blue of california

Payment Policy

Presumptive and Definitive Drug Testing	
Original effect date:	Revision date:
11/21/2016	07/01/2023

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Presumptive Drug Testing

- Billing for presumptive testing must be billed using one (1) of the most appropriate CPT/HCPC codes 80305, 80306, 80307, or H0003.
- A maximum of one (1) service unit per procedure code per date of service is allowed.

Definitive Drug Testing (Therapeutic Drug Assays)

- Billing for definitive testing must be billed using one (1) of the most appropriate CPT/HCPC codes: 0007U, 0011U, 0082U, 0328U, G0480, G0481, G0482, G0483, or G0659.
- A maximum of one (1) service unit per procedure code per date of service is allowed.
- Charges for CPT codes 80320–80377 and 83992 are denied to resubmit using the correct CPT/HCPC code for reimbursable services, to provider liability.

Specimen Validity Testing

- Specimen validity testing is considered quality control which is included in the presumptive and definitive drug testing CPT and HCPCS code descriptions and is not eligible for separate reimbursement and should not be separately billed. Charges for CPT codes 81000, 81001, 81002, 81003, 81005, 81099, 82542, 82570, 83516, 83518, 83519, 83520, 83789, 83986, 84156, and 84311 are denied as bundled into codes 80305-80307 and/or G0480-G0483, and G0659 to provider liability.

Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver shall bill using the QW modifier. Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation do not append the QW modifier to claim lines.

Policy

This policy is applied to claims with date of service on or after November 21, 2016.

In effort to reduce unjustified overutilization and prevent overpayment, Blue Shield of California has aligned with the coding guidelines established by CMS, aimed at accurately capturing medically necessary limits, work relative value units, and correct number of service units. A single presumptive and/or definitive drug test is appropriate for any acute medical presentation. Only one presumptive and one definitive drug test may be submitted per day, per member. Individual drug testing codes billed in addition to these codes will be denied as bundled.

Rationale

Blue Shield of California's Presumptive and Definitive Drug Testing payment policy is in compliance with CMS Clinical Laboratory Fee Schedule Final Determinations, CMS explained the need to refine drug screen testing codes and revise the descriptors to avoid unnecessary or excessive utilization of drug screening/ testing codes.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association** https://www.ama-assn.org/ • **Centers for Medicare & Medicaid Services** https://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
11/21/2016	New Policy Adoption	Payment Policy Committee
01/01/2017	Added new codes 80305- 80307, G0659 Removed deleted codes G0477-G0479	Annual Maintenance
07/08/2017	Formatting Revision	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
03/29/2019	Added H0003, 0006U, 0007U, 0011U, 0020U, 0082U	Annual Maintenance
01/01/2020	Removed deleted codes 80300-80304, 0020U Updated language in Policy section	Annual Maintenance
01/01/2021	Removed deleted code 0006U	Annual Maintenance
01/01/2022	Added 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U, 82542, 83516, 83518, 83519, 83520, 83789, 84156, 84311 Added detailed language in Specimen Validity Testing	Annual Maintenance
01/01/2023	Added 0328U in Definitive Drug Testing Category	Maintenance Review
07/01/2023	Removed deleted codes 0143U-0150U	Maintenance Review

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

These Policies are subject to change as new information becomes available.