

Urine Drug Testing

Policy

Mass General Brigham Health Plan reimburses medically necessary Urine Drug Testing (UDT) to detect the parent drug and/or its metabolite(s) to demonstrate use of prescription medications and illegal substances of concern for medical treatment purposes.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to [Coding Provider Payment Guidelines](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Please reference Mass General Brigham Health Plan Medical Policy for [Urine Drug Screening and Testing](#).

Mass General Brigham Health Plan's reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

MassHealth members:

[MassHealth Independent Clinical Laboratory Manual 130 CMR 401.411](#)

Commercial and Medicare Advantage members:

[CMS Local Coverage Determination \(LCD\) - Urine Drug Testing \(L36037\)](#)

Mass General Brigham Health Plan Reimburses

- CPT codes 80305-80307; 1 unit per date of service
- HCPCS codes G0480-G0483; 1 unit per date of service

Mass General Brigham Health Plan Does Not Reimburse

- Assessment for substances not established on the initial targeted screening
- Definitive Drug Class code range 80320-80377
- Laboratory services to any provider without a valid CLIA certificate on file
- Laboratory services to any provider who holds a Certification of Registration pending survey and compliance with CLIA regulations
- Reports of clinical information derived from the result of laboratory data that is mathematically calculated which are considered part of the test procedure and therefore not a separately reportable service, including confirmatory tests
- Routine specimen collection and preparation for the purpose of clinical laboratory analysis
- Services billed with an unassigned place of service code
- UDT services billed with the following diagnosis codes:
 - Z01.812 – Encounter for preprocedural laboratory examination
 - Z01.89 – Encounter for other specified special examinations

Mass General Brigham Health Plan does not reimburse UDT for non-medical purposes and/or third-party requests. Please refer to member materials for additional documentation. Excluded services include but are not limited to:

- Administrative or social service agency investigations, proceedings, or monitoring activities
- Condition for pre-employment or required compliance for continuation of employment

Provider Payment Guidelines

- Court-ordered drug testing
- Mandated drug testing for residential monitoring, including sober house requirements
- Requirement for school including but not limited to: enrollment, compliance, or participation in school or community athletic activities, programs, or other extracurricular activities
- Testing for parents involved in divorce/child custody cases

Procedure Codes

Note: This list of codes may not be all-inclusive

Code	Descriptor	Comments
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service	<ul style="list-style-type: none"> • 1 unit of 80305 or 80306 or 80307 will be reimbursed per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	<ul style="list-style-type: none"> • 1 unit of 80305 or 80306 or 80307 will be reimbursed per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service	<ul style="list-style-type: none"> • 1 unit of 80305 or 80306 or 80307 will be reimbursed per date of service
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol	<ul style="list-style-type: none"> • 1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service

Provider Payment Guidelines

Code	Descriptor	Comments
	dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed	
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed	<ul style="list-style-type: none"> 1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed	<ul style="list-style-type: none"> 1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed	<ul style="list-style-type: none"> 1 unit of G0480 or G0481 or G0482 or G0483 will be reimbursed per date of service
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	<ul style="list-style-type: none"> Not payable; bill G0480, G0481, G0482, or G0483

Provider Payment Guidelines

Code	Descriptor	Comments
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	<ul style="list-style-type: none"> Not payable; bill G0480, G0481, G0482, or G0483
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	<ul style="list-style-type: none"> Not payable; bill G0480, G0481, G0482, or G0483

Provider Payment Guidelines and Documentation

- Include the specific diagnosis code supporting the medical necessity of the UDT service
- When reporting services, report only one of the three presumptive CPT codes (80305-80307), per day. Similarly, you may report only one of the four definitive G codes (G0480-G0483) per day.
- Mass General Brigham Health Plan will deny Urine Drug Testing for dates of service exceeding 20 within a benefit period; please refer to the [Urine Drug Screening and Testing Medical Policy](#)
- Urine Drug Testing should not routinely include a panel of all drugs of abuse. The test ordered should be focused on detecting the specific drugs of concern. Frequency of testing should be at the lowest level to detect presence of drugs bearing in mind the pharmacodynamics for which the drug is being screened.
 - A full panel screen should be considered when the patient’s observed behavior suggests the use of a drug(s) not identified on the initial screening. Medical documentation must support the behavioral observation and medical justification for conducting a full panel screening. Subsequent testing should be conducted for those substances identified on the patient’s initial profile.
- Do not report Therapeutic Assays (CPT 80150-80299) for drug classes being tested as part of the drug screen service
- CPT codes 80305 and/or 80306 are eligible for reporting in the physician office setting. CPT code 80307 is eligible for reporting in free-standing and hospital-based clinical laboratories only.
- Reference the [Clinical Laboratory Improvement Amendments \(CLIA\) Categorization of Tests](#) for additional information

Documentation Requirements

Prior to performing drug screening and any associated confirmatory testing, the servicing provider must secure from the ordering provider a written request specific to the member. This request must be legibly signed and dated by the ordering provider. A rubber stamp is not an acceptable form of signature. The written request must specify the following:

Provider Payment Guidelines

- Drugs to be screened; *and*
- Whether adulteration testing is requested; *and*
- Whether confirmatory testing of positive screening results is requested; *and*
- The specific diagnosis for which the testing is requested

Requests for laboratory services must be written and include the following information:

- date of the request;
- name or any other means of identifying the member to be tested;
- name and address of the authorized prescriber;
- name of the specific laboratory tests to be performed;
- frequency for performing each laboratory test (applicable to standing orders only);
- duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only); and
- A statement by the authorized prescriber that such testing is required as part of the member's medical or drug treatment plan (applicable to standing orders only)
- Standing orders are not accepted

If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. The testing laboratory must maintain such request in its records in accordance with 130 CMR 401.416(A).

Both referring and testing laboratories must keep a record of each written request for laboratory services, each specimen, and each test result for at least **six years** from the date on which the results were reported to the authorized prescriber.

The laboratory record must contain the following information:

- condition of unsatisfactory specimens when received (i.e. broken, leaked);
- date on which the specimen was collected by the authorized prescriber or laboratory, the location of the collection, and the name of the collector;
- date on which the specimen was received in the laboratory;
- date or dates on which each test was performed;
- identification number of the specimen;
- name and address of the laboratory to which the specimen was referred, if applicable
- name or any other means of identifying the person from whom the specimen was taken;
- name of the authorized prescriber and, if applicable, the referring laboratory that submitted the specimen;

- results of each test, the name and address of all persons to whom each test result is reported, and the date of reporting;
- specific tests performed; and
- written request for laboratory services with all information required by 401.146

Related Policies

[Urine Drug Screening and Testing Medical Policy](#)

References

American Medical Association, *CPT current year, Professional Edition*

American Medical Association, *HCPCS Level II, current year, Professional Edition*

[MassHealth Independent Clinical Laboratory Manual 130 CMR 401.411](#)

[CMS CLIA Categorization of Tests](#)

[CMS Local Coverage Determination \(LCD\) - Urine Drug Testing \(L36037\)](#)

Publication History

Topic: Urine Drug Testing	Owner: Network Management
January 18, 2011	<i>Original documentation</i>
December 1, 2012	<i>Updated limitations, codes, provider payment guidelines and documentation, and references</i>
September 1, 2013	<i>Removal of limitations effective 12/1/2012</i>
May 1, 2016	<i>Updated CPT/HCPCS reimbursable codes and limitations, ICD-10 diagnosis codes added, removed definition</i>
August 11, 2016	<i>Definitive drug codes clarification</i>
January 1, 2017	<i>Removed deleted codes G0477-G0479; added new codes 80305-80307</i>
August 1, 2018	<i>Annual review; addition of clarity around documentation guidelines; updates to certain links</i>
January 1, 2019	<i>Document restructure; codes, code descriptor and references updated</i>
January 1, 2023	<i>Document rebrand; updated references</i>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.