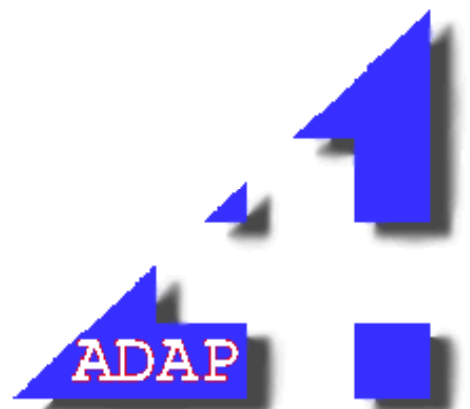


**NEW YORK STATE  
DEPARTMENT OF HEALTH  
AIDS INSTITUTE**

**UNINSURED CARE PROGRAMS  
ADAP PLUS  
LABORATORY AND ANCILLARY SERVICE MANUAL**

**Uninsured Care Programs  
Empire Station  
P.O. Box 2052  
Albany, NY 12220-0052  
1-800-832-5305**



# **PROVIDER MANUAL FOR HIV UNINSURED LABORATORY SERVICES ADAP PLUS**

## **PROGRAM DESCRIPTION**

The New York State Department of Health, AIDS Institute implemented a program to provide reimbursement to qualified primary care providers who serve uninsured persons with Human Immunodeficiency Virus (HIV).

In October 1992, the New York State Department of Health established ADAP Plus for hospital and clinic settings, to promote early intervention and to improve access to treatment for persons with HIV disease who are uninsured or underinsured. Article 28 hospitals and, diagnostic and treatment centers who enroll in ADAP Plus receive enhanced reimbursement as outlined in this Manual by entering into an agreement with the Department of Health. To expand the network of HIV primary care providers, ADAP Plus offers qualified office-based physicians reimbursement for HIV primary care services. Laboratory and ancillary service providers are also eligible to enroll in the Program.

## **GENERAL PROGRAM REQUIREMENTS**

Qualified laboratories must be certified by the New York State Department of Health, eligible to receive reimbursement through the New York State Medicaid Program and have submitted a signed Laboratory Agreement to the HIV Uninsured Care Programs.

## **CLIENT ELIGIBILITY**

ADAP Plus serves HIV-infected New York State residents who are uninsured or underinsured for primary medical care. Participants must meet the following criteria:

- (1) Residency - New York State
- (2) Medical - HIV Infection
- (3) Financial
  - Income for a household of one \$44,000 per year; \$59,200 for two and \$74,400 for three or more.
  - Liquid Assets less than \$25,000

Applicants who have partial insurance or limitations that inhibit access to primary care services may be eligible for the program. Such individuals will assign their insurance benefits to the program. Their benefits will be coordinated for maximum reimbursement. There are no co-payments required.

## **CLIENT ENROLLMENT PROCESS**

Applicants apply to the Program, providing proof of residency, income and assets. A Medical Application completed by a physician is required, verifying HIV-infection and indicating medical/disease status. Upon determination of eligibility, an ADAP Plus Identification Card is sent to the applicant which may be used to receive covered services from enrolled providers.

## **PARTICIPANT ENROLLMENT ACTIVITIES**

ADAP Plus employs several methods of outreach to enroll eligible individuals. Enrollment in ADAP and the Home Care Program will be coordinated for all eligible individuals. The Program coordinates outreach and promotional activities with ADAP and Home Care and employ their referral networks of health and human service providers. ADAP Plus will assist enrolled providers to develop internal referral systems to identify and assist potentially eligible individuals to apply to the Program.

## **MEDICAID**

Individuals enrolled in Medicaid are not eligible for the Program. Individuals awaiting Medicaid eligibility determination or who have a Medicaid Spenddown are eligible. The Program will seek, at eligibility determination and at periodic intervals, to identify individuals who are potentially eligible for Medicaid and encourage them to apply to Medicaid. Providers, whose services include assistance in applying for benefits, are required to identify, and encourage Medicaid application for potentially eligible clients.

## **IDENTIFICATION OF PARTICIPANT ELIGIBILITY**

An enrolled participant must present an ADAP Plus Identification Card whenever he/she requests medical services. In addition to the Identification Card, hospitals and participating clinics must verify participation eligibility via the Automated Eligibility Verification System (available 24 hours a day). Verification of a participants' eligibility will confirm eligibility dates and current status and assure payment for services provided. (The phone number for this service is on the participants enrollment card.)

## **PROVIDER ELIGIBILITY AND REQUIREMENTS**

Hospitals and Clinics that have been approved for the HIV Primary Care Medicaid Program are eligible to enroll in ADAP Plus.

In compliance with certification procedures, Providers are responsible for maintaining required policies and practices relating to staffing patterns, facility availability, and service functions.

In addition to meeting the requirements outlined in this Manual, Providers must meet the record-keeping requirements for their particular type of facility outlined in the regulations of the New York State Department of Health.

Please note that for ADAP plus purposes, records must be maintained for six years from the date of payment.

## **UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW**

### **Record-Keeping Requirements**

Federal Law and State Regulations require Providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to ADAP Plus Participants. Providers must furnish information regarding any payment claimed to authorized officials upon request of the State Department of Health.

The maintenance and furnishing of information relative to care included on an ADAP Plus claim is a basic condition for participation in ADAP Plus. For audit purposes, records on Participants must be maintained and be available to authorized ADAP Plus officials for six years following the date of payment. Failure to conform with these requirements may affect payment and may jeopardize a Provider's eligibility to continue as an ADAP Plus Provider.

### **Medical Review**

The Department of Health's Utilization Review Agent will, based on the data supplied in the billing process, or through chart review at the site, generate the following types of information:

- Statistical profiles, by individual Provider, of medical activity and frequency of service;
- Errors in billing or patterns of poor billing procedures;
- Indications of unacceptable practices, e.g., abusive or fraudulent activity;
- Generalized data on quality of care.

Information will be shared with the Provider either directly through ADAP Plus staff or in writing. Once aware of any errors in billing, the Provider will be able to expedite payment by correcting his/her billing procedures.

### **Unacceptable Practice**

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York or Federal statute or regulation which relates to the quality of care, services and supplies or the fiscal integrity of the Program. Examples of unacceptable practices include, but are not limited to the following:

- knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;
- practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;
- failing to maintain records necessary to fully disclose the extent of the care, services or supplies furnished;
- submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from participating in ADAP Plus;
- soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing an ADAP Plus participant to either utilize or refrain from utilizing any particular source of care, services or supplies; and
- knowingly demanding or collecting any compensation in addition to claims made under ADAP Plus.

### **Audit and Claim Review**

- (a) Providers shall be subject to audit by the Department of Health. With respect to such audits, the provider may be required:
1. to reimburse the department for overpayments discovered by audits; and
  2. to pay restitution for any direct or indirect monetary damage to the Program resulting from their improperly or inappropriately furnishing covered services.

- (b) The Department of Health may conduct audits and claim reviews, and investigate potential fraud or abuse in a provider's conduct.
- (c) The Department of Health may pay or deny claims, or delay claims for audit review.
- (d) When audit findings indicate that a provider has provided covered services in a manner which may be inconsistent with regulations governing the Program, or with established standards for quality, or in an otherwise unauthorized manner, the Department of Health may summarily suspend a provider's participation in the Program and/or payment of all claims submitted and all future claims may be delayed or suspended. When claims are delayed or suspended, a notice of withholding payment or recoupment shall be sent to the provider by the department. This notice shall inform the provider that within 30 days he/she may request in writing an administrative review of the audit determination before a designee of the Department of Health. The review must occur and a decision rendered within a reasonable time after a request for recoupment is warranted, or if no request for review is made by the provider within the 30 days provided, the department shall continue to recoup or withhold funds pursuant to the audit determination.
- (e) Where investigation indicates evidence of abuse by a provider, the provider may be fined, suspended, restricted or terminated from the Program.

#### **Audits and Recovery of Overpayments**

- (a) Recovery of overpayments shall be made only upon a determination by the Department of Health that such overpayments have been made, and recovery shall be made of all money paid to the provider to which it has no lawful right or entitlement.
- (b) Recovery of overpayments pursuant to this subject shall not preclude the Department of Health or any other authorized governmental body or agency from taking any other action with respect to the provider, including auditing or reviewing other payments, or claims for payment for the same or similar periods, imposing program sanctions, or taking any other action authorized by law.
- (c) The Department of Health may utilize any lawful means to recover overpayments, including civil lawsuit, participation in a proceeding in bankruptcy, common law set-on, or such other actions or proceedings authorized or recognized by law.
- (d) All fiscal and statistical records and reports of providers and all covered services which are used for the purpose of establishing the provider's right to payment under the Program and any underlying books, records, documentation which formed the basis for such fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation including all covered services provided shall be kept and maintained by the provider for a period of not less than six years from the date of completion of such reports, or the date upon which the fiscal and statistical records were required to be filed, whichever is later, or the date the service was provided.
- (e) All claims made under the Program shall be subject to audit by the Department of Health, his agents or designees, for a period of six years from the date of service, this limitations shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

## **Fraud**

Examples of fraud include when a person knowingly:

- Makes a false statement or representation which enables any person to obtain medical services to which he/she is not entitled;
- Presents for payment any false claim for furnishing services or merchandise;
- Submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

## **PARTICIPANT'S RIGHT TO REFUSE MEDICAL CARE**

Federal and State Laws and Regulations provide for ADAP Plus participants to reject any recommended medical procedure of health care or services and prohibits any coercion to accept such recommended health care. This includes the right to reject care on the grounds of religious beliefs.

## **CIVIL RIGHTS**

Public Law 88-352, the Civil Rights Act of 1964 as amended in 1972, Section 601, and Rehabilitation Act of 1973 reads as follows:

"No person in the United States shall, on the ground of race, color, national origin, age, sex, religion or handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

## **INQUIRIES**

All information, material requests or correspondence should be directed to:

**ADAP PLUS  
EMPIRE STATION  
P.O. BOX 2052  
ALBANY, NY 12220-0052  
or call:  
1-800-832-5305**

## **REIMBURSEMENT and COVERED SERVICES**

**The Program will use established Medicaid Fee schedules. Services reimbursed by ADAP Plus area attached as part of this manual. Only lab or ancillary services listed on the attachment will be reimburseable under the program. Not all lab or ancillary services covered by Medicaid are covered by ADAP Plus. Only labs and ancillaries ordered by a participating provider and provided to an enrolled participant will be reimbursed.**



## **BILLING SECTION**

This section contains the information needed by the provider to properly complete the claim form.

### **PROGRAM IDENTIFICATION CARDS**

There are two types of Program Identification Cards: a regular Program Identification Card, and a Medicaid Spenddown Program Identification Card. **Presentation of a Program Identification Card alone is not sufficient proof that a recipient is eligible for services.** Each of the Program Cards must be used in conjunction with the automated verification process. You must verify the eligibility of each participant each time services are requested or you risk the possibility of nonpayment for services which you provide.

### **THIRD PARTY HEALTH RESOURCES**

ADAP Plus will coordinate benefits for individuals having third party insurance coverage for services provided and covered by the Program. **Do not bill third party payers for ADAP Plus covered services provided to an ADAP Plus participant.**

### **BILLING INSTRUCTIONS**

This section of the Manual covers the preparation and submission of claim forms. It is important that the provider uses the outlined procedures. Claim forms which do not conform to the ADAP Plus requirements will not be processed or may result in a significant delay in reimbursement.

The displayed sample claim form is numbered in each field to correspond with explanations which follow. If you wish to use an alternative to this form please contact program staff. We will try to accommodate all requests that include the required data elements.

Claim forms should be typed or printed legibly in order to reduce delays in processing. Claim forms may be submitted in quantity and enclosed in a **single** envelope which has been addressed to:

**ADAP PLUS  
EMPIRE STATION  
P.O. BOX 2052  
ALBANY, NY 12220-0052  
1-800-832-5305**

Be sure to send the original claim (claims should be submitted at least monthly) and retain a copy for your files.

#### **1.) PROVIDER MEDICAID ID NUMBER**

Enter the 8-digit Medicaid Management Information System Identification Number, assigned to the provider at the time of enrollment in MMIS. ADAP Plus will use this number as the identifying number for participation in the Program. **If this number is incorrect or the provider has been terminated from Medicaid no payments will be made.**

**2.) PROVIDER BILLING TYPE**

Use this space to indicate your provider type.

**3.) LOCATOR CODE**

This code, which is the number 003 or higher, indicates the site where the service was rendered. Enter the appropriate locator code that was assigned to the provider at the time of enrollment in Medicaid for the address where the service was performed.

**NOTE:** The provider is reminded of the obligation to register in writing with the Department of Health, ADAP Plus, each service location or any change of service location to assure appropriate reimbursement. Locator codes will be verified, if not register with Medicaid no reimbursement will be made.

**4.) CLINIC SPECIALTY CODE**

Leave this blank.

**5.) CATEGORY OF SERVICE**

Use **0500** in all cases.

**6.) BILLING DATE**

Indicate in 2-digit numbers the month, day and year on which the claim form is submitted.

**Examples:** August 7, 1991 = 08/07/91

**SPECIAL NOTE:** To assure payment, claims must be submitted within 90 days of the Date of Service unless the circumstances for the delay can be documented.

In order to submit claims after 90 days, the following requirements must be met:

**VALID EXPLANATION** - acceptable reasons for late submissions are:

- Delay in ADAP Plus Client Eligibility Determination - must be submitted within thirty days from the time of notification.
- Original claim rejected or denied due to a reason unrelated to the 90 day regulation - must be resubmitted within sixty days of the date of notification.

**NOTE:** The 90 day submission period refers to calendar days.

**Single Submission** - Attach a cover letter of one or more pages to the invoice, indicate one of the acceptable reasons for late submission as shown above.

**Batch Submission** - Submit the claims with a cover letter of one or more pages detailing one of the acceptable reasons for the late submission as shown above.

If the provider's reason for submitting claims after 90 days does not fall within the "acceptable reasons" listed above, he/she may forward an appeal in writing to:

**ADAP PLUS  
EMPIRE STATION  
P.O. BOX 2052  
ALBANY, NY 12220-0052  
1-800-832-5305**

If the provider's appeal is accepted, he/she will be provided with a letter which will be attached to his/her claims when submitting for payment.

**7.) INTERNAL ACCOUNT NUMBER (OPTIONAL)**

The Provider for record-keeping purposes, may wish to identify a Participant by using an office account number (up to 10 characters). If this office account number is indicated on the claim form, ADAP Plus will print the number on the Remittance Statement for the convenience of the Provider. This is useful in locating accounts when there is a question regarding Participant Identification.

**\* For confidentiality purposes no personal client identifiers will be returned with the remittance statement.**

**8.) PROVIDER NAME and ADDRESS**

The Provider's Name and Correspondence Address

**NOTE:** It is responsibility of the provider to notify the New York State Department of Health ADAP Plus in writing of any change of address or other pertinent information within 15 days of the change.

**9.) MD NAME**

Enter the last and first name of the individual practitioner who rendered the service.

**10.) LICENSE NUMBER**

Enter the license number assigned to the individual practitioner who rendered the service(s) to the participant. If more than one practitioner provided service on the date of service for which the claim is being submitted, enter the license number of the individual who performed the major procedure or provided the most significant patient care.

**11.) TYPE (LICENSE)**

Leave this blank.

**12.) PARTICIPANT ID NUMBER**

Enter the participant's 11-character alpha/numeric ADAP Plus ID Number in the space entitled "Participant ID Number."

**NOTE:** The first 9 characters of the ID number are numeric, the next 2 are alpha (ie. - 555001000-0-A).

**13.) DATE OF BIRTH:**

Indicate 2 digit numbers the month, day and year of birth.

**Examples:** Dee Jones was born on September 12, 1960.  
Enter 09/12/60 in this field.

**14.) SEX**

Place an X on "M" for Male or "F" for Female.

**15.) PARTICIPANT NAME**

Enter the last name followed by the first name of the participant as it appears on the ADAP Plus ID Card:

**Examples:** Jones, Dee

**16.) PATIENT STATUS CODE**

Leave this blank.

**17.) DIAGNOSIS CODE PRIMARY**

Enter in this field appropriate **ICD-9-CM code which describes the primary condition or symptom of the Participant in evidence on the service date for which the claim is being submitted. If no diagnosis is provided leave this field blank.**

**18.) SECONDARY**

Enter the appropriate ICD-9-CM code which describes the primary condition or symptom of the Participant in evidence on the service date for which the claim is being submitted. If not appropriate, or unknown leave this field blank.

**NOTE:** Three-digit diagnosis codes will only be accepted when the category has no subcategories.

**19.) RECORD NUMBER**

This field will be assigned by ADAP Plus and will be used as the reference number for any claim inquiries and remittance advice.

**20.) DATE OF SERVICE**

Indicate in 2-digit numbers the month, day and year on which a service was rendered. Be sure to enter a date of service for **each** procedure description.

**Example:** July 15, 1991 = 07/15/91

Enter on the claim line the Date of Service, MMIS Rate code, ICD-9 Procedure Code, Description of service, and the establish clinic rate in the Amount Charged field.

For each additional visit, the services performed must be reported in the manner outlined above. All procedures performed during one clinic visit must be listed on a single claim form.

**\* NOTE:** Claim forms must be submitted within 90 days from the earliest Date of Service entered in this field.

**21.) RATE CODE**

Leave this field blank.

**22.) PROCEDURE CODE**

Enter the appropriate procedure code (**CPT**) which identifies the service rendered to the participant. Please refer to the enclosed list, any code or service not included on this list will be denied for payment.

**23.) PROCEDURE DESCRIPTION**

Describe each procedure rendered to the participant in this field. Descriptions will assist staff in identifying services rendered when Rate Codes or Procedure Codes are recorded incorrectly.

**24.) AMOUNT CHARGED**

Enter your established rate under the Medicaid Program.

**25.) TOTALS**

Total each column where entries appear.

**26.) SIGNATURE and DATE**

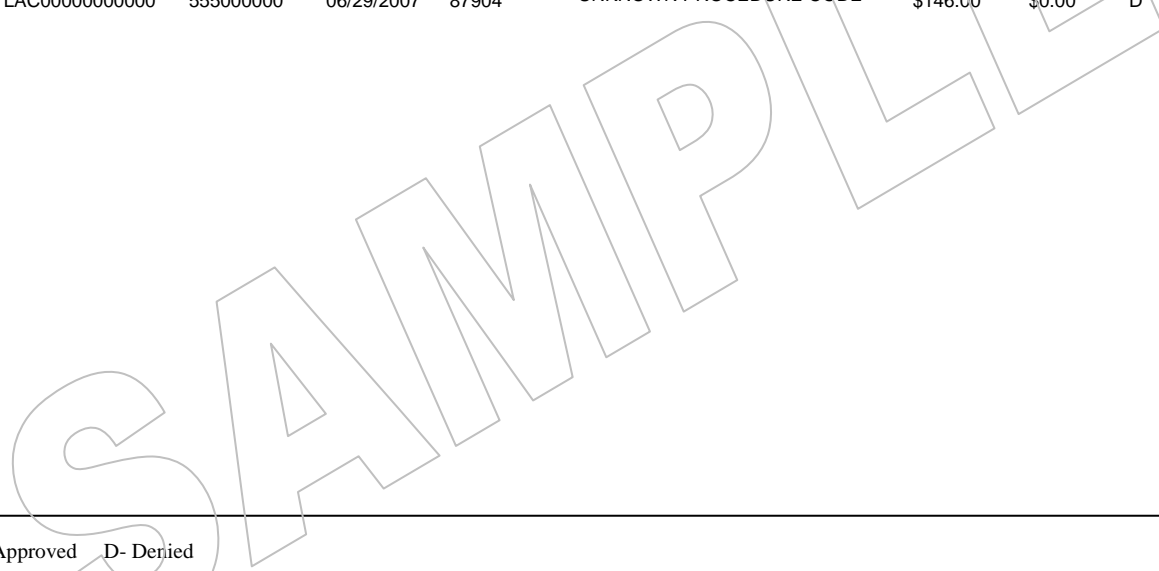
**The provider or an authorized representative must sign each claim form.** Enter the date on which the provider or an authorized representative signed the claim form.

State of New York Department of Health  
 Uninsured Primary Care Reimbursement Program  
 Remittance Statement for Batch 463

Date Printed: 9/24/07  
 Provider Name:  
 Locator Code:  
 Address: Date Paid:  
 Phone:

Page: 1  
 Billing Type: 8. Lab  
 Total Amount Approved:  
 Total Amount Paid:

| Claim/Line # | Int. Acct     | Client ID | DOS        | Procedure | Description            | Billed   | Paid    | Status | Comments |
|--------------|---------------|-----------|------------|-----------|------------------------|----------|---------|--------|----------|
| 01700377-02  | LAC0000000000 | 555000000 | 08/20/2007 | 83036     | GLYCATED HEMOGLOBIN T  | \$30.66  | \$10.64 | A      |          |
| 01700377-03  | LAC0000000000 | 555000000 | 07/20/2007 | 80076     | HEPATIC FUNCTION PANEL | \$25.95  | \$7.25  | A      |          |
| 01700377-03  | LAC0000000000 | 555000000 | 08/20/2007 | 80048     | BASIC METABOLIC PANEL  | \$25.95  | \$7.25  | A      |          |
| 01700377-04  | LAC0000000000 | 555000000 | 07/18/2007 | 83721     | UNKNOWN PROCEDURE CODE | \$27.03  | \$0.00  | D      | 10,11    |
| 01695721-01  | LAC0000000000 | 555000000 | 06/22/2007 | 86361     | T CELL, ABSOLUTE COUNT | \$46.53  | \$23.17 | A      |          |
| 01695721-02  | LAC0000000000 | 555000000 | 06/29/2007 | 87904     | UNKNOWN PROCEDURE CODE | \$146.00 | \$0.00  | D      | 2,11     |



Status: A – Approved D- Denied

Comments:

- |   |   |  |
|---|---|--|
| 1. Participant ineligible on DOS          | 2. Provider ineligible on DOS             | 3. Participant ID missing/invalid        |
| 4. Primary Diagnosis missing/invalid      | 5. Duplicate Procedure/DOS                | 6. Part. ineligible/Medicaid eligible    |
| 7. Invalid procedure code                 | 8. Billing date exceeds DOS by 90 days    | 9. Missing DOS                           |
| 10. No fee schedule for procedure         | 11. Procedure not covered                 | 12. Annual threshold exceeded            |
| 13. Provider #, Locator # invalid         | 14. DOS prior to program start            | 15. Claim billed to third party          |
| 16. Individual never approved for program | 17. Inpatient services not covered        | 18. Services paid for under clinic rates |
| 19. Bill other insurance                  | 20. Panel codes grouped under one payment |  |

Please call 1-800-832-5305 for questions regarding this statement

## REMITTANCE STATEMENT

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Statement, a sample of which appears at the beginning of this section. This document plays an important role in the communication between the provider and the Program. Aside from showing a record of transactions, the Remittance Statement will assist providers in resolving and correcting possible errors on denied claims.

**NOTE:** Before any claim is entered into the computer system, it will be screened for obvious missing or erroneous data. The claim will be rejected if required data is missing or invalid.

REJECTED CLAIMS ARE RETURNED TO THE PROVIDER IMMEDIATELY. SINCE THEY ARE NOT ENTERED INTO THE COMPUTER SYSTEM, THEY ARE **NOT** SHOWN ON THE REMITTANCE STATEMENT.

ADAP Plus produces a Remittance Statement for each payment cycle which contains all claims that have entered the computerized processing system. The Remittance Statement indicates status of the claims (paid/denied), and accompanies checks when they are mailed to providers.

## DENIED CLAIMS

A claim will be denied if the service rendered is not covered by ADAP Plus, if it is a duplicate of a prior claim or if data is invalid or logically inconsistent.

The provider should review his/her copy of the denied claim, which is indicated on the Remittance Statement and, where appropriate, completely resubmit the claim with justification of reasons for approval. Providers should not resubmit claims which have been denied due to practices which contradict either good medical practice or Program policy. The Program will accept an annotated photocopy or duplicate copy of an original claim for the purpose of resubmission along with an annotated copy of the remittance statement.

## EXPLANATION OF COLUMNS ON REMITTANCE STATEMENT

- (1-2) **ADAP PLUS CLAIM NUMBER/LINE**  
This column indicates the Record Number which is assigned by the Program.
- (3) **INTERNAL ACCOUNT NUMBER**  
The Office Account Number is optional for the provider and will only appear if it has been indicated on the claim form.
- (4) **CLIENT ID NUMBER**  
This column lists the Participant/Client ID Number.
- (5) **DATE OF SERVICE**  
This column lists the Dates of Service which have been entered on the claim form.
- (6) **PROCEDURE/RATE CODE**  
This column lists the Procedure Code (CPT) as entered on the claim form.
- (7) **DESCRIPTION OF SERVICE**

- (8) **BILLED**  
This column indicates the amount billed.
- (9) **PAID**  
This column indicates the amount of the ADAP Plus payment.
- (10-11) **STATUS/COMMENTS**  
These columns indicate the status of each claim line along with any appropriate message.

## **INFORMATION**

The Remittance Statement, as described above, will be the key control document which informs the provider of the current status of submitted claims. Should further information be required on any detail on the Remittance Statement, Providers should contact ADAP Plus at 1-800-832-5305.

| Code  | Description                       | Code  | Description                     | Code  | Description                        |
|-------|-----------------------------------|-------|---------------------------------|-------|------------------------------------|
| 71010 | CHEST X FRONTAL 1                 | 83615 | LACTATE DEHYDROGENASE           | 86698 | HISTOPLASMA                        |
| 71015 | CHEST X FRONTAL 2                 | 83690 | LIPASE                          | 86704 | HEPATITIS B ANTIBODY(HBcAb)        |
| 71020 | CHEST X /PA & LAT                 | 83718 | LIPOPROTEIN; DIRECT             | 86706 | HEPATITIS B SURFACE ANB (HBsAb)    |
| 71021 | CHEST X FRONTAL/LAT AP            | 83735 | MAGNESIUM                       | 86707 | HEPATITIS Be ANTIBODY(HBeAb)       |
| 71022 | CHEST X FRONT/LAT OBL             | 83785 | MANGANESE                       | 86708 | HEPATITIS A ANTIBODY(HAAb)         |
| 71023 | CHEST X FRONT/LAT FLUOR.          | 83890 | MOLECULAR DIAGNOSTICS           | 86709 | HEPATITIS A IgM ANTIBODY           |
| 80047 | BASIC METALBOLIC(calcium,ionized) | 83892 | ENZYMATIC DIGESTION             | 86762 | RUBELLA                            |
| 80048 | BASIC METALBOLIC(calcium,total)   | 83893 | DOT/SLOT BLOT PRODUCTION        | 86777 | ANTIBODY, TOXOPLASMA               |
| 80051 | ELECTROLYTE PANEL                 | 83894 | SEPARATION BY GEL ELECTROPHOR.  | 86778 | ANTIBODY, TOXIPLASMA-IgM           |
| 80053 | COMPREHENSIVE METALBOLIC          | 83896 | NUCLEIC ACID PROBE              | 86781 | TREPONEMA PALLIDUM                 |
| 80061 | LIPID PANEL                       | 83898 | AMP. OF PT NUCLEIC ACID, EACH   | 86800 | THYROGLOBULIN ANTIBODY             |
| 80069 | RENAL FUNCTION PANEL              | 83900 | AMP. OF PT NUCLEIC ACID, MULTI  | 86803 | HEPATITIS C ANTIBODY               |
| 80076 | HEPATIC FUNCTION PANEL            | 83902 | REVERSE TRANSCRIPTION           | 86850 | ANTIBODY SCREEN, RBC               |
| 80150 | ASSAY - AMIKACIN                  | 83912 | INTERPRETATION AND REPORT       | 86880 | COOMBS TEST                        |
| 80152 | ASSAY - AMITRIPTYLINE             | 83930 | OSMOLALITY;BLOOD                | 86900 | BLOOD TYPING,ABO                   |
| 80156 | ASSAY-CARBAMAZAPINE;TOTAL         | 83935 | OSMOLALITY;URINE                | 86901 | Rh (D)                             |
| 80160 | ASSAY - DESIPRAMINE               | 84060 | PHOSPHATASE,ACID;TOTAL          | 86905 | RBC ANTIGENS                       |
| 80162 | ASSAY - DIGOXIN                   | 84075 | PHOSPHATASE; ALKALINE           | 87015 | CONCENTRATION; INF. AGENT          |
| 80164 | ASSAY-DIPROPYLECETIC ACID         | 84100 | PHOSPHORUS INORGANIC            | 87040 | CULTURE;BATERIAL;BLOOD             |
| 80170 | ASSAY - GENTAMICIN                | 84132 | POTASSIUM; SERUM                | 87045 | STOOL CULTURE                      |
| 80173 | ASSAY - HALOPERIDOL               | 84144 | PROGESTERONE                    | 87070 | CULTURE;ANY OTHER SOURCE           |
| 80174 | ASSAY - IMIPRAMINE                | 84153 | PROSTATE SPECIFIC ANT.;TOTAL    | 87081 | CULTURE,PRESUMPTIVE,PATHOGENIC     |
| 80178 | ASSAY - LITHIUM                   | 84155 | PROTEIN;TOTAL                   | 87086 | CULTURE BACTERIAL URINE            |
| 80182 | ASSAY - NORTRIPTYLINE             | 84295 | SODIUM;SERUM                    | 87109 | CULTURE;MYCOPLASMA                 |
| 80185 | ASSAY-PHENYTOIN;TOTAL             | 84402 | TESTOSTERONE;FREE               | 87110 | CULTURE;CHLAMYDIA                  |
| 80186 | ASSAY-PHENYTOIN FREE              | 84403 | TESTOSTERONE;TOTAL              | 87116 | CULTURE;TUBERCLE W/ ISOLATION      |
| 80200 | ASSAY - TOBRAMYCIN                | 84436 | THYROXINE; TOTAL                | 87118 | CULTURE;MYCOBACTERIAL              |
| 80202 | ASSAY - VANCOMYCIN                | 84439 | THYROXINE; FREE                 | 87177 | OVA AND PARASITES;DIRECT SMEARS    |
| 81001 | UA; AUTOMATED,w/ microscopy       | 84443 | THYROID STIMULATING HORMONE     | 87190 | SUSCEPTIBILITY STUDIES;MYCOBACTER. |
| 81002 | UA; NON-AUTOMATED,w/o microscopy  | 84450 | SGOT                            | 87205 | SMEAR                              |
| 81003 | UA; AUTOMATED, w/o microscopy     | 84460 | SGPT                            | 87206 | SMEAR,FLOURESCENT/ACID FAST STAIN  |
| 81015 | UA; microscopic                   | 84478 | TRIGLYCERIDES                   | 87207 | SMEAR,SPECIAL STAIN FOR PARASITES  |
| 81025 | URINE PREGNANCY TEST              | 84479 | THYROID HORMONE (T3 OR T4)      | 87230 | TOXIN OR ANTITOXIN ASSAY           |
| 82040 | ALBUMIN                           | 84520 | UREA NITROGEN                   | 87250 | VIRUS ISOLATION                    |
| 82105 | ALPHA FETOPROTEIN(AFP) - SERUM    | 84550 | URIC ACID;BLOOD                 | 87252 | VIRUS ISOLATION;TISSUE CULTURE     |
| 82106 | ALPHA FETOPROTEIN - AMNIOTIC      | 84703 | hCG; QUANTATATIVE               | 87270 | CHLAMYDIA TRACHOMATIS              |
| 82143 | AMNIOTIC FLUID SCAN               | 85002 | BLEEDING TIME                   | 87271 | CYTOMEGALOVIRUS;DFA                |
| 82150 | AMYLASE                           | 85007 | BLOOD COUNT, MAN DIFF           | 87272 | CRYPTOSPORIDIUM                    |
| 82232 | BETA 2 MICROGLOBULIN              | 85013 | SPUN MICROHEMATOCRIT            | 87273 | HERPES SIMPLEX VIRUS TYPE 2        |
| 82247 | BILIRUBIN;TOTAL                   | 85014 | HEMATOCRIT                      | 87274 | HERPES SIMPLEX VIRUS TYPE 1        |
| 82248 | BILIRUBIN;DIRECT                  | 85018 | HEMOGLOBIN (Hgb)                | 87281 | PNEUMOCYSTIS CARINII               |
| 82270 | STOOL FOR OCCULT BLD              | 85025 | COMPLETE CBC W/ AUTOMATED WBC   | 87340 | HEPATITIS B SURFACE ANG (HBsAg)    |
| 82310 | CALCIUM;TOTAL                     | 85027 | COMPLETE CBC AUTOMATED          | 87350 | HEPATITIS Be ANTIGEN(HBeAg)        |
| 82330 | CALCIUM;IONIZED                   | 85044 | RETICULOCYTE COUNT;MANUAL       | 87385 | HISTOPLASMA CAPSULATUM             |
| 82374 | CARBON DIOXIDE                    | 85045 | RETICULOCYTE;AUTOMATED          | 87449 | IMMUNOASSAY;INF AGENT ANT.         |
| 82435 | CHLORIDE;BLOOD                    | 85048 | LEUKOCYTE; WBC AUTOMATED        | 87491 | CHLAMYDIA TRACHOMATIS, AMP. PROBE  |
| 82465 | CHOLESTEROL                       | 85097 | BONE MARROW; SMEAR INTERP.      | 87521 | HEPATITIS C, AMPLIFIED PROBE       |
| 82480 | CHOLINESTERASE;SERUM              | 85610 | PROTHROMBIN TIME                | 87522 | HEPATITIS C,QUANTIFICATION         |
| 82550 | CREATINE KINASE (CK),(CPK);TOTAL  | 85651 | SEDIMENTATION RATE;ERYTHROCYTE  | 87536 | HIV-1, QUANTIFICATION              |
| 82552 | ISOENZYMES                        | 85730 | THROMBOPLASTIN TIME;PARTIAL     | 87591 | N. GONORRHOEA, AMP. PROBE          |
| 82565 | CREATININE; BLOOD                 | 86038 | ANTINUCLEAR ANTIBODIES (ANA)    | 87800 | INF. AGNT DETECT, NUCLEIC ACID     |
| 82607 | CYANOCOBALAMIN (VITAMIN B12)      | 86039 | TITER                           | 87801 | INF. AGNT DETECT,AMP PROBE         |
| 82668 | ERYTHROPOIETIN                    | 86318 | IMMUNOASSAY,INF AGENT ANTIBODY  | 87900 | VIRTUAL PHENOTYPIC TEST            |
| 82672 | ESTROGENS;TOTAL                   | 86320 | IMMUNOELECTROPHORESIS;SERUM     | 87901 | GENOTYPIC RESISTANCE TEST          |
| 82728 | FERRITIN                          | 86325 | IMMUNOELECTROPHORESIS;OTHER     | 87902 | HEPATITIS C VIRUS                  |
| 82746 | FOLIC ACID; SERUM                 | 86359 | T-CELLS;TOTAL COUNT             | 87903 | PHENOTYPIC RESISTANCE TEST         |
| 82803 | GASES, BLOOD                      | 86360 | T-CELLS;ABSOLUTE CD4/CD8 COUNT  | 87904 | PHENOTYPIC-EACH ADDITIONAL TEST    |
| 82805 | GASES, BLOOD,W/ O2 SATURATION     | 86361 | ABSOLUTE CD4 COUNT              | 87999 | MICROBIOLOGY- TROFILE TEST         |
| 82947 | GLUCOSE,QUANTITATIVE, BLOOD       | 86403 | PARTICLE AGGLUTINATION          | 88104 | CYTOPATHOLOGY                      |
| 82951 | GLUCOSE TOLERANCE TEST (GTT)      | 86480 | TUBERCULOSIS;CELL MEDIATED IMM. | 88112 | ANAL CYTOLOGY                      |
| 82955 | G6PD                              | 86592 | SYPHILIS TEST QUALITATIVE       | 88142 | THIN PREP PAP SMEAR; CERVICAL      |
| 82977 | GGT                               | 86593 | SYPHILIS TEST QUANTITATIVE      | 88150 | PAP SMEAR; CERVICAL                |
| 82985 | GLYCATED PROTEIN                  | 86606 | ASPERGILLUS                     | 88160 | CYTOPATH SCREENING & INT           |
| 83010 | HAPTOGLOBIN;QUANTITATIVE          | 86609 | BACTERIUM                       | 88184 | FLOW CYTOMETRY, FIRST MARKER       |
| 83020 | HEMOGLOBIN-ELECTROPHORESIS        | 86611 | BARTONELLA                      | 88185 | FLOW CYTOMETRY,EACH ADDITIONAL     |
| 83036 | HEMOGLOBIN-GLYCOSYLATED           | 86635 | COCCIDIOIDES ANTIBODIES         | 88304 | SURGICAL PATHOLOGY LEVEL III       |
| 83540 | IRON                              | 86641 | CRYPTOCOCCUS                    | 88305 | SURGICAL PATHOLOGY LEVEL IV        |
| 83550 | IRON BINDING CAPACITY             | 86644 | CYTOMEGALOVIRUS (CMV)           | 88307 | SURGICAL PATHOLOGY LEVEL V         |
| 83605 | LACTATE                           | 86645 | CYTOMEGALOVIRUS (CMV), IgM      | 88309 | SURGICAL PATHOLOGY LEVEL VI        |
|       |                                   | 86674 | GIARDIA LAMBLIA                 | 89050 | CELL COUNT,EXCEPT BLOOD            |

