2017 Drug Screening Code Updates for WV Medicaid

Prior Authorization for Drug Screening Codes Beyond Service Limits
Objectives

This webinar is intended to:

1. Inform WV Medicaid providers of changes related to 2017 drug screening code changes and prior authorization limit changes;
2. Identify procedures to be implemented by Ordering, Prescribing, and Referring Providers (including Behavioral Health Providers);
3. Identify requirements for Clinical Laboratory Improvement Amendments (CLIA) approved and CLIA-waived labs;
4. Distribute the medical necessity criteria for each provider type (i.e., substance abuse providers, pain management, etc.); 
5. Educate on billing requirements for reimbursement; and
6. Inform providers on use of the Kepro AUM Medical System to obtain prior authorizations.
Effective 1/1/2017, changes have occurred related to drug testing codes and their Prior Authorization limits.

- A maximum of one presumptive urine drug test may be submitted and paid per member per date of service.
- A maximum of one definitive urine drug test may be submitted and paid per member per date of service.
- Prior authorization is required in order to EXCEED 24 drug screens in a calendar year.
- Billing denials during January and February 2017 will be given special consideration.
For presumptive testing, three new codes will replace the following G Codes, and the new service limit applies to all:

- 80305 replaces code G0477; no changes in service definition
- 80306 replaces code G0478; no changes in service definition
- 80307 replaces code G0479; presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., EIA, ELISA, EMIT, FPIT, IA, KIMS, RIA), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography (e.g., DART, DESI, GC-MS, GC-MS/MSM LC-MS, LC-MS/MS, LDTD, MALDI, TOF); includes sample validation when performed, per date of service.
For definitive testing, the following four G Codes will continue to be used, but will be subject to the new limit of 24 per calendar year.

- G0480; no changes to service definition
- G0481; no changes to service definition
- G0482; no changes to service definition
- G0483; no changes to service definition
Additionally, as of 1/1/2017 the following G Code has been added:

- G0659: 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; prior authorization is required after 24 tests in a calendar year.
Requirements for 80305, 80306 & 80307

• Presumptive testing codes 80305, 80306 and 80307 should be used instead of G0477, G0478, and G0479.

• Requests may be made back to January 1, 2017 to comply with the HCPCS code changes.

• There is an initial benefit limit per member/per code/per calendar year (24 screens per member/per calendar year WITHOUT prior authorization);

• Prior authorization will be required to exceed the benefit limits;

• Reimbursement is limited to one unit per day of a code; only one of the three codes (80305, 80306, or 80307) may be billed per day.

• The HF modifier must be included on all claims for these codes when related to substance abuse treatment (e.g. Suboxone).
• The codes must be billed with a quantity of one per episode of care regardless of the number of collection/testing items used, the number of procedures, and/or the drug classes screened.

• Multiple panel tests, such as the 80305HF and the 80306HF, must be used when complying with WV Medicaid’s Medication Assisted Treatment policy and/or testing for two or more drug substances.
Requirements for G0480-G0483, and G0659

- Requests may be made back to January 1, 2017 to comply with the CPT code effective dates.

- Prior authorization is required after the 24 screen limit is exceeded per calendar year.

- Reimbursement for procedure codes G0480 - G0483, and G0659 is limited to one unit per day. Only one of the five codes may be billed per day.

- The unit used to determine the appropriate code to bill is "drug class". The number of drug classes tested determines the appropriate code to use, except for code G0659 which is used for any number of drug classes. Each drug class may only be used once per day.

- The HF modifier must be included on all claims for these codes when related to substance abuse treatment (e.g. Suboxone).

- Any provider performing laboratory testing, must possess a valid CLIA certificate for the type of testing performed.
Service Definition Inclusions

• Specimen validity testing is not eligible to be separately billed under any procedure code. The code description for 80305-80307, G0480-G0483, and G0659 indicates that this testing is included if it was performed.

• Drug confirmation tests are no longer eligible to be separately reported under any procedure code, unlisted or otherwise. This service is considered included in the presumptive or definitive drug testing procedure codes (80305-80307, G0480-G0483, and G0659).
Criteria for Medical Necessity - Behavioral Health Requests:

- Member non-compliance with prescribed drug regimen OR evidence of intoxication or behavior suggesting recent use;
- The provider believes a previous sample has been tainted;
- Reports from member’s support network OR other medical providers indicate that drug screening in excess of 24 in the calendar year are indicated;
- Chaotic or deteriorating function despite apparent treatment compliance;
- Testing should be in compliance with the Federal Opioid Treatment standard (42 CFR 8.12) that states Opioid Treatment Programs must provide adequate testing or analysis of drugs of abuse, including at least (6) random drug abuse tests per year (but no more than one test per month) for member’s maintenance treatment.
• Justification for medical necessity to exceed 24 drug screens in a calendar year must be provided to support the request. This includes but is not limited to:

  • Progress notes indicating reports of non-compliance or abuse and treatment progress;
  
  • Documentation of incidences of suspected intoxication;
  
  • Member treatment plan indicating why more than 24 screens are indicated in a calendar year and anticipated outcomes specifically related to additional testing;
  
  • Documentation of circumstances leading to suspicion of tainted sample(s);
  
  • Documentation must support one of the criteria above and provide documentation that additional screens are not for confirmatory purposes ONLY.
Emergency Drug Screening

Criteria for Medical Necessity - Emergency Drug Screening:

- Unexplained coma;
- Unexplained altered mental status in the absence of a clinically defined toxic syndrome;
- Severe or unexplained cardiovascular instability;
- Unexplained metabolic or respiratory acidosis; or
- Seizures with an undetermined history.

Prior authorization is ONLY required to EXCEED 24 drug screens in a calendar year.

Prior Authorization requests to exceed 24 screens due to emergencies only need to include the medical justification listed above AND should be submitted as EMERGENT requests.

NOTE: Screening performed in the ER is part of the ER visit and does not require separate PA.
Pain Management Programs

Criteria for Medical Necessity - Pain Management:

• Testing is performed as a baseline screening before initiating treatment AND a plan is in place to use the test findings clinically.

• Subsequent monitoring is done at a frequency appropriate for the risk level of the member. To determine a member’s risk, providers should use a validated screening tool. In addition, members should also be screened for behavioral health conditions that may increase their risk of misuse of controlled medications and/or overdose.

• In cases of use/abuse or monitoring suspected abuse, testing should be in compliance with the Federal opioid treatment standard (42 CFR 8.12) that states opioid treatment programs must provide adequate testing or analysis of drugs of abuse, including at least (6) random drug abuse tests per year (but no more than one test per month) for member’s maintenance treatment.
Justification for medical necessity to exceed 24 drug screens in a calendar year must be provided to support the request. This includes, but is not limited to,

- Progress notes indicating reports of non-compliance or abuse and treatment progress;

- Documentation of clinical findings from previous screens supporting the need for additional testing; and

- Member treatment plan indicating why more than 24 screens are indicated in a calendar year and anticipated outcomes specifically related to additional testing as well as coordination with behavioral health programs if abuse is determined or suspected (including referrals and care coordination if member is receiving active treatment).
Ordering, Referring, Prescribing (ORP)

- Tracking member utilization and obtaining prior authorization, when required, is the responsibility of the ORP;
- The ORP should select themselves as the referring provider when making a request in the Kepro WV C3 AUM Medical system AND select the lab where the member will have the screening as the servicing provider;
- Orders should be specific as to the screen(s)/codes required;
- Laboratory orders from behavioral health providers for members utilizing an independent, CLIA approved lab should indicate the HF modifier is to be used when the screening relates to behavioral health; and
- Orders for drug screening for any other purpose do not require use of a modifier.
Exceeding the Member Benefit

• To exceed the 24 per calendar year benefit, providers must seek prior authorization through Kepro’s WV AUM C3 Medical application.

• In order to access this web-based portal, please contact Kepro at http://wvaso.kepro.com or 1-800-346-8272 for registration information, or register via the online portal at https://c3wv.kepro.com.

• Once a provider is registered, providers may either directly enter data into the web portal or fax the prior authorization requests to 1-844-633-8429.

• Authorization responses will only be available on the WV C3 AUM Medical application regardless of the method used to seek prior authorization.

• Behavioral health providers who utilize CLIA approved laboratories OR have an approved CLIA Waived laboratory site must use the WV AUM Medical C3 application when seeking authorization for the G80305HF and 80306HF.
Registering Your Provider Organization with Kepro

- To register/enroll your agency for obtaining authorizations for Medical (non-behavioral) services on CareConnection® C3 Provider Portal:
  - Go to the following website: [https://c3wv.kepro.com](https://c3wv.kepro.com).
  - Click on Provider Self Enrollment located near the bottom of the aforementioned URL.
  - Click and complete required field highlighted in red, then click on the box for Terms and Conditions, then click Submit.

- In approximately two (2) business days (or less), KEPRO’s Corporate IT Department will complete the process of establishing your C3 Provider Portal Organization on our secured website. This will have generated the initial “Organization Manager” account associated with your self-enrollment.

- The email account you listed on the electronic registration form will receive the User ID you requested and a preliminary password.
You must logon with this User ID/Password as the ORG Manager to update this account with an AUM Manager role (see attached) as well as create subsequent ORG and UAM Manager logons for your team.

Please note that the C3 user role that submits requests for authorizations plus retrieves correspondence and determinations is an AUM-Manager.

Your ORG Manager function can create either user role in addition to resetting account passwords and deactivating users. A guide has been sent with the PowerPoint for your convenience.

Lastly, you must email wvmedicalservices@kepro.com or fax 1.866.209.9632 the completed Signature and NPI attachment for your CareConnection® C3 Provider Portal account to fully function. This step is vital regardless of how you submit a prior authorization request (fax, mail, or electronic).

Kepro will link all appropriate NPIs.

Your organization’s registration is not complete until this final step has transpired.
1. Go to https://providerportal.kepro.com and enter your login and password.

2. Click on the AUM manager tab.

3. Click on search member and enter the WV Medicaid ID number and the member’s last name, then click search. (Hint: you can enter the first initial of the last name and click search.)

4. Instructions for creating and submitting a lab request are included with this PowerPoint.
Checking Prior Authorization Request Status

There are several ways to check on the request status. If you are the provider who created the request (ORP):

- Search the Authorization Request ID or member and select the request, then select view authorization from the action menu. The authorization number appears on the front screen and on the service page of the request. More detail is available by selecting the authorization number in the request.

- Select your reports tab on your log-in screen and search report by date of request and the member and the PA information will appear in the report.

If you are the servicing provider:

- Select your reports tab on your log-in screen and search report by date of request and the member and the PA information will appear in the report.
• Laboratory claims from behavioral health providers for screening performed at CLIA Waived labs must use the QW modifier on the claim.

**NOTE:** BH provider claims at CLIA waived labs will not pay without the QW modifier.

• Laboratory claims for any drug screening related to BH treatment require the HF modifier.
Kepro Contact Information

1-800-346-8272

Medical Services General Voicemail: ext. 7996

Medical Services email: wvmedicalservices@kepro.com
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**GENERAL KEPRO INFORMATION:**  [HTTP://WVASO.KEPRO.COM](http://WVASO.KEPRO.COM)

Fax #: 1-866-209-9632 (Registration and Technical Support Only)

Website for Submitting Authorizations:  [https://providerportal.kepro.com](https://providerportal.kepro.com)

Website for Org Managers To Add/Modify Users:  [https://c3wv.kepro.com](https://c3wv.kepro.com)

For Clinical Support or for Fax Forms:  1-800-346-8272

For BH Requests Contact KEPRO Behavioral Health Unit:  1-800-378-0284  (LOCAL 304.346.6732) or KEPRO BH Fax: 1-866-473-2354
Questions?