If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guideline 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Drug Testing Clinical Payment and Coding Policy

Policy Number: CPCP020

Version 6.0

Clinical Payment and Coding Policy Committee Approval Date: 12/11/2019

Effective Date: May 1, 2020 (Blue Cross and Blue Shield of Texas Only)

Reimbursement Information:

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. A provider may only bill for services the provider performs itself (pass-through billing of services performed by a third-party provider is not permitted).

Reimbursement Information (cont.)

Reimbursement under this policy is subject to the following:

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

Requirements:

CLIA Certification requirement

Any provider (facility or individual practitioner) who performs laboratory testing, including urine drug tests, must possess a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for the type of testing

CPT Codes for Presumptive (Qualitative) Drug Class Screening

The below CPTs include testing any number of drug classes, devices or procedures

CPT	DEFINITION	GUIDELINE
80305	DRUG TEST PRSMV DIR OPT OBS	CPT **80305** is appropriate 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.
80306	DRUG TEST PRSMV INSTRMNT	CPT **80306** is appropriate 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.
80307	DRUG TEST PRSMV CHEM ANLYZR	CPT **80307** is appropriate 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.

NOTE: Qualitative or presumptive drug screening must meet medical policy criteria, established in Medical Policy MED207.154 ("MED207.154"), including appropriate medical record documentation.

Validity testing is included in the base testing code and may not be billed separately. If validity testing is abnormal then subsequent testing of the sample is not reimbursable.

Quantitative Definitive Drug Testing

Quantitative Definitive Drug Testing should be done in accordance with MED207.154[(1)].

Review of presumptive (qualitative) results by the treating physician should occur before definitive (quantitative) testing is ordered and should be so reflected in the medical documentation. If a definitive test(s) is ordered without presumptive testing the documentation should contain clear patient specific justification.

NOTE: Under MED207.154, hair drug testing and oral fluid drug testing are considered experimental, investigational and/or unproven in outpatient pain management and substance use disorder treatment.

Codes

HCPCS	DEFINITION	GUIDELINE
G0480	Drug test(s), definitive, utilizing (1) 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 (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed	• 1-7 drug class(es) • Only one (1) of the definitive G codes may be billed per date of service • Validity testing is included in the base testing code and may not be billed separately.
G0481	Drug test(s), definitive, utilizing (1) 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 (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed	• 8-14 drug class(es) • Only one (1) of the definitive G codes may be billed per date of service • Validity testing is included in the base testing code and may not be billed separately.

1MED207.154 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.*

Quantitative Definitive Drug Testing (cont.)

HCPCS	DEFINITION	GUIDELINE
G0482	Drug test(s), definitive, utilizing (1) 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 (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed	• 15-21 drug class(es) • Only one (1) of the definitive G codes may be billed per date of service • Validity testing is included in the base testing code and may not be billed separately.
G0483	Drug test(s), definitive, utilizing (1) 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 (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed	• 22 or more drug class(es) • Only one (1) of the definitive G codes may be billed per date of service • Validity testing is included in the base testing code and may not be billed separately.
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 (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., 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	• Drug test definitive simple all classes • Only one (1) of the definitive G codes may be billed per date of service • Validity testing is included in the base testing code and may not be billed separately.

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.2

Laboratories that submit urine drug testing claims should possess, at a minimum, the following:

- A signed, valid requisition form from the ordering provider that specifies the tests being ordered, and
- complete results of the tests performed.

The requisition form should 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; "Reflex" (or automatic) testing 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.

Lab results should contain 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 obtain and submit medical records from ordering providers. Nevertheless, urine drug testing claims will be denied if there is insufficient documentation. The provider that submits the claim is responsible for providing, upon request, sufficient documentation 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.

Independent laboratory claims should be submitted to the Blue Cross and Blue Shield plan in the state where the referring/ordering provider is located, regardless of where the testing laboratory is located.

2 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 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 reimbursable 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.

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, 2019 HCPCS Level II, Professional Edition

CMS Publication Complying with Documentation Requirements for Laboratory Services

Policy Update History:

Approval Date	Description
11/22/2018	New policy
12/4/2019	Annual Review