL USE
Not Required
20. OUTSIDE LAB?
Not Required
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
722. 52
724. 4
Enter at least one ICD-9. Up to four in priority order
Behavioral health providers must not use DSM-4 diagnosis (dx)
22. MEDICAID RESUBMISSION CODE
A
090010000000
Required if applicable
23. PRIOR AUTHORIZATION NUMBER
Not Required
24I Required if applicable
24. A. DATE(S) OF SERVICE From To
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. #
(24 A – I) Do not use the shaded areas
1 01 01 01 24 64483 SG 50 1 2 3400. 00 1 NPI COB Information
2 01 01 01 24 64484 SG 59 2 1700. 00 1 NPI COB Information
3
4
5
6
NPI
24A Enter the beginning and ending service dates
24B Enter the two digit code for the place of service
24C Mark with a "√," an "X," or a "Y" if service was an emergency
24D Enter the CPT or HCPCS procedure code
24D Enter the procedure modifiers
24E Enter only the reference number from field 21
24F Enter total charges for each procedure
24G enter the units/days of service provider on the date(s)
PHYSICIAN OR SUPPLIER INFORMATION
25. FEDERAL TAX I.D. NUMBER SSN EIN
86-1234567
26. PATIENT'S ACCOUNT NO.
Required if applicable
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
Not Required
28. TOTAL CHARGE
$ 5100. 00
29. AMOUNT PAID
$ If applicable
30. BALANCE DUE
$ Not Required
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.)
John Doe
01/01/01
SIGNED
DATE
32. SERVICE FACILITY LOCATION INFORMATION
Required if applicable
AZ Hospital
999 E Penney Lane
Phoenix, AZ 99999
a. NPI
b. AHCCCS ID
33. BILLING PROVIDER INFO & PH #
John Doe
Dream number nine
Liverpool, AZ 99999
If a group is billing, enter the group biller's information
a. NPI
b. For atypical provider types
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

ASC Technical Assistance Document

Section 5:

Electronic Billing (837)

Contact

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