URINE DRUG TESTING
Effective 7/1/2016

Policy
Neighborhood Health Plan reimburses medically necessary Urine Drug Testing (UDT) to detect the parent drug and/or its metabolite(s) to demonstrate use of prescription medications and illegal substances of concern for medical treatment purposes.

Reimbursement
Providers are reimbursed according to the plan’s network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member’s benefit plan. The manner in which covered services are reimbursed is determined by the Neighborhood Health Plan Payment Policy and by the provider’s agreement with NHP. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member’s benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

NHP reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Please reference the NHP Medical Policy for Outpatient Drug Screening and Testing for further guidance and clarification on medical necessity requirements.
Neighborhood Health Plan Reimburses
- HCPCS codes G0477-G0483; 1 unit per date of service

Neighborhood Health Plan Does Not Reimburse
- Assessment for substances not established on the initial targeted screening
- Definitive Drug Class code range 80320-80377
- Laboratory services to any provider without a valid CLIA certificate on file
- Laboratory services to any provider who holds a Certification of Registration pending survey and compliance with CLIA regulations
- Presumptive Drug Class Screening Codes 80300-80304
- Reports of clinical information derived from the result of laboratory data that is mathematically calculated which are considered part of the test procedure and therefore not a separately reportable service, including confirmatory tests
- Routine specimen collection and preparation for the purpose of clinical laboratory analysis
- Services billed with an unassigned place of service code
- UDT services billed with the following diagnosis codes:
  - Z01.812 – Encounter for preprocedural laboratory examination
  - Z01.89 – Encounter for other specified special examinations

NHP does not reimburse UDT for non-medical purposes and/or third party requests. Please refer to member materials for additional documentation. Excluded services include but are not limited to:

- Administrative or social service agency investigations, proceedings, or monitoring activities
- Condition for pre-employment or required compliance for continuation of employment
- Court ordered drug testing
- Requirement for school including but not limited to: enrollment, compliance, or participation in school or community athletic activities, programs, or other extracurricular activities
- Testing for parents involved in divorce/child custody cases
- UDT performed for residential monitoring purposes

Procedure Codes

Note: This list of codes may not be all-inclusive

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<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Comments</th>
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<tbody>
<tr>
<td>G0477</td>
<td>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</td>
<td>1 unit of G0477 or G0478 or G0479 will be reimbursed per date of service</td>
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<td>G0478</td>
<td>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</td>
<td>1 unit of G0477 or G0478 or G0479 will be reimbursed per date of service</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Fee Schedule</td>
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<td>G0479</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service</td>
<td>1 unit of G0477 or G0478 or G0479 will be reimbursed per date of service</td>
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<td>G0480</td>
<td>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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed</td>
<td>1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service</td>
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<td>G0481</td>
<td>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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed</td>
<td>1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service</td>
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<td>G0482</td>
<td>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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed</td>
<td>1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service</td>
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<td>G0483</td>
<td>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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed</td>
<td>1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service</td>
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<td>80300</td>
<td>Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (eg, dipsticks, cups, cards, cartridges), per date of service</td>
<td>Not payable; bill G0477 or G0478</td>
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<td>80301</td>
<td>Drug screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service</td>
<td>Not payable; bill G0477 or G0478</td>
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80302  Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure  
   • Not payable; bill G0477 or G0478

80303  Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral, alkaloid plate), per date of service  
   • Not payable; bill G0478 or G0479

80304  Drug screen, any number of drug classes, presumptive, single or multiple drug class method; not otherwise specified presumptive procedure (eg, TOF, MALDI, LDST, DESI, DART), each procedure  
   • Not payable; bill G0477 or G0478

80375  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3  
   • Not payable; bill G0480, G0481, G0482, or G0483

80376  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6  
   • Not payable; bill G0480, G0481, G0482, or G0483

80377  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more  
   • Not payable; bill G0480, G0481, G0482, or G0483

### Provider Payment Guidelines and Documentation

- Include the specific diagnosis code supporting the medical necessity of the UDT service
- Report Urine Drug Testing with HCPCS Codes G0477-G0483
- When reporting services, report only one of the three presumptive G codes (G0477-G0479), per day. Similarly, you may report only one of the four definitive G codes (G0480-G0483) per day.
- Urine Drug Testing should not routinely include a panel of all drugs of abuse. The test ordered should be focused on detecting the specific drugs of concern. Frequency of testing should be at the lowest level to detect presence of drugs bearing in mind the pharmacodynamics for which the drug is being screened.
  - A full panel screen should be considered when the patient’s observed behavior suggests the use of a drug(s) not identified on the initial screening. Medical documentation must support the behavioral observation and medical justification for conducting a full panel screening. Subsequent testing should be conducted for those substances identified on the patient’s initial profile.
- Do not report Therapeutic Assays (CPT 80150-80299) for drug classes being tested as part of the drug screen service
- Reference the Clinical Laboratory Improvement Amendments (CLIA) Categorization of Tests for additional information

### Documentation Requirements

Requests for laboratory services must be written and include the following information:
- date of the request;
- name or any other means of identifying the member to be tested;
- name and address of the authorized prescriber;
- name of the specific laboratory tests to be performed;
- frequency for performing each laboratory test (applicable to standing orders only);
• duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only); and
• A statement by the authorized prescriber that such testing is required as part of the member’s medical or drug treatment plan (applicable to standing orders only)

If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. The testing laboratory must maintain such request in its records in accordance with 130 CMR 401.416(A).

Both referring and testing laboratories must keep a record of each written request for laboratory services, each specimen, and each test result for at least six years from the date on which the results were reported to the authorized prescriber.

The laboratory record must contain the following information:
• written request for laboratory services with all information required by 401.146;
• identification number of the specimen;
• name or any other means of identifying the person from whom the specimen was taken;
• name of the authorized prescriber and, if applicable, the referring laboratory that submitted the specimen;
• date on which the specimen was collected by the authorized prescriber or laboratory, the location of the collection, and the name of the collector;
• date on which the specimen was received in the laboratory;
• condition of unsatisfactory specimens when received (i.e. broken, leaked);
• specific tests performed;
• date or dates on which each test was performed;
• results of each test, the name and address of all persons to whom each test result is reported, and the date of reporting; and
• name and address of the laboratory to which the specimen was referred, if applicable

References
American Medical Association, CPT current year, Professional Edition

American Medical Association, HCPCS Level II, current year, Professional Edition


Publication History

<table>
<thead>
<tr>
<th>Topic: Urine Drug Testing</th>
<th>Owner: Provider Network Management</th>
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January 18, 2011 Original documentation
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<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>December 1, 2012</td>
<td>Updated limitations, codes, provider payment guidelines and documentation, and references</td>
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<tr>
<td>September 1, 2013</td>
<td>Removal of limitations effective 12/1/2012</td>
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<tr>
<td>May 1, 2016</td>
<td>Updated CPT/HCPCS reimbursable codes and limitations, ICD-10 diagnosis codes added, removed definition</td>
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<tr>
<td>August 11, 2016</td>
<td>Definitive drug codes clarification</td>
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes clinical coding criteria and claim editing logic in addition to auditing across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at prweb@nhp.org.