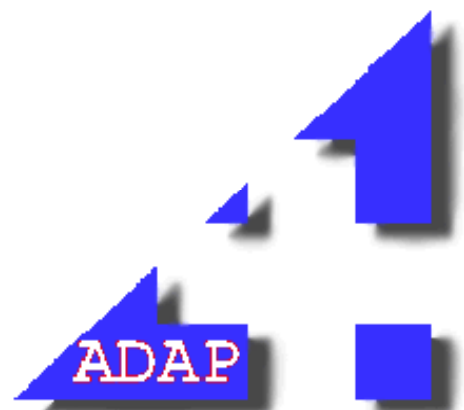


**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

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

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



PROVIDER MANUAL FOR UNINSURED CARE PROGRAMS PRIMARY CARE SERVICES ADAP PLUS

PURPOSE

This initiative provides access to ambulatory care services for low income, uninsured persons living in New York State who are HIV-infected.

BACKGROUND

The New York State Department of Health, AIDS Institute in cooperation with the HIV/AIDS Planning Councils of the New York City, Long Island, Lower Hudson and Dutchess County regions 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 as part of the Uninsured Care Programs (herein referred to as "the Program") for hospital and clinic settings to promote early intervention and 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 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 physician reimbursement for HIV primary care services. Laboratory and ancillary service providers are also eligible to enroll in the Program.

POPULATION TO BE SERVED

ADAP Plus serves HIV-infected New York State residents who are uninsured or underinsured who meet established Program eligibility criteria. Applicants who have partial insurance or limitations on their insurance are eligible to enroll in the Program, and the Program will coordinate benefits with insurance companies.

CLIENT ELIGIBILITY

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

CLIENT ENROLLMENT PROCESS

Applicants apply to the Program, providing proof of residency, income and assets. A Medical Application completed by a physician is required to verify HIV-infection and indicate 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, ADAP Plus, and the Home Care Program will be coordinated for all eligible individuals. The Program utilizes the referral networks of health and human service providers to coordinate outreach and promotional activities. ADAP Plus will assist enrolled providers in developing internal referral systems, which will identify potentially eligible individuals and aid them in applying to the Program. In addition to applying to the Program, providers are encouraged to identify other comprehensive health care options that may be more beneficial for participants and providers.

OTHER HEALTH CARE COVERAGE

I. 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.

II. Family Health Plus

Family Health Plus is a public health insurance program for adults who are aged 19 to 64 who have income or resources too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories.

Family Health Plus provides comprehensive coverage, including prevention, primary care, hospitalization, prescriptions and other services. There are minimal co-payments for some Family Health Plus services. Health care is provided through participating managed care plans in your area.

III. Medicare B & C

ADAP Plus may not be billed for Medicare covered services for which the provider agrees not to charge a beneficiary under the terms of their Medicare provider agreement or for services for which the beneficiary cannot be held liable by the provider under existing Medicare regulations.

IV. Care Rendered as a Result of Accident or Injury

Worker's Compensation benefits include all necessary medical care arising from job-related injury or illness. Therefore, no ADAP Plus payments will be made for services covered by Worker's Compensation. In the case of work-related injuries or illness, providers and participants may obtain information from the nearest Worker's Compensation Board Office or the participant's employer. In the case of injuries resulting from an accident, medical payments may be available from Worker's Compensation, auto or homeowner's liability insurance policies, etc.

V. Veteran Benefits

Veteran's Benefits CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of Veterans Administration) are similar programs administered by the Department of Defense. CHAMPUS provides benefits for health care services furnished by civilian providers, physicians, and suppliers to retired members of the Uniformed Services and to the spouses and children of active duty, retired and deceased members. The term "Uniformed Services" includes the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the U.S. Public Health Services, and National Oceanic and Atmospheric Administration. CHAMPVA provides similar benefits for the spouses and children of veterans who are entitled to permanent and total disability benefits and to widows and children of veterans who died of service connected disabilities. ADAP Plus may not provide coverage for individuals receiving medical care and coverage through CHAMPVA OR CHAMPUS; however, individual circumstances may be considered.

IDENTIFICATION OF PARTICIPANT ELIGIBILITY

An enrolled participant must present an Uninsured Care Programs 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 at **1-800-832-5305** (available 24 hours a day) on the date the service is to be provided. (This phone number is also listed on the participant's identification card.) Verification of a participants' eligibility will confirm eligibility dates and current status.

PROVIDER ELIGIBILITY AND REQUIREMENTS

Hospitals and Clinics that are enrolled in the HIV Primary Care Medicaid Program are eligible to enroll in ADAP Plus.

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.

STANDARDS OF CARE

The New York State Department of Health's Office of the Medical Director directly oversees the development, publication, dissemination, and implementation of clinical practice guidelines. These guidelines address the medical management of adults, adolescents, and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public. A detailed description of the guidelines for a comprehensive HIV care delivery system can be found at: <http://www.hivguidelines.org>

REIMBURSABLE SERVICES UNDER ADAP PLUS

The services reimbursable under ADAP Plus include most medical services, provided on an out-patient ambulatory basis. ADAP Plus uses the established Medicaid rate schedules based upon facility rate type for payment of covered services to simplify billing and ensure consistency. No co-payment can be charged to participants.

OTHER COVERED SERVICES

- Directly Observed Therapy (DOT) for tuberculosis at facilities approved and eligible for the established DOT rates.
- Nutritional Assessment & Counseling when performed by a Registered Dietician or Certified Nutritionist. Billing codes for these services are unique to ADAP Plus. N1010 covers nutritional assessment and N1020 covers nutritional counseling. Rates as follows:
 - N1010: upstate - \$55 per visit, downstate - \$60 per visit
 - N1020: upstate - \$45 per visit, downstate - \$50 per visit
- Outpatient Mental Health: Clinical psychological services must be provided by a licensed clinical psychologist or licensed clinical social worker and must be listed under the scope of services on the facility's operating certificate. Providers who bill using the APG methodology will no longer be able to submit using the P1000 procedure code when billing for psychology services.
- Dental – limited preventative services. Providers who bill using the APG methodology will no longer be able to submit using the D1000 procedure code when billing for dental services.

UTILIZATION THRESHOLDS

The Program defines a treatment year as 364 days prior to the date of service in question. Treatment year changes with each new date of service.

- **Medical/Significant APGs** (excluding mental health, dental & oral surgery, and ambulatory surgery) – 35 per treatment year.
- **Mental Health** – 24 per treatment year.
- **Dental & Oral Surgery** – 12 per treatment year.
- **Nutritional Assessment & Counseling** – symptomatic illness is 12 per treatment year, asymptomatic is 4 per treatment year.
- **Genotypic & Phenotypic resistance testing** – 3 per treatment year.
- **Viral Load Testing** – 6 per treatment year.
- **Hepatitis C Testing** – 1 per treatment year.
- **Tropism Assay** – 2 per treatment year.

SERVICES CARVED-OUT OF APGs

The following services and procedures can be billed on a fee-for-service basis:

- 87536 – HIV Viral Load Testing *
- 87900 – Virtual Phenotype *
- 87901 – HIV Genotype, Drug Resistance Test *
- 87902 – Hepatitis C Virus, Genotype Test
- 87903 – HIV Drug Resistance *
- 87999 – HIV Tropism Assay *

* Only Medicaid-enrolled clinical laboratories with Department of Health approval to perform HCV genotypic, qualitative and quantitative HCV viral load testing; HIV drug resistance testing; and/or HIV viral load testing are eligible for reimbursement.

EXCLUDED SERVICES

The Uninsured Care Programs is a Federally funded initiative with limited financial resources. In an effort to contain costs and provide an incentive for enrollment in Medicaid, certain restrictions have been placed on payments to providers. As a general reference, the following is a list of services that are not eligible for reimbursement:

- Emergency Room Services
- Inpatient Services
- Pharmacy (covered under ADAP)
- Radiology (with the exception of services packaged into the specific procedure/medical visit)
- Rehabilitative Therapy (Vocational, Physical, Speech, etc.)
- HIV Counseling & Testing (rate codes: 2983, 3111, & 3109)
- Substance Abuse & Alcoholism Services/Methadone Maintenance
- Case Management
- Psychiatric (Collateral Contact, Day Treatment, Continuing Treatment)
- Therapeutic Visit (rate code 2961)
- Provision of Vision Aids
- DME (this is covered under home care)
- Lead Screening

Other excluded services apply. Verification of covered service should be obtained prior to delivery of services to insure payment. For inquiries on a specific service, providers are asked to call the Provider Help Line at **1-800-732-9503**.

In addition to those services specifically excluded, payment will not be made for medical care and services which:

- are medically unnecessary;
- fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature;
- are rendered outside of the Client's period of eligibility;
- are fraudulently claimed;
- represent abuse or overuse;
- are for cosmetic purposes and are provided only on the basis of the participant's personal preference;
- are rendered in the absence of authorization from ADAP Plus;
- have already been rejected or disallowed by ADAP Plus when the rejection was based upon findings that the services or supplies provided were inappropriate or provided for personal comfort.

Providers must offer the same quality of service to ADAP Plus participants that they commonly extend to the general public. Providers may not bill ADAP Plus for services that are available free-of-charge to the general public.

A person covered under ADAP Plus is free to choose from among the participating hospitals and clinics that participate in ADAP Plus. "Shopping around" for medical care should be discouraged so that continuity of care may be maintained.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

In order to participate in the Ambulatory Patient Group (APG) reimbursement methodology, your facility should have sent authorization to the New York State Medicaid program prior to January 1, 2009. If your facility participates in APG reimbursement with Medicaid, then the facility is also required to participate in APG reimbursement with the Uninsured Care Programs. A copy of the facility's Medicaid authorization form must be forwarded to the Programs.

If your facility did not submit a request to Medicaid for participation in the APG reimbursement methodology, then you will continue to be paid under your existing rate structure and no action is required. Should your facility decide to change how it is reimbursed for services, written notification must be received by Medicaid prior to November 1st to be effective for dates of service on and after the following January 1st. The Program will require a copy of your intent and subsequent authorization form.

For more detailed information on APG billing and reimbursement methodology, visit the New York State Medicaid website at: www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm

UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW

I. 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.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each participant to whom care is rendered.

The minimum content of the participant record **MUST** include:

- Participant identification (name, sex, age, etc.);
- Conditions or reasons for which care is provided;
- Nature and full description of services provided;
- Type of services ordered or recommended to be provided by another practitioner or facility; and
- The dates of service provided and ordered.

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.

II. 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.

III. 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.

IV. 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.

V. 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, and 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 latest date of the following: the completion date of such reports, the date upon which the fiscal and statistical records were required to be filed, or the date the service was provided.
- e) All claims made under the Program shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the latest of either the date of service or date of payment. This limitation 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.

VI. 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 prohibit 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 read 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:

**UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052**

or by calling:
1-800-832-5305

BILLING SECTION

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 participant 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

If an ADAP Plus participant has third-party insurance coverage, he/she is required to inform the Program of that coverage and to assign any applicable benefits to the Program. ADAP Plus will coordinate benefits for individuals having third party insurance coverage for services provided and covered by the Program. ADAP Plus cannot pay partial or 'balance bill' claims. Acceptance of payment from ADAP Plus constitutes payment in full. Participants cannot be billed for services covered by ADAP. **Do not bill third party payers for ADAP Plus covered services provided to an ADAP Plus participant.**

TIMELY CLAIM SUBMISSION

Claims must be submitted within 90 calendar days from the date of service. Claims denied for late claim submission by ADAP Plus cannot be billed to participants.

BILLING INSTRUCTIONS

Claim forms should be typed or printed legibly in order to reduce delays in processing. Claim forms which do not conform to the ADAP Plus requirements may not be processed or may result in a significant delay in reimbursement. Claim forms may be submitted in quantity and enclosed in a **single** envelope which has been addressed to:

**UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052**

Be sure to send the original claim (claims should be submitted at least monthly) and retain a copy for your files. The Program accepts any claim form provided that the following information is included on the form:

- Provider MMIS number or NPI number
- Provider name & address (including zip code)
- Billing date
- Internal account number (optional – up to 15 characters)
- Physician name & NPI number
- Participant ADAP ID number, name, date of birth, & sex
- Diagnosis code(s)
- Date of service
- APG grouper access rate code
- ICD-9 diagnosis
- CPT and/or HCPCS procedure code(s)
- Procedure description
- Amount charged

REMITTANCE STATEMENT

The Remittance Statement is the key control document which informs the provider of the status of submitted claims. Should further information be required on any detail on the Remittance Statement, Providers should contact the Program at **1-800-732-9503**.

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.

DENIAL REASONS/COMMENTS

Use the following explanations to assist you when posting from the ADAP Plus remittance statement. **All resubmissions must be made within 60 days of receipt of the original denial in order to guarantee payment.**

- Code 1:** Participant is not eligible on the date of service in question. Contact the participant regarding this matter, do not keep resubmitting. Providers should be checking eligibility prior to the service being performed by calling the automated system at **1-800-832-5305**.
- Code 2:** Your facility was not eligible with ADAP Plus for the date of service in question. Contact the program before resubmitting this claim.
- Code 3:** The ADAP ID is missing/invalid.
- Code 4:** The diagnosis code is either invalid or was not submitted. Review the record and resubmit with a corrected diagnosis code.
- Code 5:** This claim has either been paid on a previous ADAP Plus batch or there is more than one clinic visit submitted for the same date of service. Unless a letter of appeal is sent in with the claim, it will continue to be denied for duplicate claim.
- Code 6:** Participant is not eligible because he/she is Medicaid eligible on the date of service in question.
- Code 7:** The procedure code is not recognized by the Program. Claims must be submitted using your facility's established Medicaid rate schedules or a valid CPT code (for ancillary services).
- Code 8:** The Program has a **90** day filing deadline. In order to guarantee payment, claims must be received within **90** days of the date of service. If funding is available, payment will be issued for claims submitted after this 90 day period, but there is no guarantee. Participants are not responsible for provider billing errors. If you

receive a denial and can correct the claim, you must send in the claim explaining that it is a resubmission within **60** days of the original denial.

- Code 9:** The date of service was not submitted or it was not a valid date.
- Code 10, 11:** The Program reimburses using established Medicaid rate schedules. If you do not know how to bill for ADAP Plus services, please contact the Claims Unit at **1-800-832-5305**. Our trained staff can assist you in the billing process. You will need to have your Medicaid provider number. These denial codes are also used if a service is not covered by ADAP Plus. If you have submitted using MMIS codes, the service is most likely not covered. Call the Claims Unit with any questions about covered services.
- Code 12:** The type of visit you have submitted is subject to an annual threshold (per treatment year). Treatment year is defined as the 364 days prior to the date of service in question.
- Code 13:** N/A
- Code 14:** The date of service was prior to the start of ADAP Plus. Verify the date of service.
- Code 15:** ADAP Plus **cannot** be balanced billed. If a participant is enrolled in the Program, ADAP Plus is the only source of payment for covered services. If your facility chooses to bill Medicare or another third party payer instead of ADAP Plus, you must be willing to accept whatever payment is issued as payment in full. The participant is **never** responsible for a co-pay, deductible, or any coinsurance.
- Code 16:** Participant was never approved for ADAP Plus.
- Code 17:** Inpatient services are not covered by ADAP Plus.
- Code 18:** The HIV specific rates and your cost-based clinic rate include all associated labs and ancillary services. The only lab services that are billable on a fee-for-service basis are the viral load test and the HIV resistance assay tests. All other labs are not billable separately, unless the tests are ordered by a physician who is enrolled in the Program as a private physician. If your facility cannot perform the necessary lab services, a contract needs to be established with a laboratory and your facility will be responsible for reimbursement. If your facility's cost-based rate has been built without the inclusion of lab and ancillary services, please notify the Program immediately.
- Code 19:** The participant has other insurance and is not eligible for ADAP Plus on the date of service in question. Contact the participant for additional information.
- Code 20:** This is not a denial code. Code 20 is used to indicate a group payment for certain chemistry tests. The payment will have the description that reads "payment for above # panels." The single payment is payment in full for all of the chemistry tests included in the submission.

Note: All reimbursement is paid at the current Medicaid rate. Your facility is responsible for providing the Program with any rate changes. The rates will be updated the day we receive the update. There will be no retroactive payments or adjustments.