REIMBURSEMENT POLICY STATEMENT MARKETPLACE PLANS

Original Effective Date	Next Annual Review	Last Revision
03/08/2017	03/08/2018	03/08/2017
Policy Name		**Policy Number**
Drug Screening Tests-Marketplace Plans		PY-0089
Policy Type		
Medical / Administrative / Pharmacy		**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Drug Screening Tests

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

Monitoring for controlled substances is performed to detect the use of prescription medications and illegal substances of concern for the purpose of medical treatment. Monitoring for controlled substances plays a key role particularly in the care of persons undergoing medical treatment with chronic pain therapy and substance use disorder (SUD). CareSource will reimburse charges for drug screening that are medically necessary for the management of members being treated with drugs that are potentially abusive or addictive such as opioids and related medications, or for members suspected of using illicit drugs solely or in combination with prescribed controlled substances. CareSource will also reimburse for qualitative/presumptive drug screening performed as part of routine, prenatal care for pregnant members.

Providers should have a working knowledge of analytic detection including primary agents, metabolites, lab threshold concentrations, and time periods involved in detection. The combination of a patient's self-report and drug testing results serve as important tools in controlled substance monitoring, as well as a point of patient engagement.
Qualitative/presumptive testing is a routine part of care, used when immediate results are needed, knowing results may be less accurate than quantitative/confirmatory tests.
Quantitative/confirmatory testing is used when results may affect changes in medication, when patients dispute qualitative/presumptive results, or in treatment transitions.
Anecdotal evidence to support testing for individual patients should be balanced with the limited population evidence for added value of multiple tests for chronic pain patients or SUD patients. For example, in a 2015 evaluation of 2,551,611 de-identified patients' urine drug test results over four years in the U.S., Quest Diagnostics identified that the best achieved yearly inconsistency rate in all urine drug tests was 53% (in 2014 vs 63% in 2011).

C. DEFINITIONS

- Qualitative analysis - The testing of a substance or mixture to determine its chemical constituents, also known as presumptive testing.
- Quantitative test - A test that determines the amount of a substance per unit volume or unit weight, also known as confirmatory testing.
- Quarter – one of the four consecutive periods of three consecutive months into which a calendar year is divided (January through March, April through June, July through September, and October through December.)
- Random alcohol and drug screen – a lab test administered at a regular interval which is not announced in advance to the person being tested, and which detects the presence of alcohol, drugs or substances in the individual.

- Outpatient Treatment Programs (OTP) drug testing requirements – for substance use disorder treatment, in the US Federal Code, "OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient."
- Multi-Panels – Orders that automatically create multiple CPTs in a request.

For further definitions please refer to Drug Screening Tests Medical Policy (MM-0066)

D. POLICY

I. **Prior Authorization**: Prior Authorization for drug screening as outlined in this policy is not required.

NOTE: Although the drug screenings covered by this policy do not require a prior authorization, CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

II. **Individualized Testing**: In all cases other than routine qualitative/presumptive drug screening as part of prenatal care, medical necessity for submitted charges must be individualized and documented in the member's medical record and included in the treatment plan of care. CareSource does not provide coverage for drug testing for forensic, legal, employment, transportation, or school purposes

III. **Non-Urine Testing:** Blood, testing is permitted in emergency department settings to evaluate acute overdose. Hair, saliva, or other body fluid testing for controlled substance monitoring has limited support in medical evidence and is not covered.

IV. **Urine Testing**: Urine for clinical drug testing is the specimen of choice because of its high drug concentrations and well-established testing procedures. Nevertheless, urine is one of the easiest specimens to adulterate.

A. If the clinician suspects such an occurrence, the clinician may choose to evaluate specimen validity using validity tests. Specimen validity testing is considered to be a quality control issue and should not be separately billed. Failure to back up customized test panels with medical necessity information for each individual member and for each of the drug test panels ordered will be considered by CareSource to be "routine test orders" and are excluded from our members' coverage and will result in the denial of the claim for reimbursement, audit, and/or overpayment requests, and any other program means for enforcing this policy.

B. Urine Drug testing should be focused on the detection of specific drugs and not routinely include a panel of all drugs of abuse.

C. Orders for "custom profiles," "standing orders," "drug screen panel", "custom panel", "blanket orders," "reflex testing" or to "conduct additional testing as needed," are not sufficiently detailed and coverage for such testing will be denied by CareSource since they would not verify medical necessity for the specific tests.

D. Testing on a routine basis is neither random nor individualized. Routine or reflex testing are not covered by CareSource. A random basis is defined as a basis which the patient cannot predict ahead of time. For example, testing performed at every clinical visit is not random.

E. CareSource does not provide coverage for testing as a requirement to stay in a facility, for example, in sober living or residential locations.

V. **Physician Orders**: A signed and dated physician order for the drug screening and/or testing is required.
   A. The physician's order must specifically match the number, level and complexity of the testing panel components performed.
   B. Non-par providers are not covered for urine drug testing laboratory services. Non-par clinicians may use par laboratories for drug testing services

VI. **Documentation Requirements**:
All documentation must be maintained in the member's medical record and available to CareSource upon request. The following additional documentation requirements apply:
   A. Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative/presumptive drug test.
   B. Every page of the record must be legible and include appropriate member identification information (e.g., complete name, dates of service(s)).
   C. The record must include the identity of the physician or non- physician practitioner responsible for and providing the care of the member.
   D. The submitted medical record should support the use of the selected ICD-10-CM code(s) with appropriate indications for urine drug testing.
   E. The submitted CPT/HCPCS code should accurately describe the service performed.
   F. Copies of test results alone without the proper clinician's order for the test are not sufficient documentation of medical necessity to support a claim.
   G. Urine drug testing records and related entries in a member's medical record shall be provided to CareSource upon request for auditing of medical necessity. Documentation must support medical necessity and specify why each test is ordered. Documentation must also support the number of analytes requested for testing, and what action the provider will take upon the findings.

VII. **Testing by Non-ordering Providers**:
   A. If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the drug test. The ordering/referring physician must include the clinical indication/medical necessity in the order for the drug test as outlined above.
   B. Laboratories performing drug testing services must bill CareSource directly. CareSource does provide coverage for claims from clinicians for drug testing services ordered by clinicians but performed by laboratories.

VIII. **Quantity Limitations**
   A. CareSource will reimburse for up to 5 qualitative/presumptive tests in a quarter for each member.
   B. CareSource will reimburse for up to 5 quantitative/confirmatory tests in a quarter for each member.
   C. Only 1 multi-panel test, (i.e., testing for each category of a drug class, including metabolite(s), if performed) may be billed per day (same date of service (DOS)).
   D. CareSource will cover only one qualitative/presumptive test per date of service.
   E. CareSource will cover only one quantitative/confirmatory test per date of service.

IX. **Confirmatory and Duplicative Testing**
   A. Except as specifically outlined in this policy, CareSource will not reimburse for routine multi-drug quantitative/confirmatory testing. Quantitative/confirmatory testing must be individualized and medically necessary. Routine confirmations (quantitative) of drug screens with negative results are not deemed medically

necessary and are not covered by CareSource. Quantitative/confirmatory testing is covered for a negative drug/drug class screen when the negative finding is inconsistent with the member's documented medical history and/or current documented chronic pain medication list.

B. CareSource will not reimburse for routine nonspecific or wholesale orders for drug screening (qualitative), confirmation, and quantitative drugs of abuse testing.

C. CareSource will not reimburse drug testing as defined in this policy with a blood, or other non-urine body fluid.

X. **Drug Testing Laboratories**

A. CareSource will not reimburse drug screening tests conducted for its members by non-participating labs or facilities, even if such tests were ordered by a participating provider or physician.
B. CareSource may require documentation of FDA-approved complexity level for instrumented equipment, and/or CLIA Certificate of Registration, Compliance, or Accreditation as a high complexity lab.
C. Both participating (contracted) physicians with CareSource, as well as, non-participating (not contracted) physicians may potentially order laboratory tests for CareSource members
D. Those participating physicians with Practice Services Agreements only, may not bill CareSource for quantitative/confirmatory drug screen testing.
E. Only providers with an Independent Laboratory Contract with CareSource can bill for quantitative/confirmatory drug screens.
F. Laboratories MUST be both CLIA certified AND contracted (participating) with CareSource.
G. Claims submitted by laboratories that are non-participating (not contracted) with CareSource will NOT be reimbursed.
H. CareSource will not reimburse drug screening for medico-legal purposes (e.g., court-ordered drug screening) or for employment purposes (e.g., as a pre-requisite for employment or as a requirement for continuation of employment).

NOTE: Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the CMS fee schedules. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html

The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.

Codes	Description
80155	Drug screen quant caffeine
80159	Drug screen quant clozapine
80171	Gabapentin, drug screen quant
80173	Assay of haloperidol
80184	Phenobarbital
80196	Salicylate
80299	Quantitation of drug, not elsewhere specified

80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	Alcohol biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamines; 3 or 4
80326	Amphetamines; 5 or more
80327	Anabolic steroids; 1 or 2
80328	Anabolic steroids; 3 or more
80329	Analgesics, non-opioid; 1 or 2
80330	Analgesics, non-opioid; 3-5
80331	Analgesics, non-opioid; 6 or more
80332	Antidepressants, serotonergic class; 1 or 2
80333	Antidepressants, serotonergic class; 3-5
80334	Antidepressants, serotonergic class; 6 or more
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 6 or more
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1-3
80340	Antiepileptics, not otherwise specified; 4-6
80341	Antiepileptics, not otherwise specified; 7 or more
80342	Antipsychotics, not otherwise specified; 1-3
80343	Antipsychotics, not otherwise specified; 4-6
80344	Antipsychotics, not otherwise specified; 7 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids, synthetic; 7 or more
80353	Cocaine
80354	Fentanyl
80355	Gabapentin, non-blood
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone

80359	Methylenedioxyamphetamines
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80366	Pregabalin
80367	Propoxyphene
80368	Sedative hypnotics (non-benzodiazepines)
80369	Skeletal muscle relaxants; 1 or 2
80370	Skeletal muscle relaxants; 3 or more
80371	Stimulants, synthetic
80372	Tapentadol
80373	Tramadol
80374	Stereoisomer (enantiomer) analysis, single drug class
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
80542	Column chromatography/mass spectrometry (e.g., GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
83789	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen
80805	Meprobamate
83992	Phencyclidine (PCP)
84311	Spectrophotometry, analyte not elsewhere specified
G0477	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

See Drug Screening Tests Medical Policy (MM-0066)

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2014	
Date Reviewed	03/08/2017	
Date Revised	03/08/2017	

H. REFERENCES

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This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

Independent medical review – 2/2015