CareSource

REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

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11/29/2017	03/17/2019		03/17/2018 - 06/03/2018
Policy Name			**Policy Number**
Drug Testing			PY-0155
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.

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A. SUBJECT

Drug Testing

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. Claims submitted to CareSource must be complete in all respects; and all use of the Health Insurance Claim Form CMS-1500 must comply with the most recent version of the Medicare Claims Processing Manual.

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). Drug testing that is 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 is billable to CareSource. Qualitative/presumptive drug testing performed as part of routine, prenatal care for pregnant members is also billable to CareSource.

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 (when the results of a drug screen are not consistent with the patient's history and prescribed medicines) 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.
- **Early and Periodic Screening, Diagnostic and Treatment** (**EPSDT**) - this benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPDST is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services through early diagnosis and treatment. The program specifically covers comprehensive

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health and developmental histories, immunizations, health education, vision services, dental services, hearing services, and any additional health care diagnostic and treatment services for physical and mental illnesses that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan. Under the EPSDT program, any Medicaid provider can find a problem, make a referral or provide treatment. This includes doctors, nurses, dentists, physical therapists, occupational therapists, speech therapists, psychologists, psychiatrists and other health care professionals.

- **Random alcohol and drug test** – a lab test administered at an irregular 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.
- **Independent laboratory** – A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.
- **Participating/Non-participating** – Participating means in-network and contracted with CareSource. Non-participating means out-of-network, not contracted by CareSource.

For further definitions, please refer to the CareSource Drug Testing Medical Policy (MM-0126) posted here: https://www.caresource.com/providers/indiana/medicaid/medical-policies/

D. POLICY

I. **Prior Authorization**: Prior Authorization is required for drug testing as outlined in this policy. CareSource will consider all prior authorization requests when they are medically necessary to the member's treatment and care, or if they fall within the standards of care under EPDST guidelines.

A. For all members, prior authorization for drug testing is not required in the emergency room (ER) setting when it is needed to evaluate acute overdose.

B. For members age 6 and younger, prior authorizations are not required for drug testing, and there is no limit on the number of drug screening tests for a child in this age group.

C. For members age 7 and older, prior authorization for drug testing is required when:

1. The member reaches the limits imposed by this policy within the rolling 90-day time period (See Section D.IX below); or,
2. The type of drug test or type of sample used for the drug testing is not covered by this policy.

NOTE: Although the drug testing covered by this policy may or may 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. **General Criteria for Coverage:** Clinical guidelines, standards, and scenarios for drug testing are outlined in detail within the CareSource Drug Testing Medical Policy, MM-0126. Please refer to this policy for in-depth information on medical necessity for drug testing, documentation required for claims, and CareSource monitoring and review of drug testing claims.

III. **Individualized Testing**: In all cases other than routine qualitative/presumptive drug testing 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, school purposes, or other third-party requirement.

IV. **Non-Urine Testing:** CareSource will reimburse blood testing in emergency department settings only, to evaluate acute overdose. Drug testing with blood samples performed in any other setting outside of an ER requires that medical record documentation meets criteria in

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the above Section D.II "General Criteria for Coverage." Hair, saliva, or other body fluid testing for controlled substance monitoring has limited support in medical evidence and is not covered unless medical record documentation meets criteria in the above Section D.II "General Criteria for Coverage." If covered, non-urine drug testing is reimbursed at the lesser of coverage amounts per CPT for urine testing and non-urine testing.

NOTE: Drug testing codes listed in this policy which may include blood or other non-urine bodily fluids, or other physical samples in their coding definitions, are not billable to and will not be reimbursed by CareSource unless (1) the test is performed in the ER setting AND the sample used is blood, as stated above; or, (2) medical record documentation meets criteria in the above Section D.II, "General Criteria for Coverage."

V. **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 provider suspects such an occurrence, the provider may choose to evaluate specimen validity using validity tests. Specimen validity testing is considered to be a quality control issue and is included in the CPT code payment. Additional codes for specimen validity testing should not be separately billed to CareSource. Tests for creatinine, specific gravity, temperature or nitrates are not billable to and will not be reimbursed by CareSource when submitted simultaneously with a drug testing CPT code and ICD substance use disorder code. Failure to document customized tests with medical necessity information for each individual member and for each of the drug tests ordered 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. 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 billable to and will not be reimbursed by CareSource.
   D. Testing on a routine basis is neither random nor individualized. Routine or reflex testing is not billable to and will not be reimbursed by CareSource unless a prior authorization has been obtained by the provider or lab. 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. Other than medically necessary indications for testing, drug testing required for a residential program is included in the cost of and payment for that program.
   F. Providers and laboratories will need to ensure specimen integrity appropriate for the stability of the drug agent being tested, until the prior authorization process is completed, for example, freezing a specimen.

VI. **Provider Orders**: **CareSource requires that the ordering provider's name appear in the appropriate lines of the claims forms; any claim that does not include this information is incomplete and therefore not billable to and will not be reimbursed by CareSource.** A signed and dated provider order for the drug testing is required. The provider's order must specifically match the number, level and complexity of the testing components performed.

VII. **Non-participating Providers**: Non-participating providers are not covered for drug testing laboratory services. Non-participating providers may use participating laboratories for drug testing services.

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VIII. **Documentation Requirements**:

All documentation must be accurate, complete, maintained in the member's medical record and available to CareSource upon request. The following documentation requirements apply:

A. Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering provider/treating provider 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 provider's order for the test are not sufficient documentation of medical necessity to support a claim.
G. Drug testing records and related entries in a member's medical record must 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.

IX. **Quantity Limitations**

A. CareSource will reimburse for up to 6 qualitative/presumptive tests in any rolling 90 day period for each member.
B. Prior authorization must be obtained by the provider or lab for any and each quantitative/definitive drug test.
C. Within these limits, 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)) unless the ordering provider or providing lab has obtained prior authorization from CareSource.
D. CareSource will cover only one qualitative/presumptive test per date of service.
E. Each CPT code is counted as a test toward these limits.
F. Prior authorization must be obtained by the ordering/referring provider or lab for any drug testing performed exceeding these limits. CareSource will consider all such requests when they are medically necessary to the member's line of treatment, or if they fall within the standards of care under EPDST guidelines.

X. **Confirmatory and Duplicative Testing**

A. Routine multi-drug quantitative confirmatory testing is not billable to and will not be reimbursed by CareSource. Quantitative/confirmatory testing must be individualized and medically necessary. Routine confirmations (quantitative) of drug tests with negative results are not covered by CareSource without review and prior authorization. Quantitative/confirmatory testing is covered for a negative drug/drug class test when the negative finding is inconsistent with the member's documented medical history and/or current documented chronic pain medication list, and indications substantiated in the medical record.
B. Routine nonspecific or wholesale orders for drug testing (qualitative), confirmation, or (quantitative) drugs of abuse testing are not billable.

XI. **Independent Laboratories**

A. Drug testing conducted for CareSource members by non-participating labs or facilities is not billable to and will not be reimbursed by CareSource, even if such tests were ordered by a participating provider.

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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 providers and non-participating providers may potentially order laboratory tests for CareSource members
D. Only participating independent laboratories contracted with CareSource can bill for quantitative/confirmatory drug tests.
E. Laboratories must have the appropriate level of CLIA certification for the testing performed and be contracted (participating) with CareSource.
F. Claims are not billable to CareSource if submitted by laboratories that are non-participating (not contracted) with CareSource.
G. The ordering/referring provider must include the clinical indication/medical necessity and any required prior authorizations in the order for the drug test as outlined above.
H. The independent laboratory performing the drug testing must maintain hard copy documentation of the lab results, along with copies of the ordering/referring provider's order for the drug test and any required prior authorizations.
I. Participating laboratories performing drug testing services must bill CareSource directly. CareSource does not allow pass-through billing of services. Any claim submitted by a provider which includes services ordered by that provider, but are performed by a person or entity other than that provider or a direct employee of that provider, is not billable to CareSource.

XIII. **Other Non-Billable Drug Testing**

A. Standing orders set up between a provider and laboratory which are prewritten and/or result in the same drugs and drug classes to be tested on a routine, repeat basis, are not billable to and will not be reimbursed by CareSource.
B. Drug testing is not billable to and will not be reimbursed by CareSource if required by a third party such as:
   1. Medico-legal purposes (e.g., court-ordered drug test); or,
   2. For employment purposes (e.g., as a pre-requisite for employment or as a requirement for continuation of employment).
   3. As a condition of:
      3.1 Participation in school or community athletic activities or programs.
      3.2 Participation in school or community extra circular activities or programs.
   4. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.), EXCEPT for once yearly screening in EPSDT programs.
   5. As a component of medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.).
   6. As a program requirement to live in sober housing or residential services. Other than medically necessary indications for testing, drug testing required for a residential program is included in the cost of and payment for that program.

NOTE: Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepay review.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting Indiana Medicaid approved HCPCS and CPT codes along with appropriate modifiers and ICD-10 codes. Please refer to the Indiana Medicaid fee schedule.
http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp

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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.

NOTE: Drug testing codes listed in this policy which may include blood or other non-urine bodily fluids, or other physical samples in their coding definitions, will nevertheless not be reimbursed by CareSource unless (1) the test is performed in the ER setting AND the sample used is blood, as stated above; or, (2) medical record documentation meets criteria in the above Section D.II, "General Criteria for Coverage." If covered, non-urine drug testing is reimbursed at the lesser of coverage amounts per CPT for urine testing and non-urine testing.

Codes	Description
80155	Drug screen quant caffeine
80159	Drug screen quant clozapine
80171	Gabapentin, drug screen quant
80173	Assay of haloperidol
80184	Phenobarbital
80299	Quantitation of drug, not elsewhere specified
Codes	**Qualitative/Presumptive Tests-Description**
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
Codes	**Quantitative/Confirmatory Tests-Description**
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

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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
83992	Phencyclidine (PCP)
84311	Spectrophotometry, analyte not elsewhere specified
Codes	**Description**
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
83789	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen
Codes	**Description**
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0482	Drug test def 15-21 classes
G0483	Drug test def 22+ classes

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AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

See Drug Testing Medical Policy (MM-0126)

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	11/29/2017	New Policy.
Date Reviewed		
Date Effective	03/17/2018	

H. REFERENCES

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

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