CBR201706:
Drugs of Abuse Testing
Webinar Questions & Answers
August 23, 2017
3:00 p.m. ET

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INTRODUCTION

These questions are excerpted from the CBR201706: Drugs of Abuse Testing webinar presented on Wednesday, August 23, 2017. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides or select a specific section of the webinar. All of these options are available from the CBR website page titled [CBR201706 Webinar](https://www.cbrinfo.net/cbr201706-webinar).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled [Medicare Coverage Database](https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: [Review Contractor Directory – InteractiveMap](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
Q. How can I find out if CBRs were sent to any providers in our practice?
A. Letters have already been disseminated to all recipients of CBR201706. If the providers in your practice did not receive CBRs, then it is likely that reports were not created for them. If you have additional questions about CBR201706, please contact the CBR Support Help Desk at 1-800-771-4430 or by email at CBRsupport@eglobaltech.com.

Q. Is this CBR specific to South Carolina, and is CMS cracking down on substance abuse?
A. CBR201706 was disseminated to providers nationwide, and is not indicative of any wrongdoing by any of the recipients. What it does is allow an individual provider to compare his/her billing patterns to those of his/her peers around the nation. Please remember that this is a national report that CMS has reviewed and approved. We have been tasked with researching the Medicare resources and references and deciphering the data to inform and educate providers about correct billing guidelines as it pertains to drugs of abuse testing.

Q. How can I get continuing education units (CEUs) for this webinar?
A. At this time, CMS does not offer CEUs for attending our CBR webinar; however, there are some professional organizations that may offer credit. For more information about CEUs, please select the following web link: Continuing Education Credits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html).

Q. Does receiving a CBR mean I will be audited?
A. CBR201706 is for informational purposes and is not considered an audit. The CBR team does not perform any audits of claims, nor do we have access to medical records needed for audits; however, we do have resources on the CBR website that may be helpful with setting up a self-audit process. If you would like to view this information, select the following web link: Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).
Q. Can anyone access my CBR letter?
A. Each CBR is private and is sent only to the individual provider. It is not shared with the general public. Although each CBR is not available to anyone other than the provider, CMS is made aware of the recipients, and the data used may be shared with CMS at their request. If you have additional questions about CBR201706, please contact the CBR Support Help Desk at 1-800-771-4430 or by email at CBRsupport@eglobaltech.com.

CLINICAL AND BILLING

Q. Does this CBR address standards of practice or does it only compare costs associated with testing?
A. CBR201706 addresses Medicare policy and guidelines on Controlled Substance Monitoring and Drugs of Abuse Testing. For your convenience, we have compiled frequently asked questions (FAQs) and references, which can be accessed from the following web links:

- [CBR201706 Recommended Links](https://www.cbrinfo.net/cbr201706-recommended-links)
- [CBR201706 Drugs of Abuse Testing FAQs](https://www.cbrinfo.net/cbr201706-faqs)

Q. Our patients’ medical carriers are forwarding our drug abuse testing claims to the mental health carriers; however, the mental health carriers are denying the claims stating that services should be covered by medical carriers. What should we do?
A. Questions about specific claims should be addressed with the MAC for your region. To locate your MAC, select the following web link: [Review Contractor Directory – InteractiveMap](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Q. Should a new order be placed every time a drug test is needed? Are standing orders not accepted?
A. Based on the definition of standing orders and the circumstances of each patient, standing orders may be acceptable for certain patients; therefore, a new order may not be necessary
each time a patient needs drug testing. Palmetto GBA LCD L35724 defines a **standing order** as a “Test request for a specific patient representing repetitive testing to monitor a condition or disease for a **limited number** of sequential visits; individualized orders for certain patients for pre-determined tests based on historical use, risk and community trend patient profiles.”

Please contact your local MAC to ensure that you are following the guidelines for your region.

Additional information can be found at the following link: [Palmetto GBA LCD L35724](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LcdId=35724&ver=35&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAACAAAAAAA%3d%3d&).

**Q. I now understand presumptive on-site testing would be billed with CPT® codes 80305-80307, and if sent for a definitive test, HCPCS codes G0480-G0659 (dependent on number of class) would be appropriate. Do I understand correctly?**

A. Effective January 1, 2017, Medicare added three new presumptive CPT® codes (80305, 80306, 80307) and one new definitive HCPCS code (G0659), and deleted HCPCS codes G0477, G0478, and G0479; however, we did not review any claims data for the new codes. Our CBR covered HCPCS codes G0477 – G0483 only. If you have questions or need assistance with billing and coding claims, please contact your MAC. For additional information, see the [CPT® Professional Edition Manual](https://commerce.ama-assn.org/store/) and the [Professional Edition HCPCS Level II Manual](https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Part%20B~eServices%20Portal~eCBR~Controlled%20Substances%20and%20Drugs%20of%20Abuse%20Screenings), which are available from the American Medical Association. You may also benefit from information located on the Palmetto GBA website. The web links below will take you directly to these websites:

- [American Medical Association (AMA) Store](https://commerce.ama-assn.org/store/)
- [Controlled Substances and Drugs of Abuse Screenings](https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Part%20B~eServices%20Portal~eCBR~Controlled%20Substances%20and%20Drugs%20of%20Abuse%20Screenings)

**Q. How can we monitor the levels of patients on chronic opioid therapy (COT) to be sure they are not using drugs with just one test per week? This seems like such low limits for urine drug testing (UDT).**

A. The CBR team is aware that practice patterns may differ for various reasons. Some practitioners have sub-specialties or distinctive focuses that aren’t apparent in claims data. According to Chapter 12 of the [Medicare Claims Processing Manual](https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Part%20B~eServices%20Portal~eCBR~Controlled%20Substances%20and%20Drugs%20of%20Abuse%20Screenings), “Medical necessity of a
service is the overarching criterion for payment in addition to the individual requirements.” Additionally, Palmetto GBA LCD L35724 states “Definitive UDT may be reasonable and necessary based on patient specific indications, including historical use, medication response, and clinical assessment, when accurate results are necessary to make clinical decisions. The clinician’s rationale for the definitive UDT and the tests ordered must be documented in the patient’s medical record.” Please contact your local MAC to ensure that you are following the guidelines for your region. To review more details, select the following web links:

- **Palmetto GBA LCD L35724** ([https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35724&ver=35&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=qAAAACAAAAAAA%3d%3d&])

**Q. What are the rules for performing a definitive test on a UDT done in the office on a Group C patient?**

A. Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment. They should be documented by the clinician in the patient’s medical record. Frequency of testing beyond the baseline presumptive UDT must be based on individual patient needs. Direct to definitive UDT without a presumptive UDT may be reasonable and necessary, when individualized for a particular patient. To see the guidelines for your region, select the link to your MAC below:

<table>
<thead>
<tr>
<th>Medicare Administrative Contractor (MAC)</th>
<th>Current LCD</th>
<th>Current LCA</th>
<th>Retired</th>
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<tbody>
<tr>
<td>CGS Administrators, LLC</td>
<td>L36029</td>
<td>A54314</td>
<td>A54315</td>
</tr>
<tr>
<td>First Coast Service Options</td>
<td>L36393</td>
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<td>N/A</td>
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<tr>
<td>National Government Services</td>
<td>L36037</td>
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<tr>
<td>Noridian Healthcare Solutions</td>
<td>L36668, L36707</td>
<td>A55001, A54998, A55030 A55031</td>
<td>N/A</td>
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<tr>
<td>Novitas Solutions</td>
<td>L35006</td>
<td>N/A</td>
<td>L32050</td>
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<tr>
<td>Palmetto GBA</td>
<td>L35724</td>
<td>A54799, A53953</td>
<td>L35105, A53952</td>
</tr>
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**Q. Where can I find guidelines on the appropriate use of G0659? The way we understand G0659 is a definitive method but would be coded as presumptive.**

A. Medicare recognizes five definitive HCPCS codes (G0480, G0481, G0482, G0483, and G0659) for drugs of abuse testing. These codes are based on the number of drug classes tested, not on
the cumulative number of drugs/metabolites tested. You can find additional guidance on the appropriate use of HCPCS code G0659 and the other definitive codes on the Palmetto GBA MolDX website at the web link titled 2017 Controlled Substance Monitoring and Drugs of Abuse Coding and Billing Guidelines (https://www.palmettogba.com/Palmetto/Moldx.nsf/docsCat/MolDx~Browse%20By%20Topic~Covered%20Tests~2017%20Controlled%20Substance%20Monitoring%20and%20Drugs%20of%20Abuse%20Coding%20and%20Billing%20Guidelines%20(M00128%20V5)?open&Expand=1).

Q. How do we determine the referring provider? We get referrals from providers such as surgeons who are not authorized for these CPT® codes.

A. According to the Medicare Learning Network® publication, “The ordering/referring provider must meet these three basic requirements:

1. Have an individual National Provider Identifier (NPI)
   NOTE: Organizational NPIs do not qualify and cannot order/refer
2. Be enrolled in Medicare in either an ‘approved’ or an ‘opt-out’ status
3. Be of a specialty type that is eligible to order/refer”


Q. Exactly what is considered low, moderate, and high risk?

A. Patients who are receiving COT are categorized as low, moderate and high risk. According to CGS Administrators LCD L36029, “Testing must be based on clinician’s documented medical necessity and reviewed by the clinician in the management of prescribing/renewing a controlled substance. Any additional definitive UDT beyond recommendations above must be justified by the clinician in the medical record in situations in which changes in prescribed medications may be needed, such as:

- Patient response to prescribed medication suddenly changes
- Patient side effect profile changes
- To assess for possible drug-drug interactions
- Sudden change in patient’s medical condition
- Patient admits to use of illicit or non-prescribed controlled substance.”
Please contact your local MAC to ensure that you are following the guidelines for your region. For more information, select the following web link: [CGS Administrators LCD L36029](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36029&ver=15&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAA%3d%3d&).

Q. **How often should a UDT be done on a chronic pain management patient without abuse?**

A. The frequency of testing must be based on a complete clinical assessment of the individual’s risk potential for abuse and diversion using a validated risk assessment interview or questionnaire and should include the patient’s response to prescribed medications and the side effects of medications.

Q. **Do presumptive tests have different cut-off values than definitive tests?**

A. The cut-off level is established on the basis of the reliability and accuracy of the test. It also is based on the test’s ability to detect a drug or metabolite for a reasonable period after a drug has been ingested. Practitioners should obtain the cut-off concentrations used in the Point Of Care Tests (POCTs) and those used by the laboratory testing their patients’ specimens. Most laboratories and POCTs use the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines. More information can be found at this web link: [Clinical Drug Testing in Primary Care](https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf).

Q. **What if a provider does not want to perform presumptive testing? Can definitive be ordered based on the known limitations of presumptive testing?**

A. There may be times when definitive testing may be appropriate without first performing presumptive testing. Palmetto GBA LCD L35724 states: “Direct to definitive UDT without a presumptive UDT is reasonable and necessary, when individualized for a particular patient. Definitive testing to confirm a negative presumptive UDT result, upon the order of the clinician, is reasonable and necessary in the following circumstances:

   a. The result is inconsistent with a patient’s self-report, presentation, medical history, or current prescribed medication plan (should be present in the sample);

   b. Following a review of clinical findings, the clinician suspects use of a substance that is inadequately detected or not detected by a presumptive UDT; or

   c. To rule out an error as the cause of a negative presumptive UDT result.
Please contact your local MAC to ensure that you are following the guidelines for your region. For more information, select the following web link: [Palmetto GBA LCD L35724](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35724&ver=35&CovSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLocUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&).

Q. **How does this CBR help an ancillary lab?**

A. This CBR is intended to educate providers about correct billing for UDT. If you need additional guidance on covered and non-covered services for specific claims, please contact the MAC for your region. For contact information, select this web link: [Review Contractor Directory – InteractiveMap](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**REPORT SPECIFICS**

Q. **Please define peers. Are specialists only compared with other physicians in their specialty?**

A. Specialty groups were not considered for this CBR. Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all referring Medicare providers practicing in the individual provider’s state who were indicated as the referring NPI on claims with allowed charges for the procedure codes included in this study
- The **national** peer group is defined as all referring Medicare providers in the nation who were indicated as the referring NPI on claims with allowed charges for the procedure codes included in this study

Q. **Are these 24,000 tests for 145 patients the same as too many services per visit?**

A. You are referring to an article published by *Reuters Health News*. The statistic that they calculated could be comparable to the **Average Services per Beneficiary** measurement shown in Table 6 of the CBR. **Average Services per Visit**, displayed in Table 7 of CBR201706, provides the average number of tests billed on a specific date of service for a beneficiary.
Q. If you have a pain clinic and see 50 patients a day, how many patients would test negative in the next four months according to your statistical research?

A. Our analysis does not include the results of that test, as only claims data is reviewed. If you have additional questions or concerns about CBR201706, please contact the CBR Support Help Desk at 1-800-771-4430 or by email at CBRsupport@eglobaltech.com.

Q. Are these calculations based on providers that direct bill, or does it also include providers that ordered tests performed outside reference labs?

A. Claims data was pulled for all Part B Medicare providers. The calculations include all claims where the provider was listed as the Referring Provider, even if the rendering provider was different.

Q. What is included in the "services" in table 7?

A. Total Services in Table 7 includes all allowed services for the procedure codes studied in this CBR.

Q. How can you have average services per beneficiary low to normal but average services per visit high?

A. These two statistics measure different concepts. The average services per beneficiary considers all testing performed on the beneficiary over the calendar year 2016. The average services per visit is the number of tests performed on a beneficiary on a specific date of service or visit. If your average services per visit is high, then this means that in comparison to your peers, you order more tests per visit on your beneficiaries; however, if your average services per beneficiary is low to normal, then over the course of the year, the total number of tests ordered for a beneficiary is comparable to your peers.

Q. Was there a cross-reference of over-use/frequency that included Place of Service (POS)? That is, was there an inordinate rate of referring clinicians and testing providers having the same POS?

A. This analysis was not done as part of this CBR.
REFERENCES

CBR201706 Webinar (https://www.cbrinfo.net/cbr201706-webinar)


Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)

CBR201706 Recommended Links (https://www.cbrinfo.net/cbr201706-recommended-links)

CBR201706 Drugs of Abuse Testing FAQs (https://www.cbrinfo.net/cbr201706-faqs)

Palmetto GBA LCD L35724 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35724&ver=35&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAAAAA%3d%3d&)

American Medical Association (AMA) Store (https://commerce.ama-assn.org/store/)

Controlled Substances and Drugs of Abuse Screenings (https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Part%20B~eServices%20Portal~eCBR~Controlled%20Substances%20and%20Drugs%20of%20Abuse%20Screenings)


CGS Administrators LCD L36029 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36029&ver=15&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAA%3d%3d&)

Clinical Drug Testing in Primary Care (https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf)