Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: LA.CP.MP.50c
Date of Last Revision: 11/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and monitoring of adherence to a controlled substance treatment regimen (e.g., for chronic non-cancer pain) and to identify drug misuse or addiction prior to starting or during treatment with controlled substances.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections *outpatient* testing for drugs of abuse is medically necessary for presumptive drug testing when a member/enrollee meets *the criteria in A,B, or C* and is limited to 24 total tests per member/enrollee per calendar year:

- **A.** Verification of compliance with treatment, identification of undisclosed drug use or abuse, or evaluation of aberrant* behavior beginning at the start of treatment, as part of a routine monitoring program for individuals who meet one of the following (*Note: aberrant behavior includes, but is not limited to, lost prescriptions, repeated requests for early refills, and prescriptions from multiple providers, unauthorized dose escalation, and apparent intoxication):
  1. Receiving treatment for chronic pain with prescription opioid or other potentially abused medications;
  2. Undergoing treatment for, or monitoring for relapse of, opioid addiction or substance use disorder;
- **B.** Clinical evaluation suggests use of non-prescribed medications or illegal substances;
- **C.** On initial entrance into a pain management program.

II. It is the policy of Louisiana Healthcare Connections that *outpatient* testing for drugs of abuse (DOA) is medically necessary for confirmatory/definitive (quantitative) testing for a specific drug(s) when members/enrollees meet *the criteria in A, B, or C* and limited to 12 total tests per calendar year:

- **A.** The member/enrollee has a documented history or suspicion of illicit or prescription drug use or noncompliance or a high probability of non-adherence to a prescribed drug regimen documented in the medical record; *and all of the following:*
  1. A preliminary/presumptive drug test has been previously performed, unless no reliable test exists;
  2. The findings from that preliminary/presumptive (qualitative) test (either positive or negative) are either:
     a. Inconsistent with the expected results as suggested by the member's/enrollee's medical history, clinical presentation, and/or member's/enrollee's own statement after a detailed discussion about their recent medication and drug use;
     b. Consistent with the clinical scenario but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result;
  3. Resolving the inconsistency is essential to the ongoing care of the member/enrollee,
  4. The requested confirmatory/definitive test(s) is for ≤14 drugs/drug classes,

5. Tests are only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results;

B. The provider expects the presumptive test to be positive (e.g. the member/enrollee reports recent use), *and all of the following:*
1. Information regarding specific substance and/or quantity is desired;
2. There are established benchmarks for clinical decision making based on specific substance and/or quantitative levels;
3. ≤14 drugs/drug classes are requested;
4. Tests are only for the specific drug(s) or number of drug classes for which the presumptive test is expected to be positive;

C. The request is for a serum therapeutic drug level in relation to the medical treatment of a disease or condition (e.g. phenobarbital level in the treatment of seizures).

III. It is the policy of Louisiana Healthcare Connections that outpatient confirmatory/definitive (quantitative) drug testing of more than 14 drugs/drug classes is not medically necessary.

IV. Urine drug testing is considered not medically necessary if provided for reasons that include, but are not limited to, the following:
A. In a primary care setting without signs or symptoms of substance use or without current controlled substance treatment
B. As a condition of:
1. Employment or pre-employment purposes (pre-requisite for employment or as a requirement for continuation of employment). OR
2. Participation in school or community athletic or extracurricular activities or programs

C. Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations).
D. Screening in asymptomatic patients, except as listed in sections I or II.
E. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.).
F. As a component of a medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.).
G. Same-day screening of drug metabolites in specimens sourced from any combination of blood, saliva and urine by either preliminary or confirmatory/definitive analyses.
H. Blanket orders.
I. Reflex definitive drug tests when presumptive testing is performed at point of care.
J. Routine standing orders for all patients in a physician's practice. Physician-defined standing orders for pre-determined drug panels according to specific patient profiles for a limited sequential period may be reasonable and necessary and must be documented in the patient's medical record.
K. Billing of individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered.
L. Performing presumptive point of care testing and ordering presumptive immunoassay (IA) testing from a reference laboratory.
M. Performing presumptive IA testing and ordering presumptive IA testing from a reference laboratory with or without reflex testing.

N. Performing IA presumptive screening prior to definitive testing without a specific physician's order for the presumptive testing.
O. IA testing, regardless of whether it is qualitative or semi-quantitative used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Semi-quantitative IA testing provides a presumptive test (numerical) result. Definitive UDT provides specific identification and/or quantification by GC-MS or LC-MS/MS.
P. Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.

Background
A drug of abuse is defined as a drug, chemical, or plant product known to be misused for recreational purposes. In the United States, the basic screening test for DOA includes five drugs: amphetamine, cocaine, marijuana, opioids, and phencyclidine. Other common drugs tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamine. These tests can vary by region based on epidemiologic trends. There currently is no uniformity for what is included in extended DOA assay testing, or what cutoff values should be used for detection of drugs that are not covered by workplace testing laws.

The three methods of drug assays include immunoassay, chromatography, and mass spectrometry. Immunoassay is the most widely used method for initial testing for DOA and offers results within minutes. They are able to detect low concentrations of a drug with a high degree of sensitivity but lack some specificity. This can be most easily performed using point-of-care test kits such as a urine drug cup. Unfortunately, in the clinical setting point-of-care testing does not perform to manufacturers' claims and untrained staff can improperly interpret test results.

Gas chromatography/mass spectrometry (GC/MS) or liquid chromatography (LC/MS) are typically used as confirmatory tests. Chromatography is used to separate a specimen into its component parts and mass spectrometry to identify those parts. Chromatography, LC/MS and GC/MS require highly trained lab staff and instruments to provide a highly sensitive and specific technique for detecting drugs or metabolites. It often takes many hours to obtain results, thus these methods are generally not used for initial screening in the clinical setting. The mass spectrometer is capable of detecting even minute amounts of a given substance and is considered to have the highest specificity of all lab detection methods. It is most commonly used for confirmatory test results that are primarily of forensic importance. GC/MS rarely provides results that are clinically necessary or useful beyond those obtained by standard immunoassays or chromatography.

The ordering clinician must be knowledgeable regarding the type of testing being requested, level of suspicion for drug use or exposure, the purpose for obtaining the test, and the likelihood of false-positive or false-negative results. Knowledge of potential drug exposure allows a clinician working in an addiction or chronic pain management program to include testing for a metabolite of a parent drug instead of simply testing for the parent drug for a patient with a tendency for opioid abuse. If initial screening does not correlate with expected findings, then

confirmatory testing improves the accuracy of initial results especially with concern of false-positive or false-negative results.

Immunoassays can yield false-positive results when cross-reacting medications or drugs are present. Cross-reacting substances can be found in common prescription medications, over-the-counter cold medications, and even in some food substances. The highest false-positive results occur with amphetamine testing due to the chemical structure of amphetamine being present in many over-the counter medications and herbal supplements. False-negative results can occur from improper specimen collection, transport, or testing procedures or from patient attempts to subvert the testing. The most common cause of false-negative results is a test failure to detect a specific drug within a given class of drugs.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes That Support Coverage Criteria

HCPCS Codes	Description
G0480	Drug test(s), definitive, utilizing (1) 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), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing (1) 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), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed

HCPCS Codes That Do Not Support Coverage Criteria

HCPCS Codes	Description
G0482	Drug test(s), definitive, utilizing (1) 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), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

ICD-10-CM Codes That Support Coverage Criteria

ICD-10-CM	Description
F10.10-F10.19	Alcohol abuse
F10.20-F10.29	Alcohol dependence
F10.920-F10.99	Alcohol use, unspecified
F11.10-F11.19	Opioid abuse
F11.20-F11.29	Opioid dependence
F11.920-F11.99	Opioid use, unspecified
F12.10-F12.19	Cannabis abuse
F12.20-F12.29	Cannabis dependence
F12.920-F12.99	Cannabis use, unspecified
F13.10-F13.19	Sedative, hypnotic or anxiolytic abuse
F13.20-F13.29	Sedative, hypnotic or anxiolytic- related dependence
F13.920-F13.99	Sedative, hypnotic or anxiolytic- related use, unspecified
F14.10-F14.19	Cocaine abuse
F14.20-F14.29	Cocaine dependence
F14.920-F14.99	Cocaine use, unspecified
F15.10-F15.19	Other stimulant abuse
F15.20-F15.29	Other stimulant dependence

F15.920-F15.99	Other stimulant use, unspecified
F16.10-F16.9	Hallucinogen abuse
F16.20-F16.29	Hallucinogen dependence
F16.920-F16.99	Hallucinogen use, unspecified
F18.10-F18.19	Inhalant abuse
F18.20-F18.29	Inhalant dependence
F18.920-F18.99	Inhalant use, unspecified
F19.10-F19.19	Other psychoactive substance abuse
F19.20-F19.29	Other psychoactive substance dependence
F19.920-F19.99	Other psychoactive substance use, unspecified
F55.0	Abuse of antacids
F55.1	Abuse of herbal or folk remedies
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F55.4	Abuse of vitamins
F55.8	Abuse of other non-psychoactive substances
Z79.81	Long term (current) use of opiate analgesic

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Reworded Criteria I to limit to 24 total tests per member/enrollee per calendar year. Criteira II to limit to 12 test per calendar year. Removed (HCPCS codes G0482, G0483) from the policy statement in III. Added "In a primary care setting without signs or symptoms of substance use or without current controlled substance treatment" to section IV. Removed Protocols for testing requiring prior authorization. Added "and may not support medical necessity" to coding implications. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Removed CPT codes. Removed G0659 from HCPCS codes. Updated ICD-10-CM Codes That Support Coverage Criteria. Updated references. Changed all instances of member to member/enrollee. Added "c" to the end of the policy number.	11/2022	1/14/23

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

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