<table>
<tr><td>  </td><td>Reimbursement Policy</td></tr>
<tr><td colspan="2">Subject: Drug Screen Testing</td></tr>
<tr><td>Effective Date:
10/01/19</td><td>Committee Approval Obtained:
03/15/19</td><td>Section:
Laboratory</td></tr>
<tr><td colspan="3">*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****</td></tr>
<tr><td colspan="3">These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:
• Reject or deny the claim.
• Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.</td></tr>
<tr><td>Policy</td><td colspan="2">Amerigroup allows reimbursement for properly ordered presumptive and definitive drug screening services unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.</td></tr>
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	When definitive drug testing is submitted on the same date of service as presumptive drug testing by instrumented chemistry analyzers for the same member by an independent clinical laboratory with a place of service 81, Amerigroup allows separate reimbursement for the definitive drug testing of 1-7 drug classes. Definitive drug testing for eight or more drug classes will not be separately reimbursed when performed on the same date of service as presumptive testing. Definitive drug testing may be done to confirm a negative presumptive test or to identify substances when there is no presumptive test available. Provider's documentation and member's medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test. When a reference lab (POS = 81) performs both presumptive and definitive tests on the same date of service, records should reflect that the ordering/treating provider issued a subsequent order for definitive testing based on the results of the presumptive tests. **Nonreimbursable** Amerigroup does not allow reimbursement for employment/pre-employment drug screening.
Exemptions	• Amerigroup Community Care in Maryland does not reimburse providers for drug screening services. • Amerigroup Texas, Inc. and Amerigroup Insurance Company allows separate reimbursement for definitive testing when billed on the same day as presumptive drug testing. The HCPCS code identifying the specific drug class range is required. • Medicare Advantage allows, in certain circumstances, definitive drug testing by reference laboratories to be separately reimbursed when reported on the same date of service as presumptive drug testing.
History	• Initial approval 03/15/19 and effective date 10/01/19
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • Optum, 2018

Definitions	• **Presumptive Drug Class Screening:** screening used to identify possible use or non-use of a drug or drug class (presumptive drug screening may or may not be followed by definitive drug class screening); presumptive drug testing is either done on a random basis or for cause, the latter which should be documented in the medical record • **Definitive Drug Class Screening:** screening which includes qualitative (drug is present or absent), semi-quantitative or quantitative (measured) tests to identify possible use or non-use of a specific drug; typically therapeutic drug assay procedures are quantitative tests • **General Reimbursement Policy Definitions**
Related Policies	• None
Related Materials	• None