

<b>Commercial Reimbursement Policy</b>	
Subject: <b>Outpatient Drug Screen Testing - Facility</b>	
Policy Number: <b>C-17004</b>	Policy Section: <b>Facilities</b>
Last Approval Date: <b>02/23/2026</b>	Effective Date: <b>02/23/2026</b>

**Policy**

The health plan allows reimbursement for presumptive drug screen testing (CPT) and definitive drug screen testing (HCPCS Level II) when submitted on an outpatient facility claim, unless provider, state, federal contracts and/or requirements indicate otherwise.

The health plan considers the CPT® definitive drug screen testing codes to be always bundled codes and not eligible for reimbursement. When HCPCS Level II definitive drug code G0659 is reported with G0480, G0481, G0482, or G0483, only G0659 will be eligible for reimbursement.

Definitive drug testing may be used to detect specific substances not identified by presumptive methods and to refine the accuracy of the presumptive test results. Provider’s documentation and member’s medical records should reflect that the test was properly ordered. For cases where the definitive testing is confirmatory, the provider’s documentation should support that the order was based on the result of the presumptive test.

**Related Coding**

Description	Coding Grids
Definitive and Presumptive CPT and HCPC Level II codes	<a href="#">Definitive and Presumptive CPT and HCPC Level II codes</a>

**Definitions**

Presumptive/Qualitative Drug Testing	Used to determine the presence or absence of drugs or drug classes in a urine sample; results expressed as negative or positive or as a numerical result.
Definitive/Quantitative Drug Testing	Used to identify specific medications, illicit substances, and metabolites; reports the results of analytes absent or present typically in concentrations such as ng/ml.
General Reimbursement Policy Definitions	

**Related Policies and Materials**

Drug Screen Testing - Professional
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**References and Research Materials**

This policy has been developed through consideration of the following: <ul style="list-style-type: none"> <li>• Clinical Laboratory Improvement Amendments (CLIA) guidelines</li> <li>• CMS</li> </ul>
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- Optum EncoderPro 2025

**Policy History**

02/23/2026	Review approved and effective: updated Related Coding Section code list by removing examples
12/11/2023	Review approved and effective: updated policy title from <i>Outpatient Drug Screen Billing – Facility</i> ; updated Definitions section; added coding link to Related Coding section
07/23/2021	Review approved: policy language updated for clarity only
11/26/2019	Review approved: policy language updated
06/01/2029	Policy template updated
08/17/2017	Initial approval 08/17/2014and effective 12/14/2017

**Disclaimer**

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, or item is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

**Use of Reimbursement Policy**



This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.

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