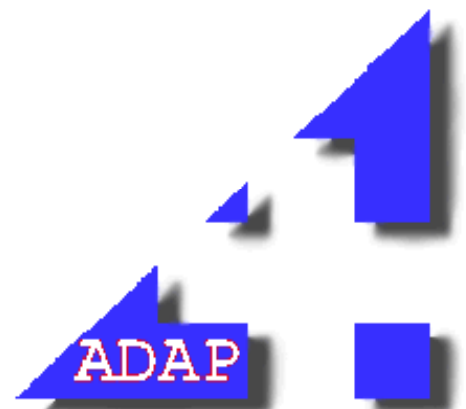


**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

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

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



LABORATORY AND ANCILLARY SERVICE MANUAL HIV UNINSURED CARE PROGRAMS ADAP PLUS

BACKGROUND

The N.Y.S. Department of Health, AIDS Institute offers four programs to provide access to health care (ADAP, Primary Care, Home Care, and APIC) for New York State residents with HIV infection who are uninsured or underinsured. The four programs use the same application form and enrollment process, additional forms are required for Home Care and APIC.

- 1) AIDS Drug Assistance Program (ADAP) pays for medications for the treatment of HIV/AIDS and opportunistic infections. The drugs paid for by ADAP can help people with HIV/AIDS live longer and treat the symptoms of HIV infection. ADAP can help people with no insurance, partial insurance, Medicaid Spend-down / Surplus or Medicare Part D.
- 2) ADAP Plus (Primary Care) pays for primary care services at participating clinics, hospitals, laboratory providers, and private doctor's offices. The services include ambulatory care for medical evaluation, early intervention and ongoing treatment.
- 3) HIV Home Care Program pays for home care services for chronically medically dependent individuals as ordered by their doctor. The program covers home health aide services, intravenous therapy administration and supplies and durable medical equipment provided through enrolled home health care agencies.
- 4) ADAP Plus Insurance Continuation (APIC) pays for cost effective health insurance premiums for eligible participants with health insurance including, COBRA, Medicare Part D and private or employer sponsored policies.

PROGRAM DESCRIPTION

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 (Chronic medical dependency due to HIV illness and physician's orders to be eligible for Home Care services)

- 3) Financial - Financial eligibility is based on 435% of the Federal Poverty Level (FPL). FPL varies based on household size and is updated annually. Households cannot have liquid assets greater than \$25,000. Liquid assets are cash, savings, stocks, bonds, etc. Liquid assets do not include car, home or federally recognized retirement accounts.

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.

**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 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

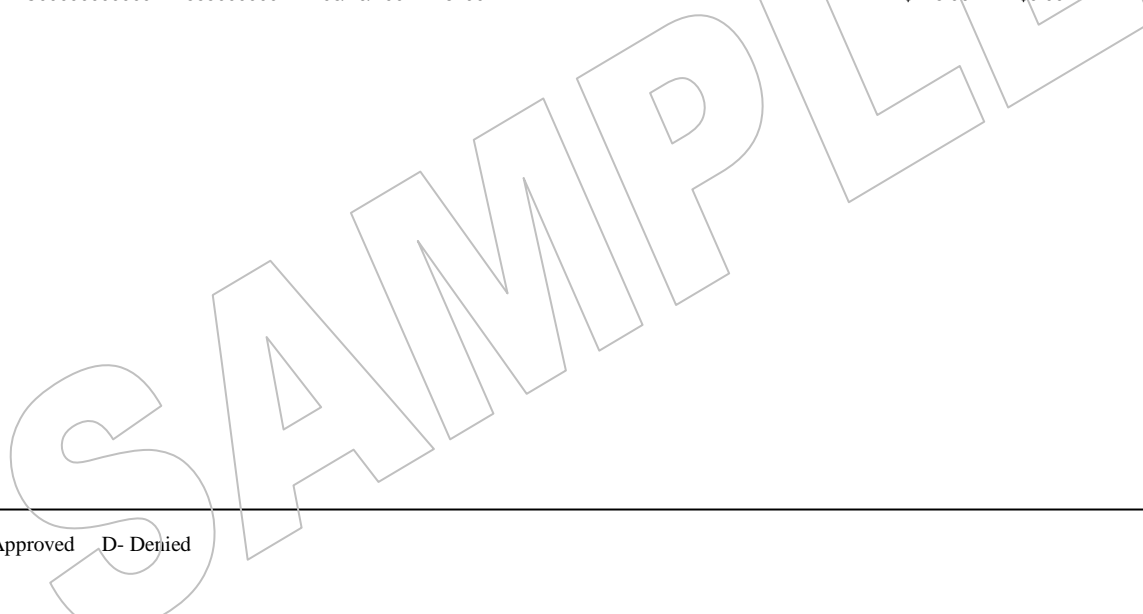
The provider or an authorized representative must sign each claim form. Enter the date on which the provider or an authorized representative signed the claim form.

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; microscop	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

