Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Drug Screen Testing - Professional**	
Policy Number: **C-12004**	Policy Section: **Laboratory**
Last Approval Date: **04/24/2024**	Effective Date: **04/24/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Wellpoint member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Wellpoint allows reimbursement of properly ordered presumptive and definitive drug testing when applicable codes are submitted, unless provider, state, federal contracts and/or requirements indicate otherwise.

When definitive drug testing is performed by an independent clinical laboratory (POS=81) on the same date of service as presumptive drug testing by instrumented chemistry analyzers for the same member, the Health Plan will allow separate reimbursement for definitive drug testing of 1-7 drug class(es). Definitive drug testing for 8 or more drug classes will not be separately reimbursed when performed on the same date of service as the presumptive testing.

Definitive drug testing may be used to detect specific substances not identified by presumptive methods and to refine the accuracy of the presumptive test results. Provider's documentation and member's medical records should reflect that the test was properly ordered. For cases where the definitive testing is confirmatory, the provider's documentation should support that the order was based on the result of the presumptive test.

Nonreimbursable:
We do not allow separate reimbursement for specimen validity testing when utilized for drug screening. Specimen validity testing is included in the presumptive and definitive drug testing CPT and HCPCS code descriptions. No modifiers will override the bundle edit.

Related Coding

Description	Coding Grids
Definitive and Presumptive CPT and HCPC Level II codes	Definitive and Presumptive CPT and HCPCS Level II codes

Policy History

04/24/2024	Review approved and effective: added frequency limitations to G0480-G0483 in Related Coding section; removed frequency limitations from Frequency Editing Professional (C-08012);
12/11/2023	Review approved and effective: updated Definitions section, added coding link to Related Coding section
06/25/2021	Review approved 06/25/2021 and effective 12/01/2021: updated policy language updated for clarity; updated Related Policies section; added language around specimen validity testing, added codes to related coding section
11/26/2019	Review approved: updated policy language; removed language on bundled services; updated Related Coding section.
03/15/2019	Review approved and effective 04/28/19: updated policy language to allow lower level definitive code (G0480) on the same day as presumptive drug testing.
06/01/2019	Review approved: policy template updated
01/18/2019	Review approved: updated policy language for clarity to indicate that the lab cannot perform drug screen testing without an outside order; Policy template updated, codes were removed from the policy body and added to the coding section with indication of what codes are reimbursable and not reimbursed.
08/31/2017	Review approved 08/31/2017 and effective 01/01/2018: updated policy language; definitive drug testing is not allowed when reported on the same date of service as presumptive drug testing.

01/03/2017	Review approved: update coding: 1. Deleted codes for 2017: 80300-80304 (presumptive) and G0477-G0479 (presumptive) 2. Add codes for 2017: 80305-80307 (presumptive) and G0659 (definitive) 3. Add that when G0659 is reported with G0480-G0483, only G0659 is eligible for reimbursement, no modifier override 4. Added full code descriptions
06/07/2016	Review approved; updated language for clarity 1. That we will bundle the CPT codes 2. That the "per day" presumptive and definitive codes are each allowed once per day per member per provider 3. Adding that modifiers will not override the limit edit that allow the presumptive and definitive test once per day
01/05/2016	Review approved: 1) CPT codes same services 80300-80304 (presumptive) and 80320-80377 and 83992 (definitive) will be always bundled services and not eligible for reimbursement beginning with dates of service 03/15/2016 2) HCPCS effect 1/1/2016 for presumptive (G0477-G0479) and definitive drug testing (G0480-G0483) are to be reported; these are "per day" services with incremental # of tests per code
01/06/2015	Review approved: updated policy language to reflect new coding for 2015; update to the title to "Drug Screen Testing"; 1) Updating language in the description section to define the services "are typically used to monitor a patient's clinical response to prescribed medication" 2) Removing information regarding high complexity testing 3) Adding information on presumptive and definitive drug screen testing 4) Policy statement is revised based on new coding for 2015 to now read: Current Procedural Terminology (CPT®′) lists coding for presumptive drug class screening in addition to individual definitive drug testing codes (80150-80377). Therefore, based on Healthcare Common Procedure Coding System (HCPCS Level II) instructions in the temporary "G" code section to refer to CPT for possible alternate codes, Wellpoint considers HCPCS codes G0431 (drug screen, qualitative), G0434 (drug screen, other than chromatographic) and G6030-G6058 (drug testing/assays) for drug screen testing to be bundled services that will not be eligible for reimbursement. (See also our Bundled Services and Supplies reimbursement policy.) 5) Removing the coding table since we will give an abridged description of the codes in the policy section
07/01/2014	Review approved: updated language 1) There are minor grammatical and punctuation updates but there are no changes to the policy position or criteria 2) In the description section, added 2nd minimal paragraph: This policy documents the position on reimbursement and reporting of qualitative drug screen testing
07/02/2013	Review approved: updated with Minor Revisions: 1. Punctuation and language updates such as spelling out US Food and

	Drug administration the first time FDA is used 2. In the third line of the policy section, include independent and hospital laboratories to our guidelines
07/10/2012	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Clinical Laboratory Improvement Amendment (CLIA) guidelines
- Optum EncoderPro 2023

Definitions

Presumptive/Qualitative Drug Testing	Used to determine the presence or absence of drugs or drug classes in a urine sample; results expressed as negative or positive or as a numerical result
Definitive/Quantitative Drug Testing	Used to identify specific medications, illicit substances and metabolites; reports the results of analytes absent or present typically in concentrations such as ng/ml
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services - Professional
Distinct Procedural Service, Modifiers 59 and XE, XP, XS, & XU - Professional
Frequency Editing - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.