2015 Lab Drug Testing & Screening Code Changes & Impacts

Winter-Spring 2015

As of January 1, 2015 the AMA is overhauling a select group of presumptive testing laboratory CPT codes. While code updates are common occurrences, this particular change is magnified by the requirement differences across payers, required adjustments to your existing CDM and claims logic, and the reimbursement variability for contracted payers. The Wilshire Group knows the right questions to ask and what it takes to get Epic configured appropriately.

This shift moves us from a structure based on an identifying code for type of test performed to one that groups like tests based on number performed on a specific date of service. Further complicating issues is Medicare's decision to use G codes for 2015 to allow them time to determine appropriate payment mechanisms and rates to avoid overpayment. Two examples are outlined in the first table below (Fig. 1). Actual impacts to claims are outlined in the second table (Fig. 2).

	2014	2015				
HCPCS DESCRIPTION	HCPCS	Group #	Base CPT	Group CPT	Group Quantity	Medicare G Codes
Alcohols	82055	1	80321	80321 80322	1-2 3 or more	G6040
Amphetamines	82145	2	80324	80324 80325 80326	1-2 3-4 5 or more	G6058 G6042

Fig. 1

	2014		2015 (Standard)		2015 (Medicare)	
Case	Charges	Claim	Charges	Claim	Charges	Claim
Single amphetamine test	82154	82154-Qty 1	80324	80324-Qty 1	G6042	G6042-Qty 1
Four amphetamine tests done on same date of service	82154 82154 82154 82154	82154-Qty 4	80324 80324 80324 80324	80325-Qty 1	G6058 G6058 G6042 G6042	G6058-Qty 2 G6042-Qty 2
Three amphetamines tests done on one date of service and one done the next day	82154 82154 82154 82154	82154-Qty 4	80324 80324 80324 80324	80324-Qty 1 80325-Qty 1	G6058 G6058 G6042 G6042	G6058-Qty 2 G6042-Qty 2

Fig, 2

The two critical areas you must ensure are reviewed, understood, and prepared for are system configuration and business measures. System configuration entails all CDM and claims setup needed to support these changes. Factors included are the code changes touched on above, other alternate code sets used by other payers (some Medicaid programs can be a year behind), accurate claim rollups, retiring older codes, charge capture mechanisms and assessment/coordination for ancillary applications that may exist in the lab.

Within your business measures you need to take the necessary steps to facilitate revenue neutrality with the CDM changes and monitor expected reimbursement.