



Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

TO: Contracted Medicaid Managed Care Plans
Contracted MyCare Ohio Plans

FROM: Roxanne Richardson, Deputy Director
Office of Managed Care

DATE: October 7, 2019

SUBJECT: Qualified Laboratory Requirements in July 2019 Provider Agreements

The Ohio Department of Medicaid (ODM) will not be amending the language added to the July 1, 2019 provider agreements related to requirements for out-of-network qualified laboratories (Appendix H.4.c.x) at this time. ODM does understand the concerns raised by the Medicaid Managed Care plans (MCPs) and MyCare Ohio plans (MCOPs) including potential cost increases and program integrity issues. As a reminder, this language is limited to drug and alcohol testing. In an effort to address these concerns, the Department recommends and supports the plans efforts in the following manner:

As it pertains to out-of-network laboratory providers, plans may use their discretion related to what code sets are required to be used (e.g. G-codes). ODM recommends prior authorization of G codes as follows:

- Prior authorization of any presumptive UDS after 30 and any definitive UDS after 12 per individual per year per the ODM UDS Guidelines¹.
- If using G-codes, prior authorization of G0483, which represents definitive drug testing for over 22 drug classes. Because this code is for definitive tests, documentation is required to determine the need to test for over 22 drug classes.

Definitive drug testing codes below should be reported based on number of drug classes tested. These HCPCS codes only require prior authorization once the annual benefit limit has been reached.

- G0480 Definitive drug testing 1-7 classes
- G0481 Definitive drug testing 8-14 classes
- G0482 Definitive drug testing 15-21 classes

In accordance with OAC rule 5160-26-03.1, plans must have a utilization management (UM) program with decisions based upon medical necessity. The UM program may include post payment review and prior authorization of services. Plans may require out-of-network qualified laboratories to submit reports as evidence that test results were provided to the referring health care provider within two business days. Based on these reports, the plans may choose to implement post-payment review and recoup any money for tests not provided within the required timeframe.

Any questions or concerns should be sent to ManagedCarePolicy@medicaid.ohio.gov.

¹ <https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/PolicyGuidance/Urine-Drug-Screen-Guidance.pdf>