# Pain Management Coding Alert

## Lab Testing: Say Goodbye to G0431 and G0434 for Drug Test Coding

**Be sure you're prepared for multiple changes.**

2015 was a year full of comments regarding the clinical lab fee schedule for 2016. Although CMS published several proposals, they delayed pricing in order to allow for input and further consideration. Here's where things stand with the drug testing codes you probably report most often.

**Trace Back How Things Have Evolved**

Current coding for testing for drugs of abuse relies on a structure of "screening" (known as "presumptive" testing) followed by "confirmation" to confirm the results of the screening tests and quantitative or "definitive" testing that identifies the specific drug and quantity in the patient. In the 2015 Clinical Laboratory Fee Schedule (CLFS) final determinations file, CMS decided to not pay for new CPT® codes related to testing for drugs of abuse. The group cited concern over the potential for overpayment when billing for each individual drug test rather than a single code that pays the same amount regardless of the number of drugs that are being tested.

As a stop-gap, CMS maintained the 2014 status quo for 2015 by creating alphanumeric G codes to replace the 2014 CPT® codes that were deleted for 2015. You reported the new G codes as you had the previous, corresponding codes.

In July 2015, CMS proposed to delete all current drug testing G codes and create a single G code for presumptive testing and a single G code for definitive testing. CMS released the 2016 CLFS Preliminary Determinations file in September 2016 and again proposed to delete all current drug testing G codes and continue to not recognize the new CPT® codes for drug testing that AMA introduced in 2014. More changes to the original recommendations and led to what you'll be following in Calendar Year (CY) 2016.

**Get Familiar With the CMS Stance for 2016**

The final CLFS rule for this year covers seven important areas:

1. Delete codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method [e.g., immunoassay, enzyme assay], per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter)
2. Delete HCPCS codes G6030 through G6058 for tests of specific drugs ranging from acetaminophen or nicotine to opiates or alcohol
3. Continue to not recognize AMA CPT® codes 80300 through 80377 for presumptive and definitive drug screening/testing procedures
4. Create three G codes for presumptive testing. You can bill only one of these codes per day.
5. Create four G codes for definitive testing. Again, you can bill only one of these codes per day.
6. For definitive testing, the unit used to determine the appropriate G code is "drug class." Each drug class may be used only once per day in determining the appropriate definitive G code to bill.
7. Drug classes are consistent with their usage in the AMA's CPT® Manual. Check your CPT® Manual for examples of individual drugs within each class.

The three new G codes for presumptive testing are as follows:

- G0477 – Drug tests(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
- G0478 – ... 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
- G0479 – ... any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.

**Take note:** The presumptive code descriptors are clear that you can bill the code with a maximum of 1 unit of service (don't miss the "any number of drug classes" in the descriptors). In addition, all three descriptors include the verbiage that the testing includes validity testing if performed. What this means is that not only for Medicare but any payer that adopts these codes, it is very clear that validity testing should not be separately billed.

The new definitive drug testing codes you'll begin using this year are:

- 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 dehydrogenase]); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
- G0481 – ... per day, 8-14 drug class(es), including metabolite(s) if performed
- G0482 – ... per day, 15-21 drug class(es), including metabolite(s) if performed
- G0483 – ... per day, 22 or more drug class(es), including metabolite(s) if performed.

"A huge change in the definitive code set is that only one code will be billed to represent all definitive testing," says **Marvel Hammer, RN, CPC, CCS-P, ACS-PM, CPCO,** owner of MJH Consulting in Denver, Co. "The descriptor also clearly states that definitive testing does not include immunoassay and enzyme methods – which is a very similar stance/verbiage as CPT®. In addition, similar to the presumptive codes, the single definitive code would be billed with a maximum of 1 unit of service."