# BMS Changes to Drug Screening Codes

Prior Authorization for Drug Screening

Codes (G Codes) Beyond Service Limits

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

# Introductions

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# Objectives

This webinar is intended to:

1.  Inform WV Medicaid providers of changes related to drug screening codes including the addition of new codes.

2.  Identify procedures to be implemented by Ordering, Prescribing and Referring providers (including behavioral health providers).

3.  Indicate 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.

6.  Inform providers on use of the APS AUM Medical system to obtain prior authorizations.

# Policy Changes for G0431 & G0434

Beginning July 1, 2015, drug screening codes G0431 and G0434 will require new procedures to receive payment related to substance abuse treatment services (e.g. Suboxone).

These changes include:

- Establishment of an initial benefit limit per member per code (30 screens per member WITHOUT prior authorization);

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

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

- Confirmation testing will not be reimbursed related to substance abuse treatment (e.g. Suboxone).

The G0431HF and G0434HF should 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.

- The Bureau for Medical Services does not consider multiple individual tests to be medically necessary when a single test to screen for all drug classes is available.

- Although tests targeting individual substances are available (codes G0630-G0657), multiple panel tests, such as the G0431HF and the G0434HF, must be used when complying with WV Medicaid's Non-Methadone Assisted Treatment policy and/or testing for two or more drug substances.

# G0431HF

G0431 (drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient.

This code may only be reported if the drug screen tests are classified as CLIA high complexity tests with the following restrictions:

- G0431 may only be reported when tests are performed using instrumented systems (e.g., durable systems capable of withstanding repeated use).

- CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.

G0434 (drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes and cards, that are interpreted visually, with the assistance of a scanner or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (e.g., non-instrumented devices).

This code is also used to report any other type of drug screen testing using tests that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity tests, keeping the following points in mind:

- G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc. that are not CLIA waived.

- 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.

- Only one unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the QW modifier on claim lines.

# Policy Changes for G6030-G6057

Beginning January 1, 2015, the new HCPCS codes G6030-G6057 will be covered services for specific drugs and drug classes.

These are new codes in 2015 and require laboratory certification: toxicology.

Requirements for these codes include:

- Establishment of an initial benefit per member per code (30 screens per rolling year);

- Prior authorization required to exceed the benefit;

- Not to be utilized when G0431 & G0434 can be appropriately used to screen for multiple drug classes;

- Not to be used solely for monitoring substance abuse treatment interventions; and

- HF modifier is to be billed when the Ordering/Prescribing/Referring (ORP) indicates the screening is related to substance abuse treatment.

# Policy Changes for G6058

- This is a new code in the HCPCS in 2015 and requires laboratory certification: toxicology.

- This code is <u>not</u> to be used for substance abuse treatment and monitoring substance abuse treatment interventions.

- This code does <u>not</u> require prior authorization but is subject to retrospective record review, as is any service.

# 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 <u>referring</u> provider when making a request in the APS 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.

- Member benefit is 30 screens per year, per code.

- To exceed benefit, providers must seek prior authorization though APS Healthcare's WV AUM C3 Medical application.

- In order to access this web-based portal, please contact APS Healthcare at wvmedicalservices@apshealthcare.com or 1-800-346-8272 for registration information or register via the online portal at www.C3wv@apshealthcare.com.

# Exceeding the Benefit (continued)

- All providers requiring prior authorization for these codes must register.

- Once established, providers may direct data into the web portal or fax the prior authorization requests to 1-800-957-0344.

- 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 G0431HF and G0434HF.

# Registering Your Provider Organization with APS

- 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.apshealthcare.com](https://c3wv.apshealthcare.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) APS Healthcare'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 a 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@apshealthcare.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).

- APS will link all appropriate NPIs.

- <u>Your organization's registration is not complete until this final step has transpired.</u>

1. Go to https://providerportal.apshealthcare.com and enter your login and password.



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.

## Substance Abuse Treatment and Program Monitoring:

- 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 30 in the rolling 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 30 drug screens in a rolling 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 30 screens are indicated in a rolling 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:**

- 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.

- Seizures with an undetermined history.

- Prior authorization is ONLY required to EXCEED 30 drug screens in a rolling year.

- Prior Authorization requests to exceed 30 screens in instances where the member has used the allowable screenings 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.

**Drug Screening for Pain Management Programs:**

- 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.

# Medical Necessity-Pain Management (continued)

Justification for medical necessity to exceed 30 drug screens in a rolling 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 30 screens are indicated in a rolling 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).

- 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.

# 1-800-346-8272

## Medical Services General Voicemail:

## ext. 7506954

## Medical Services email:

## [wvmedicalservices@apshealthcare.com](mailto:wvmedicalservices@apshealthcare.com)

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**General APS Information:  www.apshealthcare.com/wv**

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

**Website for Submitting Authorizations:  https://providerportal.apshealthcare.com**

**Website for Org Managers To Add/Modify Users:  https://c3wv.apshealthcare.com**

**For Clinical Support, to Request Smart Sheets, or for Fax Forms, Contact WVMI:**
**1-800-642-8686  or www.wvmi.org**

**For BH Requests Contact APS BH Unit:  1-800-378-0284  (LOCAL 304.346.6732) or**
**APS BH Fax: 1-866-473-2354**

A Suboxone Provider is seeing a patient for behavioral health treatment. The treatment plan calls for screenings 2X per month for code G0431.

- Do I need PA for the independent lab to do theses screenings?

- Do I need to put anything specific on the order?

- What if emergency screens are needed?

- What if I am associated with a BH Center with a CLIA Waived lab?

- What if different screenings are added to the plan of care?

- What if I become aware the member is seeing other providers who are ordering screens?

A patient is being seen at a Pain Management Clinic. The treatment plan calls for screenings at each monthly appointment (about 12 per year) for G6045 Dihydrocodeinone.

- Do I need PA for the independent lab to do theses screenings?
- Do I need to put anything specific on the order?
- What if emergency screens are needed?
- What if different screenings are added to the plan of care?
- What if I become aware the member is seeing other providers who are ordering screens?
- What if the member enters SA treatment based on positive screening results?

I receive an order for a member I have screened frequently. How do I know if there is a PA in place?

- How can I check if a PA may be needed?

- Based on the testing ordered we think the member may be receiving SA Treatment but there is no HF modifier indicated. What do I do? How should the claim be billed?

- We have a claim denied for a G code for no prior authorization. What do we do?

# Questions?