

In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Drug Testing Clinical Payment and Coding Policy

Policy Number: CPCP020

Version 4.0

Clinical Payment and Coding Policy Committee Approval Date: 11/22/2018

Effective Date: 04/01/2019 (Blue Cross and Blue Shield of Texas Only)

Description:

This policy is to provide a guideline on the coding and documentation requirements for the reimbursement of drug testing.

Reimbursement Information:

Billing guidelines for urine drug testing, with a few exceptions, are intended to be consistent with those established by CMS for the safety, accuracy, and quality of diagnostic testing. Reimbursement for presumptive testing will be considered for claim submissions containing CPT codes 80305, 80306 and 80307. Reimbursement for definitive testing will be considered for claims submissions containing HCPCS codes G0480, G0481, G0482, G0483 or G0659 based on CMS guidelines published in 2018 for drug testing. This policy will be modified as needed, in accordance with CMS coding changes.



CLIA Certification requirement

Laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Therefore, any provider (facility or individual practitioner) who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

CPT Codes for Qualitative Drug Screen (Presumptive Drug Testing)

Use **80305** for testing capable of being read by direct optical observation only. The test includes validity testing when performed and may be performed only once per date of service.

Use **80306** when the test is read by instrument- assisted direct optical observation. The test includes validity testing when performed and may be performed only once per date of service.

Use **80307** when the test is performed by instrumented chemistry analyzers (e.g. Immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, CHPC, GC mass spectrometry). The test includes validity testing when performed and may be performed only once per date of service.

Qualitative or presumptive drug screening must meet medical policy criteria including appropriate medical record documentation.

The above-listed codes include any number of drug classes, devices or procedures. Only one presumptive code may be billed per date of service.

Confirmation Drug Testing

Consistent with the plan's Medical Policy MED207.154, Drug confirmation (definitive testing) is inconsistent with the list of medications prescribed to the patient.¹

NOTE: Under HCSC's medical policy, hair drug testing and oral fluid drug testing are considered experimental, investigational and/or unproven in outpatient pain management and substance use disorder treatment.

Definitive Drug Testing

The below listed codes are tests utilizing drug identification methods to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to gas chromatography/mass spectrometry (GC/MS), (any type, single, or tandem) and liquid chromatography/mass spectrometry (LC/MS) (any type, single, or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. Alcohol dehydrogenase)); qualitative or quantitative, all sources, including specimen validity testing. Only one (1) of the definitive G codes may be billed per date of service.

¹ The plan's Medical Policy MED207.154 states: "*Quantitative (definitive) testing is not appropriate for every specimen and should not be done routinely. This type of test should be performed in a setting of unexpected results and not on all specimens. The rationale for each quantitative test must be supported by the ordering clinician's documentation. The record must show that an inconsistent positive finding was noted on the qualitative (presumptive) testing or that there was not an available qualitative (presumptive) test to evaluate the presence of semi-synthetic or synthetic opioid in a patient.*"

- **G0480** – 1-7 drug class(es), including metabolites
- **G0482** – 15-21 drug class(es), including metabolites
- **G0481** – 8-14 drug class(es), including metabolites
- **G0483** – 22 or more drug class(es), including metabolites

Billing & Documentation Information & Requirements

A provider may only bill for services they perform (pass-through billing is not permitted).

Documentation Requirements

The clinician’s documentation must be patient-specific and accurately reflect the need for each test ordered. Each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient’s medical record. As stated more fully in the plan’s Medical Policy MED207.154:

Drugs or drug classes for which screening is performed should only reflect those likely to be present, based on the patient’s medical history or current clinical presentation and without duplication. Each drug or drug class being tested for must be indicated, by the referring clinician, in a written order and so reflected in the patient’s medical record. Additionally, the clinician’s documentation must be patient-specific and accurately reflect the need for each test.

Laboratories that submit urine drug testing claims should possess, at a minimum, (1) a signed, valid requisition form from the ordering provider that specifies the tests being ordered, and (2) complete results of the tests performed. The requisition form must include the following:

- A list of the specific drugs or drug classes being tested. Reference to a standard order or a “custom panel” is not acceptable;
- The identity of the patient;
- The identity of the ordering provider, including full name, credentials, and NPI number;
- A legible signature from the ordering physician (not a stamp or photocopy, and it is not acceptable to state that the physician’s signature is on file);
- The facility and location where the sample was collected (e.g. office , home, hospital, residential treatment center);
- The type of sample (i.e., urine);
- The date and time the sample was collected;
- The identity of the individual who collected the sample; and
- The date and time the sample was received in the laboratory.

1. Lab results containing the following:

- The complete identification of the entity performing the testing (including name, address, and CLIA number);
- The patient's name and date of birth;
- The ordering provider's name and NPI number;
- Facility name, if applicable;
- The date the sample was collected;
- The date the sample was received in the laboratory;
- The date the test results were reported; and
- Complete test results, including validity testing if performed.

The plan does not require billing laboratories to recover and submit medical records from ordering providers. Nevertheless, if the plan conducts an audit or review of a urine drug testing claim and finds that there is insufficient documentation that claims will be denied. The provider that submits the claim is responsible for providing, upon request, documentation sufficient to support all services submitted on the claim form. Complying with a request for laboratory orders and documentation, as described above, does not guarantee reimbursement. Medical Policies, benefits, eligibility, and medical record documentation are the additional determining factors for reimbursement. Individual benefit/coverage information may be found by contacting the customer service number on the back of the member's insurance card or utilizing your preferred web vendor for an online verification of benefits.

Independent laboratory claims should be submitted to the state where the referring/ordering provider is located (usually where the sample is obtained) regardless of where the testing laboratory resides.

Orders

Orders for diagnostic tests, including laboratory tests, must be patient-specific and include the rationale/need for the test requested. Panel testing is restricted to panels published in the current CPT manual. Orders must be signed and dated by the ordering health care professional. "Custom" panels are not specific to a particular patient and are not allowed. Further, the following are not reimbursable: **Routine screenings**, including quantitative (definitive) panels, performed as part of a clinician's protocol for treatment, without documented individual patient assessment;

Standing orders, which are routine orders given to a population of patients and may result in testing that is not individualized, not used in the management of the patient's specific medical condition and **Validity testing**, which is an internal process to affirm that the reported results are accurate and valid.

Claims that are accompanied by medical records that do not meet documentation requirements will not be reimbursed.

Reimbursement is subject to:

- Medical record documentation, including appropriately documented Orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(ies)



References:

[Medical Policy MED207.154](#), Drug Testing in Pain Management and Substance Use Disorder Monitoring

American Medical Association, Current Procedural Terminology (CPT®)

American Medical Association, 2018 HCPCS Level II, Professional Edition

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909221.html>

CPT copyright 2017 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Policy Update History:

Approval Date	Description
11/22/2018	New policy