



2017 Billing/Documentation Guidelines for Urine Drug Tests

Blue Cross and Blue Shield of Oklahoma (BCBSOK) will continue to follow Medicare's lead and zero-price the CPT® drug testing codes (80300 – 80377, other than the new presumptive codes listed below).

With a few exceptions, BCBSOK's billing guidelines for urine drug testing are consistent with those established by CMS for safety, accuracy and quality of diagnostic testing and will make use of the newly defined CPT codes 80305, 80306 and 80307 for presumptive testing and HCPCS codes G0480, G0481, G0482, G0483 or G0659 for definitive testing that CMS published for 2017 drug testing. Previously defined presumptive drug testing codes HCPCS G0477, G0478 and G0479 are deleted, effective 1/1/2017.

New for 2017, Physician owned/operated laboratories will use **G0659** (*Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes*) when performing urine drug testing using GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem).

CLIA Certification requirement

Facilities and private providers who perform 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 who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

Newly Defined CPT Codes for Qualitative Drug Screen (Presumptive Drug Testing)

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

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

Use **80307** when test is performed by instrumented chemistry analyzers (e.g. Immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, CHPC, GC mass spectrometry). 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.

All of these codes include any number of drug classes, devices or procedures. Only one of the presumptive codes may be billed per date of service.

Confirmation Drug Testing

Consistent with HCSC Medical Policy MED207.154, Drug confirmation (definitive testing) is indicated when the result of the drug screen is different than that suggested by the patient's medical history, clinical presentation or patient's own statement.¹

NOTE: Saliva or oral swabs do not meet the HCSC medical policy for drug testing.

Definitive Drug Testing

All of these codes are tests utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS, (any type, single, or tandem) and LC/MS (any type, single, or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg. 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.

- **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

REMINDER: Physician office laboratories will bill definitive testing using G0659, once per date of service.

Billing & Documentation Information & Requirements

BCBSOK does not allow Pass-through Billing or Other Billing/Service Arrangements

- Pass-through billing occurs when a Physician or other provider requests and bills for a service, but the service is not actually performed by that Physician or provider. Physician or other provider is not permitted to bill for services that are rendered by another entity or provider.
- "Under arrangement" billing and other similar billing or service arrangements are not permitted by BCBSOK. "Under arrangement" billing refers to situations where services are provided by a Physician, but the services are billed by another provider or facility under that entities' participation agreement, rather than under the agreement with the Physician that performed the services. Physician or other provider is not permitted to allow another entity or individual to bill or submit claims for reimbursement to BCBSOK under the other entities' Participation Agreement (contract) for services rendered by Physician or other provider. "

¹ HCSC Medical Policy MED207.154 states: *Confirmatory 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 confirmatory test must be supported by the ordering clinician's documentation. The record must show that an inconsistent positive finding was noted on the qualitative test testing or that there was not an available qualitative test to evaluate the presence of semi-synthetic or synthetic opioid in a patient.*

Facility billing of urine drug testing (UDT): BCBSOK has published guidelines concerning hospitals billing UDT: https://www.bcbsok.com/pdf/lab_billing_guidelines_faqs.pdf

It should be noted that UDT performed on patients in Residential Treatment Centers (RTC) and/or during Intensive Outpatient (IOP) substance abuse treatment should not be billed separately. The testing is a part of the per diem rates for such services.

All testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

BCBSOK may monitor the manner in which these new test codes are billed, including frequency of testing. Abusive billing, poor or no documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

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 HCSC 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.

Orders

Orders for diagnostic tests, including laboratory tests, must be specific to both the patient and the 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, **Standing orders** which may result in testing that is not individualized and/or not is used in the management of the patient's specific medical condition and **Validity testing**, 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)