Connecticut Medical Assistance Program PB 2014-96
Policy Transmittal 2014-41 December 2014

Effective Date: January 1, 2015
Roderick L. Bremby, Commissioner Contact: Edith Atwerebour @ 860-424-5671

TO: General Hospitals, Independent Laboratories, Physicians, Nurse Practitioners, Nurse-Midwives, Podiatrists and Optometrists
RE: Consolidated Laboratory Fee Schedule Update

Effective for dates of service January 1, 2015 and forward, the Department of Social Services will incorporate the 2015 HCPCS changes (additions, deletions and description changes) to its Consolidated Laboratory Fee Schedule. The Department is making these changes to ensure that its laboratory fee schedule remains compliant with the Health Insurance Portability and Accountability Act. These changes apply to the HUSKY Health programs which include HUSKY A, HUSKY B, HUSKY C and HUSKY D. Limits and cost sharing for HUSKY B clients remain as outlined in the benefit descriptions of these programs.

DRUG TESTING GUIDELINES

The American Medical Association and Center for Medicare and Medicaid Services (CMS) have made significant changes to the drug testing HCPCS codes available for 2015. Codes for many of the drug screens and drug assays in the 80100 to 84127 range are being discontinued for 2015. Medicare has decided to delay adoption of the new CPT codes 80300 - 80377 and instead will utilize the G codes on an interim basis starting in January 2015, while they finalize appropriate pricing and editing for the new codes. It is anticipated that Medicare will adopt the new CPT codes in 2016. DSS will also delay implementation of these codes until 2016.

The following Level II HCPCS code is being retained for the use of drug testing:

- G0431-Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter.

The following Level II HCPCS code is being added for the use of drug testing, effective January 2015 and forward:

- G0434-Drug screen, other than chromatographic any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter.

Fee Schedule Modifications

In addition, temporary drug assay and chemistry codes (G6030-G6057) are being added as direct replacements for the drug assay and chemistry tests being discontinued.

The Department of Social Services will mirror Medicare coverage policy on drug testing codes as follows:

- To remain HIPAA-compliant, deleted codes within the 80100 through 84127 range will be discontinued as payable codes;
- G0431 will be retained as an active code;
- G0434 will be added to the consolidated lab fee schedule;
- Temporary codes G6030 through G6057 will be added to the fee schedule as direct one-for-one replacements of the drug assay and chemistry tests being discontinued; and
- G6058 will be added to replace 80102.

Additional Guidelines

- Clinical decision making for urine drug testing must be supported by documentation in the medical record.
- Testing should focus on detecting the specific drug(s) of concern based on the member's medical history.
- Frequency and choice of testing should be based on medical necessity and a complete clinical assessment of the individual member's risk potential for abuse and diversion.
- A presumptive test may be followed by a definitive test, in order to specifically identify drugs or metabolites. Such tests should be based on the member's presentation and history and only include what is needed for safe patient management.
- Physician orders for drug testing must be tailored to the individual member's medical needs and documented in the medical record.
- Standing orders must be signed and dated by the ordering provider no more than 60 days prior to the date of specimen collection. Standing orders must contain the frequency of laboratory testing.

- The Department will not make separate payment for the testing of adulterants or specimen validity. There are a number of multi-panel, CLIA Waived urine drug test kits available which test for pH, specific gravity and oxidants to determine if the specimen has been adulterated.

- The Department does not consider the following as medically necessary:
  - Tests performed by an in-house laboratory and independent laboratory for the same test on the same date of service.
  - Testing for residential monitoring.
  - Specimen validity testing, which is considered a quality measure.
  - Urine drug testing ordered by third parties, such as schools, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.

MOLECULAR PATHOLOGY CODES

The Department is also adding new molecular pathology codes 81246, 81288, 81313, 81410-81471 and 81519 to the Laboratory fee schedule. A majority of the molecular pathology codes will require prior authorization (PA). Please check the fee schedule to determine whether the service being ordered or provided requires PA. Prior authorization must be requested prior to the date of service; services will not be authorized retroactively. Providers must submit an outpatient PA request to CHNCT and obtain approval for the services prior to providing them to HUSKYHealth members and billing the Department. Please refer to the HUSKYHealth Web site at www.huskyhealthct.org, under the Provider section of the "Benefits and Authorizations" page for specific PA information.

It is anticipated that CMS will not establish a fee for these new codes during the first year of activation so all have been set to manually price. If Medicare does establish a fee for any code, DSS will also establish a fee for that code. Pricing will be retroactive to January 1, 2015. Providers will be notified that final pricing is available via a Banner Message on their remittance advice and an Important Message on the Home page of the www.ctssmap.com Web site.

EXISTING CODES

Effective January 1, 2015 the Department has established revised fees for many codes on its Consolidated Laboratory Fee Schedule to more closely reflect pricing in other Medicaid programs and the commercial sector. Please review the fee schedule carefully for the codes typically provided and billed.

Please note that pricing of ATP codes is also being revised. However, due to required system changes, the new fees for ATPs will be effective February 1, 2015 as opposed to January 1, 2015.

ACCESSING THE FEE SCHEDULE

The updated laboratory fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Web site: www.ctdssmap.com. From this Web site, go to "Provider", then to "Provider Fee Schedule Download", then to the "Lab" fee schedule. DSS now posts fee schedules in only the CSV (Comma separated value) format. To access the CSV file press the control key while clicking the CSV link, then select "Open". The new CSV version will be posted the last week in December.

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions: Holders of the Connecticut Medical Assistance Program Provider Manual should replace their existing fee schedule with the new schedule. Policy transmittals can also be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by HP.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Edith Atwerebour, Policy Consultant, (860) 424-5671.

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