2018 Drug Screening Code Updates for WV Medicaid

Medical Necessity Authorization for Drug

Screening Codes Beyond Service Limits

Effective July 1, 2018

WEST VIRGINIA
Department of
Health &
Human
Resources
BUREAU FOR
MEDICAL SERVICES

Objectives

This webinar is intended to:

1. Inform WV Medicaid providers of changes related to 2018 drug screening code changes and medical necessity authorization 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 seeking medical necessity authorization on use of the Kepro AUM Medical System.

Effective 7/1/2018, changes have occurred related to drug testing codes and their Medical Necessity Authorization limits.

➢ Medical Necessity Authorization is required in order to <u>EXCEED</u> 24 presumptive drug screens in a calendar year (1/1-12/31)- this includes CPT codes 80305, 80306 & 80307 in COMBINATION.

➢ Medical Necessity Authorization is required in order to <u>EXCEED</u> 12 definitive drug screens in a calendar year (1/1-12/31)- this includes HCPCS codes G0480, G0481 and, G0482 in COMBINATION.

➢ Policy has been updated to require medical necessity authorization for G0483 and G0659 from the initial service in the calendar year.

➢ This revised policy is effective July 1, 2018.

CMS Drug Screening Code Changes

For presumptive testing, three codes are covered, <u>and the new service limit applies to all in COMBINATION</u>:

- 80305- Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service;

- 80306- Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service;

- 80307- Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

- Medical Necessity Authorization is available when service limits are exceeded AND there is documented clinical justification for the need for additional presumptive testing. The least costly procedure to meet the documented clinical need will be authorized.

For definitive testing, the following G Codes will continue to be used but limits have been modified,

- G0480; G0481; G0482 <u>will be subject to the new limit of 12 per calendar year in COMBINATION</u>;

- G0483 and G0659 now require medical necessity authorization from the initial service in the calendar year;

- Medical Necessity authorization is available when required or when service limits are exceeded AND there is documented clinical justification for the need for additional definitive testing. The least costly procedure to meet the documented clinical need will be authorized.

- Presumptive testing codes 80305, 80306 and 80307 should be used within accepted standards of practice (e.g. ASAM) and not solely based on a specific program requirement set by the provider.

- There is an initial benefit limit per member/80305, 80306 and 80307 in combination/per calendar year (24 screens per member/per calendar year WITHOUT medical necessity authorization);

- Medical necessity 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.

Justification for medical necessity to exceed 24 drug screens in a calendar year for presumptive testing (codes 80305, 80306 & 80307 in COMBINATION) 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 definitive purposes ONLY

- Definitive testing codes G0480-G0483 and G0659 should be used within accepted standards of practice (e.g. ASAM) and not solely based on a specific program requirement set by the provider.

- Medical necessity authorization is required after the 12 definitive test limit for G0480 - G0482 in COMBINATION is exceeded per calendar year.

- G0483 is utilized when 22 or more drug classes need to be evaluated. This code requires medical necessity authorization from the initial service. Medical justification must include the reason(s) G0480-G0482 are not sufficient to meet the member's need for definitive testing.

- G0659 requires medical necessity authorization from the initial service. This definitive testing code is utilized when the substance cannot be distinguished using G0480-G0483. A medical justification for utilizing this code must be provided in the medical necessity justification when the medical necessity authorization is requested.

- 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, <u>except</u> 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 <u>must be included</u> 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.

- <u>For G0480-G0482 up to 12 definitive tests are allowed in a calendar year without medical necessity authorization. G0483 and G0659 require medical necessity authorization from the initial service in the calendar year. Definitive Testing is considered for reimbursement when the test results will alter patient management decisions under the following circumstances:</u>

- Presumptive test results are different from that suggested by the member's treatment plan and there is a positive inconsistent finding from the previously performed presumptive test. The definitive test must be ordered by the treating physician with the results documented in the member's medical record.

- Treatment Plan must indicate why definitive testing is needed and presumptive testing is insufficient.

- Definitive testing may be medically necessary when there is no available, commercially or otherwise, qualitative test to evaluate the presence of a semi-synthetic or synthetic controlled substance. In these instances G0659 may be the appropriate code and this code requires medical necessity authorization from the <u>initial</u> service in the calendar year.

- Result of presumptive drug screen is negative and the negative finding is unexpected or inconsistent with the member's current medication program.

- Suspect the sample has been tampered with or tainted.

- 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.

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.

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- Justification for medical necessity to exceed the benefit for presumptive or definitive testing 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 testing is indicated in a calendar year <u>and</u> 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.

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;

- Drug testing done in the emergency room does not require a medical necessity authorization and does not count toward the policy limits for the member.

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 authorization to exceed 24 presumptive and/or 12 definitive 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 presumptive and/or definitive tests 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 to determine when a medical necessity authorization is required because the benefits without medical necessity authorization are exceeded and obtaining medical necessity authorization, when required, is the responsibility of the ORP;

- The ORP should select themselves as the <u>referring</u> 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 <u>servicing</u> 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 calendar year for either presumptive and/or definitive testing or to request medical necessity authorization for G0483 or G0659 for fee-for-service (FFS) members, providers must seek medical necessity 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 medical necessity 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 medical necessity 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 80305HF 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:

  o Go to the following website: https://c3wv.kepro.com.

  o Click on Provider Self Enrollment located near the bottom of the aforementioned URL.

  o 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.

Registration with KEPRO (cont.)

- 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 medical necessity 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.

Submitting Laboratory Requests

1. Go to https://providerportal.kepro.com and enter your login and password.
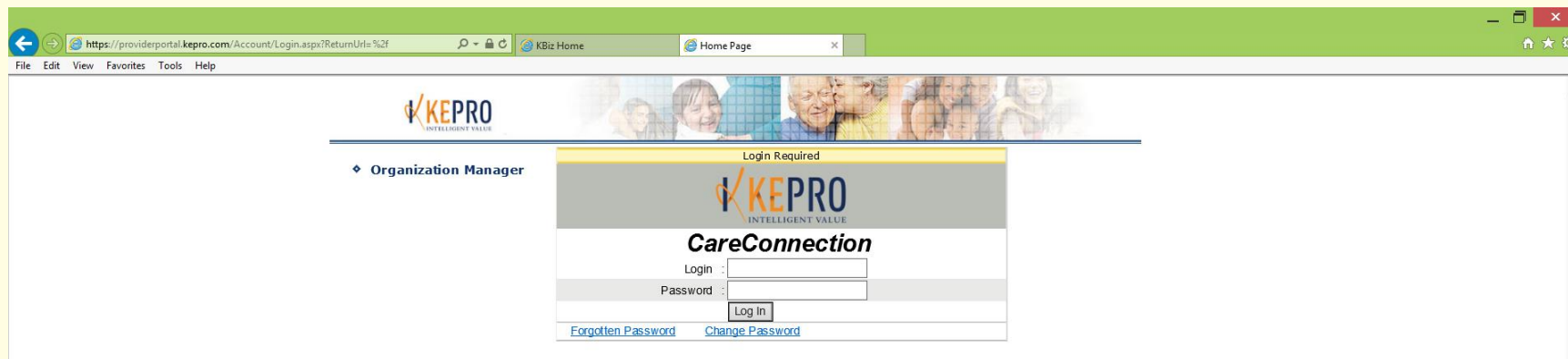
2. Click on the AUM manager tab.

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 Medical Necessity 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.

  <u>NOTE</u>: 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.

Medicaid Members in Managed Care

- BMS Policy 529.2 Drug Screenings applies to all Medicaid members in Fee for Service (FFS) Medicaid and in Managed Care Plans;

- For members in Managed Care please consult the appropriate MCO for procedures and requirements related to service authorization and the basic benefit for presumptive and definitive drug testing;

- To request presumptive and/or definitive testing or to request medical necessity authorization for G0483 or G0659 for Medicaid Managed Care members the specific managed care provider should be consulted for requirements and procedures;

- There is a specific Drug Testing Medical Necessity Authorization form that may be used to request medical necessity authorization for Medicaid members.

1-800-346-8272

Medical Services General Voicemail:

ext. 7996

Medical Services email:

wvmedicalservices@kepro.com

KEPRO Contact Information (continued)

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EMILY PROCTOR	BEHAVIORAL HEALTH	EBPROCTOR@KEPRO.COM	EXT. 4455

GENERAL KEPRO INFORMATION: HTTP://WVASO.KEPRO.COM

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

Website for Submitting Authorizations: https://providerportal.kepro.com

Website for Org Managers To Add/Modify Users: 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?