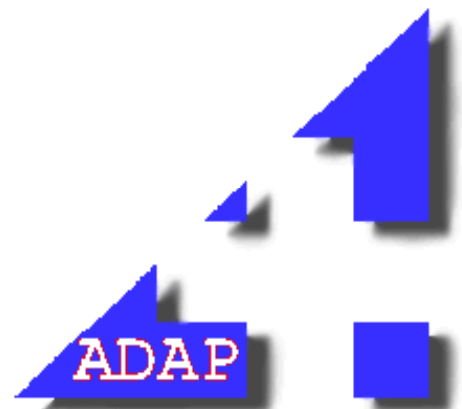


**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

**UNINSURED CARE PROGRAMS
ADAP PLUS
PHYSICIAN PROVIDER MANUAL**

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



ADAP PLUS PHYSICIAN MANUAL

Uninsured Care Programs

PROGRAM DESCRIPTION

The New York State Department of Health, AIDS Institute implemented a program to provide reimbursement to qualified primary care physicians and specialists who provide services to uninsured persons with Human Immunodeficiency Virus (HIV). The Department invites interested physicians meeting certain eligibility and practice requirements to enroll in ADAP Plus.

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 may enroll in ADAP Plus and receive enhanced reimbursement as outlined in the ADAP Plus Provider Manual by entering into an agreement with the Department of Health. To further expand the network of HIV primary care providers, ADAP Plus has offered qualified office-based physicians reimbursement for HIV primary care services as outlined in this manual for the uninsured and underinsured HIV population.

GENERAL PROGRAM REQUIREMENTS

Qualified physicians must be board certified or eligible for board certification and have hospital admitting privileges. Physicians must be enrolled in the HIV Enhanced Fee For Physicians (HIV-EFP) Program in order to participate in ADAP Plus. The HIV-EFP program offers qualified office-based physicians enhanced Medicaid reimbursement for HIV primary care services. Enrollment in HIV-EFP does not require a physician to accept new patients. It simply allows a physician to access the enhanced reimbursement provided by the program. Services the physician may provide in a clinic setting can not be billed under this program by the physician through the clinic if it is also enrolled in ADAP Plus. All services provided in a clinic setting must be billed under the clinics' service agreement.

CONFIDENTIALITY OF PHYSICIAN PARTICIPANTS

The names of physicians who enroll in the ADAP Plus Program will not be disclosed to any agency or individual outside of the AIDS Institute or the NYS Department of Health without prior written approval of the participating physician except as may be otherwise required by Law. Enrolled physicians are under no obligation to accept additional HIV patients because of their participation in this program. However, if an enrolled physician wishes to be added to the referral list of providers offering services to persons with HIV, the AIDS Institute will assist physicians in linking them with the appropriate community based health and social service agencies which maintain referral lists. If requested ADAP Plus will provide the physician's name and phone number to enrolled ADAP Plus participants through its hot-line.

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 (U.S. citizenship is not required.)

(2) Medical: HIV-infection

(3) Financial: Annual income less than \$44,000 for a household of 1, \$59,200 for a household of 2 and \$74,400 for a household of 3 or more. Liquid

assets less than \$25,000.

Applicants who have partial insurance or limitations that inhibit access to primary care services will be eligible for the program. Such individuals will assign their insurance benefits to the program. Their benefits will be coordinated for maximum reimbursement to the program.

Adolescents who do not have access to the financial or insurance resources of their parents/guardians may be eligible for the program.

Undocumented persons who may not be able to access Medicaid, Medicare or other entitlement programs may be eligible for the program.

There are no copayments required.

ADAP Plus determines applicant eligibility and issues an ID card to enrolled participants.

REIMBURSEMENT and COVERED SERVICES

Effective October 16, 2003, the program will use established Medicaid Fee schedules. Services reimbursed by ADAP Plus fall under the HIV Enhanced Fees for Physicians Medicaid Fee schedule. Reimbursement for office visits is based on the following reimbursement and coding methodology. The fee structure for all visits incorporates a regional adjustment for upstate and downstate. The counties considered downstate for this program are Bronx, Kings, Queens, New York, Richmond, Nassau, Putnam, Rockland, Suffolk and Westchester.

REIMBURSEMENT and UTILIZATION LIMITATIONS

Due to Federal limitations, HIV counseling and testing services and inpatient consultations are not reimbursable under this program.

All visits are limited to a maximum of 30 per patient per treatment year. For questions regarding Program service limitations, billing or payment processes please call 1-800-832-5305.

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the **practitioners office**. A patient is considered an outpatient until inpatient admission to a health care facility occurs. **The maximum reimbursable amount for Evaluation and Management procedure codes is dependent on the Place of Service reported.** Report the place of service code that represents the location where the service was rendered in claim form field number 8 - Place of Service.

For Evaluation and Management services rendered in the practitioners private office, report place of service as "1". The Maximum Fee for Office Evaluation and Management services is \$42.22 for County Group A or \$37.35 for County Group B.

NEW PATIENT

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

- 99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 20 minutes face-to-face with the patient and/or family.

- 99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity.

Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.

- 99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.

- 99205** Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

- 99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

- 99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making.

Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.

- 99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, and/or medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and/or medical decision making of high complexity.

Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.

LAB/ANCILLARY SERVICES

Lab or ancillary services are reimbursable if;

They are performed by an ADAP Plus enrolled lab or ancillary vendor and are covered under the program (Refer to Attachment 1 for a list of covered services).

Lab vendors are eligible to enroll in the program if they are actively enrolled in the New York State Medicaid Program and are certified by the New York State Department of Health.

If you are currently using a lab and they are not ADAP Plus enrolled, please refer the laboratory to provider liaison staff at 1-800-542-2437 for enrollment information.

Physicians will not be reimbursed for Laboratory services.

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS INSTITUTE
PRIMARY CARE REIMBURSEMENT PROGRAM - **CLAIM FORM**

Provider Information

1. Provider Medicaid ID#	2. Provider Billing Type PAC <input type="checkbox"/> Clinic <input type="checkbox"/> Lab <input type="checkbox"/> Doctor <input type="checkbox"/>	3. Locator Code	4. Specialty Code	5. Category of Service	6. Billing Date / /	7. Internal Account #
8. Provider Address				9. MD Name		
				10. License #		11. Type

Participant Information:

12. Participant ID Number	13. Date of Birth / /	14. Sex M <input type="checkbox"/> F <input type="checkbox"/>	15. Participant Name	16. Status Code

Service Delivery Information

17. Diagnosis Code Primary	18. Diagnosis Code Secondary	19. Record Number		
20. Date of Service / /	21. MMIS Rate Code	22. ICD-9 Code	23. Description	24. Amount Charged
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
25. TOTAL				\$

Certification:

By signing this claim form, it is hereby agreed that Health Research Incorporated and the New York State Department of Health shall be held from any and all liability of any kind or nature whatsoever, including claims of personal injury or property damage or of any other kind arising out of service(s) which reimbursement is being requested hereunder.

I certify that the statements included with this bill are true and correct.

26. Signature Date

BILLING PROCEDURES

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 with which you will need to become familiar; a regular Program Identification Card, and a Medicaid Spenddown Program Identification Card. Presentation of a Program Identification Card alone is not sufficient proof that an ADAP Plus participant is eligible for services. Each of the Program Cards must be used in conjunction with the electronic verification process (Dial 1-800-832-5305 to begin the payment authorization process) or through program staff during regular business hours. 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. This section relates to claims submitted manually rather than through electronic format. It is important that the provider use 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 or denial of reimbursement.

The sample claim form (see preceding page) is numbered in each field to correspond with the explanations which follow.

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**

Be sure to send the original claim (claims must be submitted within 90 days of the date of service) and retain a copy for your files. Information and instructions for the submission of electronic claims is included in the Primary Care electronic claim submission manual.

1.) PROVIDER ID NUMBER

Enter the 8-digit Medicaid Management Information System Identification Number, assigned to the provider at the time of enrollment in Medicaid. 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.

Your MMIS/Medicaid Number must be used when ordering lab or ancillary services at an ADAP Plus participating vendor. Please call the ADAP Plus Hot-line, 1-800-542-2437 for a list of enrolled Laboratory Vendors

2.) PROVIDER BILLING TYPE

Use this space to indicate that you are billing as a private physician.

3.) LOCATOR CODE

This code indicates the location you have on file with the ADAP Plus Program. 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 to register with the Department of Health, ADAP Plus, each service location or change of service location to assure appropriate reimbursement. ADAP Plus will not make payments for locator codes that are not valid in both the Medicaid and ADAP Plus systems.**

4.) SPECIALTY CODE

Use Specialty code 249 to assure access to the enhanced fees.

5.) CATEGORY OF SERVICE

Use 0400 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, 2001 = 08/07/01

SPECIAL NOTE: **Because we are a grant funded Program all claims must be submitted within 90 days of the Date of Service unless the circumstances for the delay can be documented and sufficient funds are available to pay the claim.**

All claims must be submitted within 90 days. The following are the only circumstances under which a claim may be submitted after 90 days:

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 application.

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 claim denial 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**

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 the only client identifiers to be used on the remittance statement are; Internal Account Number and the ADAP Plus Participant ID.**

8.) PLACE OF SERVICE

Enter the code for practitioners office (1)

9.) PROVIDER NAME and ADDRESS

The Provider's Name and Correspondence Address

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

10.) MD NAME

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

11.) LICENSE NUMBER

Enter the license number assigned to the individual practitioner who rendered the service(s) to the participant.

12.) TYPE (LICENSE)

Enter the appropriate 2-digit code which indicates the profession or specialty of the practitioner who provided the service. For example, if the practitioner is a General Practice Physician, enter Code 01.

	CODE
General Practice Physician (MD or DO)	01
General Dentist	02
Other	03
General Surgeon	04
Orthopedic Surgeon	05
Psychiatrist	06
Otolaryngologist	07
Other Physician Specialist	08
Physician's Assistant	09
Oral Surgeon	21
Other Dental Specialist	23
Ophthalmologist	24
Optometrist	25
Podiatrist	26

13.) 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 10 characters of the ID number are numeric; the next one is alpha (i.e. 555001000-O-A).

14.) DATE OF BIRTH:

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

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

15.) SEX

Place an X to the right of "M" for Male, "F" for Female and "T" for Transgender.

16.) PARTICIPANT NAME

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

Example: Jones, Dee

17.) PATIENT STATUS CODE

This code indicates a specific condition or status of the participant as of the last Date of Service on the claim form. Enter in this field one of the numbers below:

- Continuing Care 0
- Deceased..... 1
- Admitted to Hospital 2
- Admitted to Skilled Nursing Facility (SNF) 3
- Admitted to Intermediate Care Facility (ICF or HRF) 4
- Admitted to Domiciliary Care Facility (DCF) 5
- Plan of Care Completed 6
- Care terminated due to eligibility or other reason 7
- Participant Medicaid Eligible..... 8
- Transferred to Home Health Care Agency..... 9
- Admitted to Long Term Home Health Care..... 10

18.) 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.

19.) SECONDARY

Enter the appropriate ICD-9-CM code which represents the most important secondary condition or symptom affecting treatment. If not appropriate, leave this field blank.

20.) 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.

21.) 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, 2001 = 07/15/01

22.) RATE CODE

Enter the appropriate CPT Procedure as described in this manual.

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 Enhanced Fees for Physicians 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 344

Date Printed: 10/10/06

Provider Page: 1 of 1

Billing Type: Private Phys

Amount Paid: \$74.70

Claim/ Line #	Int Acct #	Client ID	Date	Procedure CPT Codes	Description	Billed	Paid	Status	Comments
01009395	01	OTEJA000234	09/19/06	99201	New Office Brief	37.35	37.35	A	
01009396	01	DELAD000231	09/18/06	99204	New Off Mod Complex	37.35	37.35	A	
01009519	01	THOER000123	08/20/06	99215	Estab Off High Complex	37.35	0	D	1

SAMPLE

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 on the preceding page. 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.

REJECTED CLAIMS – CLAIMS THAT ARE SO FLAWED THEY CANNOT BE ENTERED INTO OUR SYSTEM 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 (approximately bi-weekly) which contains all claims that have been entered in the processing system. The Remittance Statement indicates the status of the claims (paid/denied).

DENIED CLAIMS

A claim will be denied if service rendered is not covered by ADAP Plus, if it is a duplicate of a prior claim, if the participant is not eligible on the date of service, 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.

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 Rate or Procedure Codes as entered on the claim form.
- (7) **DESCRIPTION OF SERVICE**
This column indicates the descriptive reference associated with the procedure code.
- (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 comments, denial codes.

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	MANGANASE	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