

Affected Programs: BadgerCare Plus, Medicaid

To: Adult Mental Health Day Treatment Providers, Advanced Practice Nurse Prescribers with Psychiatric Specialty, Ambulatory Surgery Centers, Case Management Providers, Community Care Organizations, Community Recovery Services Providers, Community Support Programs, Comprehensive Community Service Providers, Crisis Intervention Providers, Family Planning Clinics, Federally Qualified Health Centers, HealthCheck “Other Services” Providers, HealthCheck Providers, Home Health Agencies, Hospice Providers, Hospital Providers, Independent Labs, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Master’s-Level Psychotherapists, Nurse Midwives, Nurse Practitioners, Nurses in Independent Practice, Nursing Homes, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Personal Care Agencies, Physician Assistants, Physician Clinics, Physicians, Prenatal Care Coordination Providers, Psychiatrists, Psychologists, Qualified Treatment Trainees, Rehabilitation Agencies, Rural Health Clinics, Substance Abuse Counselors, Substance Abuse Day Treatment Providers, HMOs and Other Managed Care Programs

Changes to Coverage Policy for Testing for Drugs of Abuse

This *ForwardHealth Update* announces changes to coverage policy regarding testing for drugs of abuse effective for dates of service on and after January 1, 2016.

Changes to Coverage Policy

The Centers for Medicare and Medicaid Services (CMS) has updated the Healthcare Common Procedure Coding System (HCPCS) Level II code set used to describe testing for drugs of abuse. Effective for dates of service (DOS) on and after January 1, 2016, providers are required to use HCPCS procedure codes G0477–G0483 when submitting claims for testing for drugs of abuse. HCPCS procedure codes G0431, G0434, and G6030–G6058 have been enddated and are no longer valid.

Providers should continue to use *Current Procedural Terminology* (CPT) procedure codes when submitting claims for therapeutic drug testing.

Covered Services

The HCPCS code set G0477–G0483 consists of two primary categories of drug testing: presumptive and definitive.

Presumptive drug tests are used to detect the presence or absence of a drug or drug class; they do not typically indicate a specific level of drug but rather give a positive or negative result. A presumptive drug test may be followed with a definitive drug test in order to identify specific drugs or metabolites. Definitive drug tests are qualitative or quantitative tests used to identify specific drugs, specific drug concentrations, and associated metabolites.

Presumptive Drug Tests

ForwardHealth covers medically necessary presumptive drug tests for the following clinical indications:

- Suspected drug overdose, unreliable medical history, and an acute medically necessary situation. Medically necessary situations include, but are not limited to, unexplained coma, unexplained altered mental status, severe or unexplained cardiovascular instability, undefined toxic syndrome, and seizures with an undetermined history.
- Monitoring of a member’s compliance during treatment for substance abuse or dependence. This applies to testing during an initial assessment, as well as ongoing monitoring of drug and alcohol compliance. Decisions

about which substances to screen for should be well documented and should be based on the following:

- ✓ The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings.
- ✓ The substance the member is suspected of misusing.
- ✓ The member's prescribed medication(s).
- ✓ Substances that may present high risk for additive or synergistic interactions with the member's prescribed medication(s).
- ✓ Local information about substances commonly abused and misused, such as input from the Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network that compiles prevalence data on drug-related emergency department visits and deaths (available at www.samhsa.gov/data/emergency-department-data-dawn/).

- Monitoring of a member receiving chronic opioid therapy (COT). Decisions about which substances to screen for should be well documented and should be based on the following:
 - ✓ The member's history of past drug use or abuse, the results of any physical examinations, and any of the member's previous laboratory findings.
 - ✓ The member's current treatment plan.
 - ✓ The member's prescribed medication(s).
 - ✓ The member's risk assessment plan.

Definitive Drug Tests

Definitive drug tests can be used to evaluate presumptive drug test results, which can minimize the potential for a clinician to rely on a false negative or false positive result. Definitive drug tests can also be used to guide treatment when it is necessary to identify a specific drug within a drug class or identify a specific concentration of a drug. A definitive drug test order must be medically necessary and reasonable. The order for a definitive drug test must describe the medical necessity for each drug class being tested. A member's self-report may reduce the need for a definitive drug test.

Definitive drug testing includes direct-to-definitive drug tests. Direct-to-definitive drug tests are tests that are used without first performing a presumptive drug test of the sample. Direct-to-definitive drug tests are used when presumptive drug tests do not adequately detect the substance or metabolite identified for testing. Presumptive drug tests are inadequate when the component for a particular drug class does not react sufficiently to the identified drug or drug metabolite within that drug class, resulting in a false negative. Synthetic opioids, some benzodiazepines, or other synthetic drugs may not be adequately detected by presumptive drug tests. Direct-to-definitive drug tests are only appropriate in rare circumstances.

ForwardHealth covers medically necessary definitive drug tests for members when at least one of the clinical indications for presumptive drug tests applies and when there is at least one of the following needs:

- A definitive concentration of a drug must be identified to guide treatment.
- A specific drug in a large family of drugs (e.g., benzodiazepines, barbiturates, and opiates) must be identified to guide treatment.
- A false result must be ruled out for a presumptive drug test that is inconsistent with a member's self-report, presentation, medical history, or current prescriptions.
- A specific substance or metabolite that is inadequately detected by presumptive drug testing (direct-to-definitive testing), as determined on a case-by-case basis in accordance with community standard guidelines set by the practice, must be identified.

Testing Frequency

Testing for drugs of abuse should not be performed more frequently than the standard of care for a particular clinical indication. The testing frequency must be medically necessary and documented in the member's medical record.

Acute Medical Testing

A single presumptive and/or definitive drug test is appropriate for any acute medical presentation.

Chronic Opioid Therapy

Providers are required to document the testing frequency and rationale for testing (including a validated risk assessment) for members receiving COT. The following testing frequencies are based on a member's risk for abuse:

- Members with low risk for abuse may be tested up to one to two times per year.
- Members with moderate risk for abuse may be tested up to one to two times every six months.
- Members with high risk for abuse may be tested up to one to three times every three months.

Noncovered Services

ForwardHealth does not cover the following:

- Any drug test performed without a specific order. Routine, nonspecific, wholesale, standing, or blanket orders for drug tests are not covered.
- Drug testing solely for 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).
- Reflex testing. Reflex tests are definitive drug tests that are performed automatically by a laboratory following a presumptive drug test; they are not based on a specific order.
- Definitive drug tests when a presumptive drug test result (positive or negative) is consistent with a member's self-report, presentation, medical history, and current prescriptions and when definitive drug testing is not necessary to further guide treatment.
- Presumptive drug tests when a direct-to-definitive drug test is performed.

In all cases, providers should only test for drugs or drug classes likely to be present based on the member's medical history, current clinical presentation, and illicit drugs that are in common use. In other words, it is **not** medically necessary or reasonable to routinely test for substances (licit or illicit) that are not used in a member's treatment population or, in the instance of illicit drugs, in the community at large.

Services Not Separately Reimbursable

Separate reimbursement is not available for the following circumstances:

- Testing of two different specimen types from the same member on the same DOS, regardless of the number of providers performing the tests
- More than one presumptive or definitive drug tests performed per member per DOS, regardless of the number of providers performing the tests

Claim Submission

Providers should use HCPCS Level II procedure codes and follow CMS guidance in the most recent Clinical Laboratory Fee Schedule (CLFS) Final Rule when submitting claims for drug testing to ForwardHealth. The prescribing/referring/ordering provider is required to be Medicaid-enrolled and to be indicated on the claim form.

Procedure Codes

Providers should use procedure codes G0477–G0479 when submitting claims for presumptive drug tests. Providers are required to select the appropriate code based on the type of presumptive drug test used.

When submitting claims for definitive drug tests, providers should use procedure codes G0480–G0483. Providers are required to select the appropriate code based on the number of drug classes for which definitive drug testing is medically necessary. Definitive drug testing for more than seven drug classes (using procedure codes G0481–G0483) is only appropriate in rare circumstances.

Only one of the three presumptive drug tests may be submitted per day, per member. Only one of the four definitive drug tests may be submitted per day, per member.

Documentation Requirements

The member's medical record must contain documentation that fully supports the medical necessity for services rendered. This documentation includes, but is not limited to, relevant medical history, physical examination, risk assessment, and results of pertinent diagnostic tests or

procedures. The medical record must include the following information:

- A signed and dated member-specific order for each drug test. This order must provide sufficient information to substantiate each testing panel component performed. “Standing orders,” “custom profiles,” or “orders to conduct additional testing as needed” are insufficiently detailed and cannot be used to verify medical necessity.
- A copy of the test results.
- Rationale for ordering a definitive drug test for each drug class tested.
- If a direct-to-definitive drug test is ordered, documentation supporting the inadequacy of presumptive drug testing.

As a reminder, if the provider of the service is not the ordering/referring provider, the provider of the service is still required to maintain documentation of the lab results and copies of the order for the drug test. The clinical indication/medical necessity for the test must be documented in either the order or the member’s medical record.

Reimbursement for Testing for Drugs of Abuse

For presumptive and definitive drug tests, providers are reimbursed at the lesser of the billed amount or the maximum allowable fee established by ForwardHealth. To access the ForwardHealth interactive maximum allowable fee schedules, go to the ForwardHealth Portal home page at www.forwardhealth.wi.gov/, click the Fee Schedules link in the Providers link box, and then click the Interactive Max Fee Search link in the Quicklinks box.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

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