Medical Policy

Drug Screening/Testing for Drugs of Abuse and/or Controlled Substances

Policy Number: OCA 3.98  
Version Number: 10  
Version Effective Date: 01/01/17

Product Applicability

<table>
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<tr>
<th>All Plan+ Products</th>
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<tr>
<td>Well Sense Health Plan</td>
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<tr>
<td>New Hampshire Medicaid</td>
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<tr>
<td>NH Health Protection Program</td>
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<td>Senior Care Options ◊</td>
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</tbody>
</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers drug screening/testing (DS/T) of specimens from any source for the detection of Drugs of Abuse or Controlled Substances and/or their metabolites to be medically necessary, subject to the prior authorization criteria listed below in the Medical Policy Statement section and Limitations section. Prior authorization guidelines are specified by code in the Applicable Coding section. Refer to Plan’s applicable reimbursement policy for important information regarding payment for DS/T (i.e., Reimbursement Guidelines - Drug Screening/Testing for Drugs of Abuse and/or Controlled Substances, policy number 4.94, for BMC HealthNet Plan members and Reimbursement Guidelines – Drug Screening/Testing: Drugs of Abuse, policy number WS 4.94, for Well Sense Health Plan members).

Drug Testing/Testing for Drugs of Abuse and/or Controlled Substances

+ Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
**Description of Item or Service**

**Drug Screening/Testing (DS/T):** Chemical analysis of specimens from any source to determine the presence or absence of specified parent drugs or their metabolites.

**Medical Policy Statement**

The Plan considers presumptive drug screening/testing (DS/T) for the purpose of monitoring compliance with a prescribed Controlled Substance medication regimen and/or to detect known or suspected Drugs of Abuse or illicitly used Controlled Substances to be medically necessary when Plan criteria are met and documented in the member’s medical record. The Plan considers primary definitive DS/T for the purpose of monitoring compliance with a prescribed Controlled Substance medication regimen and/or to detect known or suspected Drugs of Abuse or illicitly used Controlled Substances to be NOT medically necessary. Definitive testing of positive presumptive testing results or, as it relates to prescribed Controlled Substances, unexpectedly negative results is considered medically necessary. DS/T performed at set intervals without consideration of the specific member’s history and/or clinical evaluation is considered NOT medically necessary. The frequency of testing should be limited to the lowest level necessary to detect the Drug(s) of Abuse or Controlled Substances of concern and effectively manage the patient’s health. Similarly, screening/testing should be focused on detecting known Drugs of Abuse or Controlled Substances or specific drug(s) of concern.

A. Plan prior authorization is NOT required for the **first 30 encounters for a member per calendar year** for presumptive DS/T for Drugs of Abuse or Controlled Substances ordered by an Authorized Provider, regardless of setting. (See the Definitions section for definitions of presumptive Drug Screening/Testing and an Authorized Provider.)

B. Plan prior authorization is REQUIRED for all presumptive DS/T for Drugs of Abuse or Controlled Substances after the first 30 encounters for a member in a calendar year and must be ordered by an Authorized Provider (as specified in the Definitions section of this policy); presumptive DS/T **greater than 30 services for a member per calendar year** is considered medically necessary when ONE (1) of the following applicable criteria is met, as specified below in item 1 (criteria for a member participating in a Plan-approved substance abuse treatment program) or item 2 (criteria for a member not participating in a Plan-approved substance abuse treatment program):

1. **Member Participating in Plan-Approved Substance Abuse Treatment Program:**

   In the cases of members participating in a Plan-Approved Substance Abuse Treatment Program, as defined in this policy, at least ONE (1) of the following criteria is met, as specified below as item a or item b:
a. Prescribed Controlled Substances Medication Regimen:

Presumptive DS/T requested to monitor compliance with a prescribed Controlled Substance medication regimen as evidenced by office visit or other progress notes completed by an Authorized Provider within 30 calendar days of the proposed DS/T that identify ALL of the following, as specified below items (1) through (4):

(1) The Controlled Substance of interest, the dosage, and the frequency of administration; AND
(2) The specific diagnosis for which the Controlled Substance is prescribed; AND
(3) The rationale for the requested frequency of testing; AND
(4) Assessment of the member’s progress in the program during the prior 90 days; OR

b. Known or Suspected Drugs of Abuse or illicitly Used Controlled Substances:

Presumptive DS/T requested to detect known or suspected Drugs of Abuse or illicitly used Controlled Substances as evidenced by office visit or other progress notes completed by an Authorized Provider within 30 calendar days of the proposed DS/T that identify ALL of the following, as specified below in items (1) through (4):

(1) The specific Drugs of Abuse or Controlled Substances of interest; AND
(2) The specific diagnosis associated with the evaluation of the member; AND
(3) The rationale for the requested frequency of testing; AND
(4) Assessment of the member’s progress in the program during the prior 90 days: OR

2. Member Not Participating in Plan-Approved Substance Abuse Treatment Program:

In the cases of members NOT participating in a Plan-Approved Substance Abuse Treatment Program, as defined in this policy, at least ONE (1) of the following criteria are met, as specified below as item a or item b:

a. Prescribed Controlled Substances Medication Regimen:

Presumptive DS/T requested to monitor compliance with a prescribed Controlled Substance medication regimen as evidenced by office visit or other progress notes completed by an Authorized Provider within 30 calendar days of the proposed DS/T that identify ALL of the following, as specified below items (1) through (4):

(1) The Controlled Substance of interest, the dosage, and the frequency of administration; AND
(2) The specific diagnosis for which the Controlled Substance is prescribed; AND
(3) The rationale for the requested frequency of testing; AND
(4) Assessment of the member’s progress in the program during the prior 90 days; OR

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Authorized Provider **within 30 calendar days** of the proposed DS/T that identify ALL of the following, as specified below in items (1) through (4):

(1) The Controlled Substance of interest, the dosage, and the frequency of administration; AND

(2) The specific diagnosis for which the Controlled Substance is prescribed; AND

(3) The Individualized Treatment Plan necessitating monitoring compliance with the Controlled Substance medication regimen; AND

(4) The rationale for the requested frequency of testing; OR

b. Known or Suspected Drugs of Abuse or Illicitly Used Controlled Substances:

Presumptive DS/T requested to detect known or suspected Drugs of Abuse or Illicitly used Controlled Substances as evidenced by office visit or other progress notes completed by an Authorized Provider **within 30 calendar days** of the proposed DS/T that identify ALL of the following, as specified below in items (1) through (4):

(1) The specific Drugs of Abuse or Controlled Substances of interest; AND

(2) The specific diagnosis associated with the evaluation of the member; AND

(3) The Individualized Treatment Plan necessitating screening for Drugs of Abuse or illicitly used Controlled Substances; AND

(4) The rationale for the requested frequency of testing

**Limitations**

Presumptive drug screening/testing (DS/T) for ANY of the following purposes is considered NOT medically necessary and therefore is not covered, as specified below in item 1 or item 2:

1. When billed with generic laboratory examination ICD-10 diagnosis codes Z00.00, Z01.812 and Z01.89; AND/OR

2. When mandated by any third party, including but not limited to a residential facility, employer or potential employer, school, and/or athletic or other extracurricular program.
Definitions

**Authorized Provider:** Any individual practitioner who is authorized under the applicable state law to prescribe drugs.

**Clinical Laboratory Improvement Amendments (CLIA):** Federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.

**Drugs of Abuse or Controlled Substances:** For the purposes of this policy, drugs of abuse or controlled substances shall be any drug subject to the Controlled Substances Act (Act) on the date of service. Further, the policy applies to prescribed drugs regulated by the Act and to controlled substances used illicitly. A list of current controlled substances is available at: [http://www.deadiversion.usdoj.gov/schedules/index.html](http://www.deadiversion.usdoj.gov/schedules/index.html)

**Drug Screening/Testing (DS/T):** Process of chemical analysis designed to determine the presence of a drug or class(es) of drugs in the body for medical, legal, or other purposes. Categories of DS/T include:

1. **Presumptive Testing:** Presumptive DS/T determines if a drug or class of drug is present in the specimen and may be performed by various methods, including chromatography, spectrometry, immunoassay, enzyme assay, and chemical or “spot” method. Presumptive DS/T is the required first step in DS/T for Plan members.

2. **Definitive Testing:** Definitive testing determines the specific drug(s) present in the specimen and, for Plan members, may only be performed when presumptive DS/T returns a positive result or unexpectedly negative result.

**Individualized Treatment Plan:** A structured, goal-oriented schedule of services developed jointly by the recipient and the treating provider. The plan is a dynamic document based on an initial assessment and periodic re-assessments of the recipient’s status, needs, and resources.

**Known or Suspected Drugs of Abuse:** Controlled Substances as defined above present on an individual’s initial drug profile, or those for which the member has described a history of use during the initial or subsequent medical evaluation, or those for which the member’s behavior during a documented evaluation of the member by an authorized provider on the day the specimen is requested is suspicious.

**Plan-Approved Substance Abuse Treatment Program:** For the purposes of this policy, a program whose standard treatment protocol(s) have been submitted to the Plan and have, as it relates to scope and frequency of DS/T, been approved as a standard of care by a Plan Medical Director. Plan approval notwithstanding, DS/T services are subject to all Plan requirements, including those in this policy and in Policy 4.94, Reimbursement Guidelines: Drug Screening/Testing for Drugs of Abuse and/or Controlled Substances.
Standing Order: A request by an authorized prescriber for a servicing provider to repeat one or more tests over a specified period of time.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

<table>
<thead>
<tr>
<th>CPT Code or HCPCS Code</th>
<th>Condensed Description</th>
<th>Plan-Approved Use</th>
<th>Prior Authorization Required After 30 Encounters per Calendar Year</th>
<th>Max Units per Calendar Day</th>
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<tbody>
<tr>
<td>80305</td>
<td>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</td>
<td>The Plan’s required initial screening to detect the presence of Drugs of Abuse or Controlled Substances per the definition in the Definitions section</td>
<td>Yes</td>
<td>Only 1 unit of CPT code 80305, 80306, or 80307 will be reimbursed per date of service</td>
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(cont.)

Drug Testing/Testing for Drugs of Abuse and/or Controlled Substances

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<tr>
<td>80306</td>
<td>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</td>
<td>The Plan’s required initial screening to detect the presence of Drugs of Abuse or Controlled Substances per the definition in the Definitions section</td>
<td>Yes</td>
<td>Only 1 unit of CPT code 80305, 80306, or 80307 will be reimbursed per date of service</td>
</tr>
<tr>
<td>80307</td>
<td>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</td>
<td>The Plan’s required initial screening to detect the presence of Drugs of Abuse or Controlled Substances per the definition in the Definitions section</td>
<td>Yes</td>
<td>Only 1 unit of CPT code 80305, 80306, or 80307 will be reimbursed per date of service</td>
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<tr>
<td>60480</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers, qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed</td>
<td>Any test confirming the presence of Drugs of Abuse or Controlled Substances identified as positive on presumptive screening or any prescribed Controlled Substances unexpectedly identified as negative on presumptive screening</td>
<td>No</td>
<td>Limited to controlled substances identified as positive on presumptive screening or prescribed controlled substances unexpectedly identified as negative on presumptive screening</td>
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<tr>
<td>G0481</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers; qualitative or quantitative, all sources, includes specimen validity, 8-14 drug class(es), including metabolite(s) if performed</td>
<td>Any test confirming the presence of Drugs of Abuse or Controlled Substances identified as positive on presumptive screening or any prescribed Controlled Substances unexpectedly identified as negative on presumptive screening</td>
<td>No</td>
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<tr>
<td>G0482</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers, qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed</td>
<td>Any test confirming the presence of Drugs of Abuse or Controlled Substances identified as positive on presumptive screening or any prescribed Controlled Substances unexpectedly identified as negative on presumptive screening</td>
<td>No</td>
<td>Limited to controlled substances identified as positive on presumptive screening or prescribed controlled substances unexpectedly identified as negative on presumptive screening</td>
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<tr>
<td>G0483</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers; qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed</td>
<td>Any test confirming the presence of Drugs of Abuse or Controlled Substances identified as positive on presumptive screening or any prescribed Controlled Substances unexpectedly identified as negative on presumptive screening</td>
<td>No</td>
<td>Limited to controlled substances identified as positive on presumptive screening or prescribed controlled substances unexpectedly identified as negative on presumptive screening</td>
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Drug Testing/Testing for Drugs of Abuse and/or Controlled Substances

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<tr>
<td>G0659</td>
<td>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), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes</td>
<td>Any test confirming the presence of Drugs of Abuse or Controlled Substances identified as positive on presumptive screening or any prescribed Controlled Substances unexpectedly identified as negative on presumptive screening</td>
<td>No</td>
<td>Limited to controlled substances identified as positive on presumptive screening or prescribed controlled substances unexpectedly identified as negative on presumptive screening</td>
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</table>

**Clinical Background Information**

At the time of the Plan’s most recent policy review, the Centers for Medicare & Medicaid Services (CMS) local coverage determination (LCD) L36037 for urine drug testing includes indications and expected frequency of testing for safe medication management of prescribed substances in risk stratified pain management patients and/or in identifying and treating substance use disorders, as well as defining the treating provider’s required medical record documentation for medically necessary urine drug testing. Verify CMS criteria in the applicable national coverage determination (NCD) or LCD in effect on the date of the prior authorization request for a Senior Care Options member.

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References


Drug Screen/Quantitative Drug Test Claim Edit; Drug Screens Performed For Residential Monitoring, MassHealth Bulletins Independent Clinical Laboratory Number 9, Acute Outpatient Hospital Number 28, Physician Number 94, Community Health Center Number 74.


Drug Testing/Testing for Drugs of Abuse and/or Controlled Substances

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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>05/05/13 Version 1</td>
<td>Medical Policy Manager as Chair of MPCTAC and member of QIC</td>
<td>Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and Quality Improvement Committee (QIC)</td>
</tr>
<tr>
<td>Internal Approval: 03/27/13: MPCTAC 03/29/13: QIC</td>
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</table>

* Effective Date for the Well Sense Health Plan product(s): 10/01/15. (Policy was not applicable for Well Sense Health Plan products from 08/11/14 to 09/30/15.)

*Effective Date for Senior Care Options Product(s): 01/01/16.

Policy formerly titled Urine Drug Testing until 08/10/14; renamed Drug Testing/Testing for Drugs of Abuse and/or Controlled Substances as of 08/11/14.

### Policy Revisions History

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<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tr>
<td>08/01/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Conducted Plan review of policy for the Well Sense Health Plan product and BMC HealthNet Plan products. No change to criteria or applicable code list.</td>
<td>05/05/13 Version 2</td>
<td>08/14/13: MPCTAC 08/15/13: QIC</td>
</tr>
<tr>
<td>05/01/14 and 06/01/14</td>
<td>First annual review of policy at MPCTAC on 05/21/14 with approval of policy without revisions; this version was not reviewed by QIC because a second annual review was conducted by MPCTAC on 06/02/14. Second annual review of policy for effective date 08/11/14. Revised title, Summary section, and Definitions section. Revised criteria in the Medical Policy Statement section and Limitations section. Updated list of applicable codes and Plan-approved indications for use in the Applicable Coding section. Removed Well Sense Health Plan as an applicable product.</td>
<td>08/11/14 Version 3</td>
<td>05/21/14: MPCTAC 06/02/14: MPCTAC (electronic vote) 06/09/14: QIC (electronic vote)</td>
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<tr>
<td>12/01/14</td>
<td>Review for effective date 03/01/15. Updated Applicable Coding to reflect replacement of deleted CPT code 80102 with HCPCS code G6058. Updated references.</td>
<td>03/01/15 Version 4</td>
<td>12/02/14: MPCTAC (electronic vote) 12/10/14: QIC</td>
</tr>
<tr>
<td>02/01/15</td>
<td>Review for effective date 04/01/15. Updated</td>
<td>04/01/15</td>
<td>02/18/15: MPCTAC</td>
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**Policy Revisions History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Version</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>06/01/15</td>
<td>Policy review for effective date 10/01/15. Added Well Sense Health Plan products as applicable for the Plan policy (and requiring prior authorization for services, as specified in this Plan policy). Updated Definitions and References sections.</td>
<td>Version 6</td>
<td>06/17/15: MPCTAC</td>
</tr>
<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.</td>
<td>Version 7</td>
<td>11/18/15: MPCTAC (electronic vote)</td>
</tr>
<tr>
<td>03/01/16</td>
<td>Review for effective date 05/01/16. Revised the Summary, Definitions, References, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement and Limitations sections.</td>
<td>Version 9</td>
<td>03/16/16: MPCTAC</td>
</tr>
<tr>
<td>12/05/16</td>
<td>Industry-wide revisions to the applicable code list effective 01/01/17.</td>
<td>Version 10</td>
<td>Not applicable because industry-wide code revisions.</td>
</tr>
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**Last Review Date**

12/05/16

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**Next Review Date**

03/01/17

**Authorizing Entity**

QIC

**Other Applicable Policies**

Reimbursement Guidelines – *Community Health Centers and Federally Qualified Health Centers*, policy number 4.107

Reimbursement Guidelines – *Drug Screening/Testing: Drugs of Abuse*, policy number 4.94


Reimbursement Guidelines – *Free Standing Rural Health Clinic/Federally Qualified Health Center*, policy number WS 4.30

Reimbursement Guidelines – *General Billing and Coding*, policy number 4.31

Reimbursement Guidelines – *General Billing and Coding*, policy number WS 4.17

Reimbursement Guidelines – *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108

Reimbursement Guidelines – *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18

Reimbursement Guidelines – *Physician and Non-Physician Practitioners*, policy number WS 4.28

Reimbursement Guidelines – *Physician and Non-Physician Practitioners*, policy number 4.608

**Reference to Applicable Laws and Regulations**


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Disclaimer Information:

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.