Drug Screening Payment Policy

Applies to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct – Health Connector
- ☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- ☒ Tufts Health RITogether – A RI Medicaid Plan
- ☐ Tufts Health Unify – OneCare Plan

The following payment policy applies to Tufts Health Plan contracting providers who render services for Tufts Health Public Plans products.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary urine drug testing with contracting labs to detect the use of prescription medication and illegal substances of concerns for the purpose of medical treatment.

All urine drug testing should be performed at an appropriate frequency based on clinical needs. The frequency should be at the lowest level to detect the presence of drugs.

DEFINITIONS

A drug screening is a test to detect the presence of certain drugs and classes of drugs. Commonly screened drugs include but are not limited to, amphetamines, cocaine, opiates, barbiturates, benzodiazepines, cannabinoids, and ethanol.

A routine drug screening is a test repeatedly performed for a member one or more times weekly over a period of time.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Written Order Requirements

Tufts Health Plan requires written orders for each drug screen a member receives. ”Standing orders” for drug screening may not exceed 30 days. Written orders must include the requested date of the drug screening, a list of tests ordered, the appropriate member diagnosis code, and the printed name and signature of the ordering provider.

Tufts Health Plan does not accept “blanket” or “standing” orders, “custom profiles” or other identical orders for all patients in a clinician’s practice. The drugs or drug classes requested in the written order must reflect the specific member’s medical history. Screenings should only test for the drugs likely to be present, based on the member's medical history or current clinical presentation. Payment will be denied as not medically necessary if the drug screening does not reflect the member's medical history. Tufts Health Plan conducts periodic audits of claims to confirm the presence of appropriate written orders for each test.

Drug Screening Reimbursement

Drug screenings, including urine drug testing, may be reimbursed for the following:

- Diagnosis of:
  - Altered mental status
  - A medical or psychiatric condition where drug toxicity may be a contributing factor
  - Fetal withdraw syndrome
  - Possible exposure of the fetus to illicit drugs taken by the mother
- Assessment of:
  - Substance use disorders, followed by treatment
  - Medication compliance

Drug screenings are not reimbursed for the following:

- Medicolegal purposes
- Employment or pre-employment purposes
- Presence of the same drug in blood and urine simultaneously
- ICLS performed in relation to drug screening for the following purposes:
  - Calculations (e.g., red cell indices, A/G ratio, creatinine clearance) and ratios calculated as part of a profile
  - Civil, criminal, administrative, or social service agency investigations, proceedings, or monitoring activities
  - Screenings not included in a plan for medical treatment documented by a contracted provider
  - Residential monitoring and sober home requests

Note: Screening performed for residential monitoring purposes, including requests signed by an in-network authorized prescriber, does not meet medical necessity requirements if performed to comply with a sober home's residential monitoring policy. Sober homes do not meet the definition of an authorized prescriber.

Referring and Testing Laboratories

When referring a specimen to a testing laboratory, the referring laboratory must send the original written order and the testing laboratory must retain the written order in its records. Both referring and testing laboratories must keep a record for at least six years from the date on which the results were reported to the authorized prescriber. Each laboratory record must contain the following information:

- Written request for laboratory services with all information required by state Medicaid regulations
- Identifying information:
  - Identification number of the specimen
  - Name of the authorized prescriber and, if applicable, the referring laboratory that submitted the specimen
  - Name and address of the testing laboratory
- Collection
  - Name or other identifier of the member from whom the specimen was collected
  - Date when the authorized prescriber or laboratory collected the specimen, location of the collection, and name of the collector
- Testing
  - Date when the laboratory received the specimen
  - Condition of unsatisfactory specimens when received (i.e., broken, leaked)
  - Date when the laboratory performed each test
  - Specific tests performed
  - Results of each test, the name and address of all persons to whom each test result is reported, and the date of reporting

Tufts Health Plan covers urine drug testing when billed with the following procedure codes only: 80305, 80306, or 803070.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Drug Testing Frequency

Effective for dates of service on or after January 1, 2019, Tufts Health Public Plans will not routinely compensate 80305-80307 (Presumptive drug testing) or G0480-G0483, G0659 (Definitive drug testing) when billed more than one combined unit per day.

Effective for dates of service on or after July 1, 2019, Tufts Health Public Plans will not routinely compensate drug testing (80299, 82570, 82575, 83992, or G0480-G0483) if billed on the same date of service as presumptive drug class screening (80305-80307) by any provider on any claim type.

DOCUMENT HISTORY

- July 2020: Updated general benefit information and billing instructions boiler plate language
- May 2019: Added edit for drug testing frequency, effective for dates of service on or after July 1, 2019
- November 2018: Added claim edits for presumptive and definitive drug testing effective for dates of service on or after January 1, 2019
- March 2018: Template updates
- November 2017: Updated to include RITogether; clarified policy, definitions and billing information.
- February 2017: Template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.