



Clinical Policy Title: Drug testing

Clinical Policy Number: CCP.1306

Effective Date: June 1, 2017
Initial Review Date: April 19, 2017
Most Recent Review Date: February 5, 2019
Next Review Date: February 2020

Policy contains:

- Qualitative (presumptive) drug test.
- Quantitative (definitive) drug test.
- Drug dependence.
- Chronic pain (opioid) treatment.

Related policies:

CCP.1355 Medication-assisted treatment for opioid use disorder

ABOUT THIS POLICY: AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies, along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their members. AmeriHealth Caritas' clinical policies are reflective of evidence based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas considers the use of clinical drug testing for substance use and misuse from blood, urine, or saliva to be clinically proven and, therefore, medically necessary when ordered and arranged for by participating providers, and the following general and specific testing criteria are met (American Congress of Obstetricians and Gynecologists, 2017; American Society of Addiction Medicine, 2013, 2017; Manchikanti, 2012; Substance Abuse and Mental Health Services Administration, 2012, 2015):

- General testing criteria:
 - The member has been evaluated by a licensed clinician, and the tests ordered are within the scope of the ordering clinician's authority.
 - Documentation for testing includes the clinical rationale for the tests, symptomatology, and reasons for the drugs or drug classes to be tested, with specific reference to any specialty tests ordered.
 - The test results must be used in the management of the member's care, and documented in the care plan.

- Qualitative (presumptive) drug testing to identify the presence or absence of one or more drugs or drug classes (usually with urine drug tests) for any of the following indications:
 - Detection of inappropriate substance use or drug-drug interaction in members who present with signs and symptoms of substance abuse, drug toxicity, unreliable history, or multiple drug ingestion.
 - For members with a Diagnostic and Statistical Manual of Mental Disorders (DSM V) diagnosis of substance use disorder:
 - Baseline testing before or at initiation of treatment.
 - Compliance monitoring at random intervals as determined by the clinician and documented in the treatment plan (see Limitations).
 - For members on chronic pain (opioid) treatment or other drugs of addictive potential:
 - Baseline testing before or at initiation of treatment.
 - Compliance monitoring at random intervals (see Limitations).
- Quantitative (definitive) drug testing to validate the identity and quantity of a specific drug or drug metabolite when all of the following criteria are met (American Society of Addiction Medicine, 2013; Dowell, 2016):
 - The qualitative drug test met the above criteria for medical necessity.
 - There is documentation of how quantitative test results will affect clinical management.
 - Testing is for no more than six different drugs.
 - For one of the following indications:
 - A positive qualitative drug test for a prescription drug with abuse potential that was not prescribed.
 - An inappropriate or unexplained result on a qualitative drug test that is inconsistent with a patient’s medication plan.
 - Suspicion of a specific substance or its metabolite that would be inadequately detected or not detected by qualitative drug testing (e.g., certain synthetic or semi-synthetic opioids).
 - Knowledge of a specific drug concentration is needed for clinical decision making.
 - Differential assessment of medication efficacy, side effects, or drug-drug interactions.

AmeriHealth Caritas considers the use of sweat or hair sample testing for evidence of substance abuse to be investigational and, therefore, not medically necessary.

Limitations:

Qualitative drug testing is limited to one test of a single source of bodily fluid per person per date of service.

Universal urine drug screening in a primary care setting is not medically necessary, as its effects on health outcomes has not been established in general primary care populations (American Congress of Obstetricians and Gynecologists, 2012; Levy, 2014).

For compliance monitoring of members on prescribed drugs of abuse potential (e.g., opioids), the frequency of qualitative drug testing is limited to (Dowell, 2016; Manchikanti, 2012):

- Random testing one to two times every 12 months.
- Follow-up testing of an inappropriate or unexplained result.

For compliance monitoring of members during active treatment for substance use or dependence, the frequency of drug testing is limited to (Medicare Local Coverage Determinations L35006, L35724, L36037, L36393):

- Qualitative urine drug testing:
 - With 0 to 90 consecutive days of abstinence, up to three physician-directed tests per week.
 - With > 90 consecutive days of abstinence, up to three physician-directed tests per month.
- Definitive urine drug testing:
 - With 0 to 30 consecutive days of abstinence, one physician-directed testing profile per week.
 - With 31 to 90 consecutive days of abstinence, one to three physician-directed testing profiles per month.
 - With > 90 day of consecutive abstinence, one to three physician-directed testing profiles in three months.

Quantitative drug testing must be ordered within 24 hours of the qualitative test result, when criteria for medical necessity have been met.

All other uses of drug testing are not medically necessary, including but not limited to:

- Blanket orders (i.e., an identical test order for all patients in a clinician's practice).
- Routine standing orders for a specific patient that represents repetitive testing to monitor a condition or disease for a limited number of sequential visits.
- Routine testing for confirmation of negative qualitative results.
- Drug testing ordered by nonparticipating providers, or as a requirement of school, employment, law-enforcement or government requirements.
- Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, or creatinine.

For Medicare members only:

AmeriHealth Caritas considers the use of clinical drug testing for substance use and misuse to be clinically proven and, therefore, medically necessary when ordered and arranged for by participating providers, and

the above general and specific testing criteria are met, subject to limitations in accordance with Medicare Local Coverage Determinations (L34645, L35006, L35724, L36037, L36393).

For monitoring patient adherence and compliance during active treatment for substance use or dependence (Medicare Local Coverage Determinations L35006, L35724, L36037, L36393):

- Presumptive urine drug testing:
 - With 0 to 90 consecutive days of abstinence, up to three physician-directed tests per week.
 - With > 90 consecutive days of abstinence, up to three physician-directed tests per month.
- Definitive urine drug testing:
 - With 0 to 30 consecutive days of abstinence, one physician-directed testing profile per week.
 - With 31 to 90 consecutive days of abstinence, one to three physician-directed testing profiles per month.
 - With > 90 day of consecutive abstinence, one to three physician-directed testing profiles in three months.
- Testing frequencies in excess of these limits is not reasonable and necessary and not covered by Medicare.

For members on chronic opioid treatment, monitoring is for prescribed medications and non-prescribed medications that may pose a safety risk if mixed with prescribed and illicit substances based on patient history, clinical presentation, and/or community usage. Test frequency is based on member's risk potential for abuse and diversion prior to initiation of treatment (L35006, L35724, L36037, and L36393):

- Low risk—random testing one to two times every 12 months.
- Moderate risk—random testing one to two times every six months.
- High risk—random testing performed one to three times every three months.
- Members with specific signs and symptoms of medication aberrant behavior or misuse may be tested in accordance with the above guidance for monitoring patient adherence and compliance during active treatment (< 90 days) for substance use or dependence.

Alternative covered services:

- Standard medical and behavioral health treatment of substance abuse through participating providers.

Background

The misuse and abuse of alcohol, tobacco, and prescription and illicit drugs are significant health problems. The annual cost to the United States of tobacco, alcohol, and illicit drug use — including crime, lost work productivity, and health care — is approximately \$712 billion (National Institute on Drug Abuse, 2015). Alcohol is the most commonly used addictive substance in the United States; one in 12 adults suffer from

alcohol use or dependence, while millions more engage in binge drinking (National Council on Alcoholism and Drug Dependence, 2015).

Of particular public interest is the rising use of prescription pain relievers, especially opioids. In 2013, 6.5 million Americans aged 12 or older (or 2.5 percent) had used prescription drugs nonmedically in the past month (National Institute on Drug Abuse, 2015). National Institute on Drug Abuse (2018) reported a 3.1-fold increase in the total number of deaths from opioid use from 2002 to 2017. The majority of deaths are due to therapy of 100 mg or more of morphine equivalent per day and to multiple prescriptions, doctor shopping, or drug diversion (Manchikanti, 2012). In the United States, diversion and abuse of prescription opioids increased between 2002 and 2010 and plateaued or decreased between 2011 and 2013, suggesting some progress is occurring in controlling opioid analgesic abuse (Dart, 2015).

Federal requirements for coverage of substance abuse services under the Mental Health Parity and Addiction Equity Act were expanded under the Affordable Care Act as one of ten essential health benefit categories. As a result, Medicaid programs are broadening coverage of substance abuse services for adults and for children in compliance with their obligations under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment requirements (Centers for Medicare & Medicaid Services, 2014, 2015).

Drug testing:

Testing for drug abuse and misuse has become a component of the response to these growing public health concerns, as the test results can influence diagnosis, treatment, and level of care decisions. According to the Substance Abuse and Mental Health Services Administration (2012), the terms "drug testing" and "drug screening" are often used interchangeably, but each term represents specific clinical applications:

- Drug screening (qualitative) refers to the use of immunoassay testing to distinguish specimens that test negative for a drug or metabolite from positive specimens, either laboratory-based or at point-of-care.
- Drug testing (quantitative) targets only specific drugs or drug classes and can detect substances only when they are present above predetermined thresholds in a biological sample, using gas or liquid chromatography with or without mass spectrometry.

Point-of-care screening provides the most rapid response. It is currently limited to a relatively narrow range of drug classes and a few specific drugs (usually ≤ 15) and to urine and oral fluid samples. Laboratory-based immunoassay testing requires an antibody response, which some drugs do not elicit, and assays are not available for all drugs.

Quantitative drug testing is used to determine the specific quantity of drug or drug metabolite present in the sample. Quantitative drug testing can identify a multitude of drugs and their metabolites, including most illicit substances and reports the results of analytes as absent or present in concentrations such as ng/mL. The advantages of quantitative testing over immunoassay testing include greater sensitivity, greater specificity, and the ability to rapidly detect multiple drugs at one time and at lower concentrations of drugs in small matrix volumes. Ultimately, the choice of technology for drug testing is based on the clinical

situation, patient risk, and cost in balance with the clinical goals for each patient (American Society of Addiction Medicine, 2013).

The chemical compounds that act on reward pathways in the brain can be taken into the body by various routes. Historically, drug tests involved mainly urine and blood; newer forms of testing can include oral fluid, hair, nails, sweat, and breath (American Society of Addiction Medicine, 2013). While testing has become more sophisticated, the proliferation of drugs has limited the ability of tests to detect presence and levels of these drugs; typically, most drug tests include less than 20 drugs, often as few as five (DuPont, 2013).

Uses for drug testing:

Qualitative and quantitative drug tests provide information about recent drug use. They do not identify substance use disorders or physical dependence; therefore, these tests do not distinguish between occasional users and individuals who are dependent on or otherwise impaired by drug use. Multiple variables can affect the results of drug testing and must be considered in the choice of testing and interpretation of test results, such as proficiency in sample collection, pharmacology, and test interpretation. To balance medical necessity with patient privacy, ordered tests must match treatment needs, the documented history, and diagnosis.

In the ambulatory or inpatient setting, a knowledgeable clinician can use drug test results to verify self-reports, confirm diagnoses, identify denial and minimization of drug and alcohol use, enhance motivation for treatment, measure biological adaptation, assist in treatment planning, monitor treatment response, document treatment effectiveness and outcomes, support patient advocacy by validating abstinence from alcohol and drug use, and validate adherence in taking prescribed controlled substances. In acute care settings, such as the hospital emergency room or within a hospitalization, drug tests may be used to evaluate acute life-threatening symptoms such as unconsciousness, bizarre behavior, seizures, or acute cardiac events, and evaluation of suspected rape.

Screening, brief intervention, and referral to treatment is a public health approach to the delivery of early intervention and treatment for people with substance use disorders and those at risk of developing these disorders (Substance Abuse and Mental Health Services Administration, 2015). With this approach, substance abuse screening using drug testing or questionnaires is incorporated into mainstream health care settings to assess substance use and provide the appropriate intervention based on the screening results.

Searches

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality.
- Centers for Medicare & Medicaid Services.
- The Cochrane Library.

We conducted searches on January 14, 2019. Search terms were: “substance abuse detection” (MeSH), “substance-related disorders/diagnosis*” (MeSH), “prescription drug misuse” (MeSH), and free text terms “drug addiction” and “drug testing and treatment.”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

Drug testing, when used properly, has value for a number of clinical indications. However, drug testing can be invasive, yield only limited information, and be easily misinterpreted. Urine or oral fluid is the preferred biological specimen for testing. The urine drug test is the most commonly ordered drug test in clinical settings, because it has a one- to three-day window of detection for most drugs and their metabolites and is currently the most extensively validated biologic specimen for drug testing. Testing with hair or oral specimens may be considered when subversion is suspected, although it will not detect very recent use (American Society of Addiction Medicine, 2013).

Current qualitative and quantitative urine drug tests can yield false positives and false negatives that may present obstacles to effective diagnosis and treatment (Nelson, 2016; Quest, 2014). Qualitative drug screens can identify most drug classes but are unable to identify specific drugs within many drug classes. They lack sufficient sensitivity to detect other drugs such as fentanyl, carisoprodol, tramadol, tapentadol, or synthetic designer drugs. Definitive quantitative testing may be medically necessary when the screen is negative or when a definitive concentration of a drug is needed to guide management. However, at the present time neither blood nor urine drug concentrations alone can accurately discern adherence to prescribed treatment from potential hoarding or diverting, or the presence of tampering.

Proper interpretation of drug testing requires the whole clinical context of the patient, including other methods of assessing adherence (e.g., pill counts, prescription monitoring programs) and the potential for tampering. Yet, limited empirical evidence suggests that many ordering clinicians may not use test results optimally to improve compliance and curtail overall medication misuse, which may negatively affect therapeutic decisions (Dupouy, 2014; Reisfield, 2007a, 2007b). This issue may be based in physician training, as another study of 99 residents at a New York City medical center found a low level of interns’ ability to interpret urine drug test scores (Starrels, 2012).

Drug testing for substance abuse is performed primarily in patients seeking substance abuse treatment; outcomes from these studies cannot be extrapolated to asymptomatic primary care populations. Other uses include: initial assessment to rule in/rule out a substance use disorder, psychiatric evaluation, treatment for a substance use disorder, and monitoring of individuals who are no longer in an active phase of addiction treatment. While scheduled or random urine drug testing has become a standard of care in the addiction treatment setting, it has not been universally used in chronic pain management settings, or with internists or family practitioners who treat a smaller number of patients with chronic pain. When integrated into a screening, brief intervention, and referral to treatment approach, drug screening is effective in identifying substance use in persons with substance use disorders or at risk of developing such disorders.

Guidelines:

Guidelines on testing for illicit drug use have existed for many years, especially in populations that would be helped most by such screens. Recently developed guidelines reflect concerns for the growing abuse of prescription opioids for chronic pain. Guidelines agree that drug testing should supplement information obtained by history and physical examination and should never be the sole basis for making a diagnosis of a substance use disorder. However, there is limited evidence-based guidance for patient selection criteria, test frequency, sample collection and handling, test selection, and test interpretation.

The test matrix, selection, and frequency should fit the needs of the tested population, with more intense and less predictable testing reserved for persons at highest risk of drug use. In substance abuse treatment settings, routine testing is recommended during stabilization and in maintenance. In settings where testing is seldom ordered, American Society of Addiction Medicine (2013) encourages using drug tests that are easily adopted, such as urine or oral fluid testing. Confirmatory quantitative testing should be restricted to situations and substances for which results can reasonably be expected to affect patient management (e.g., the need to detect specific opioids that cannot be identified on standard immunoassay or the presence of unexpected urine drug test results) (American Society of Addiction Medicine, 2013; Dowell, 2016).

The American College of Emergency Physicians does not recommend routine laboratory testing in alert, adult patients with acute psychiatric symptoms, as the results rarely change emergency department management or disposition (Nazarian, 2017). A subset of patients at high risk of substance abuse or new-onset psychosis may benefit from such testing. Urine drug testing may be helpful in obtaining an objective understanding of the patient's potential substance abuse on transfer to a psychiatric facility. Medical history, previous psychiatric diagnoses, and physician examination should guide testing in most cases.

In a primary care setting, for asymptomatic adolescents, adults, and pregnant women, the evidence is insufficient to support the use of routine drug tests to screen for illicit drug use (American Congress of Obstetricians and Gynecologists, 2012; Levy, 2014). The majority of studies have included persons seeking treatment for substance abuse or receiving chronic pain management therapy. Blood or urine drug testing can provide objective evidence of drug use, but such tests do not distinguish between occasional users and those who are impaired by drug use. The American Society of Addiction Medicine (2017) and American Congress of Obstetricians and Gynecologists (2012) recommend urine drug testing to detect or confirm suspected substance use and only with the patient's consent and in compliance with state laws.

When prescribing opioids for chronic pain therapy, guidelines agree that baseline and periodic urine drug testing are important tools of prescription monitoring programs (Department of Veterans Affairs and Department of Defense, 2010; Dowell, 2016; Federation of State Medical Boards, 2013; Manchikanti, 2012). Current Centers for Disease Control & Prevention guidelines recommend urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs; urine drug testing can be performed with a relatively inexpensive immunoassay panel for commonly prescribed opioids and illicit drugs, but patients prescribed less commonly used opioids might require specific testing for those agents (Dowell, 2016).

Policy updates:

In 2018, we updated professional guidance documents from the American Congress of Obstetricians and Gynecologists (2015 [update of 2008], 2017 [update of 2012]) and Department of Veterans Affairs and Department of Defense (2017, update of 2010).

In 2019, we clarified the limits on the frequency of urine drug testing as it relates to monitoring the compliance of individuals on prescribed drugs of addictive potential and those receiving active treatment for substance use disorder. Immunoassay urine drug testing is often used as a point-of-care test because of its convenience, low cost, and relatively rapid results, but concerns for quality control, appropriate use, and correct interpretation of results remain, particularly among individuals on prescribed drugs of addictive potential (Manchikanti, 2012). In addition, questions of in whom and how often urine drug testing should be performed persist, as empirical research correlating improved outcomes with more intensive testing is lacking. In most cases, lower testing frequency is justified in stable individuals at low risk of relapse, diversion, or other non-compliant behaviors. The medical necessity for higher testing frequency must be justified to reduce the risk of diverting resources toward inappropriate use.

The policy was modified in the following ways:

- We added a statement regarding universal urine drug screening in a primary care setting not being medically necessary, as its effects on health outcomes has not been established in general primary care populations (American Congress of Obstetricians and Gynecologists, 2012; Levy, 2014).
- We adopted Medicare's limitations on the frequency of compliance monitoring for members receiving active treatment for substance use disorder and dependency.
- We limited the annual number of urine drug tests for compliance (adherence) monitoring in patients receiving drugs of addictive potential to two, unless improved outcomes can be demonstrated with greater frequency (Manchikanti, 2012).
- We added a coverage section for Medicare members outlining different medical necessity criteria for testing frequencies in accordance with several Local Coverage Determinations.

The policy ID was changed from CP# 00.01.04 to CCP.1306.

References

Professional society guidelines/other:

American College of Obstetricians and Gynecologists:

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- Drug testing: A white paper of the American Society of Addiction Medicine. <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2013/12/12/drug-testing-a-white-paper>. Published October 26, 2013. Accessed January 14, 2019.
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Substance Abuse and Mental Health Services Administration:

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- Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32. HHS Publication No. (SMA) 12-4668. Rockville, MD: Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/file/23397/download?token=q4hPgYiq>. Published 2012. Accessed January 14, 2019.
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Center for Medicare & Medicaid Services National Coverage Determinations:

130.5 Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic.

130.6 Treatment of Drug Abuse (Chemical Dependency).

130.7 Withdrawal Treatments for Narcotic Addictions.

Local Coverage Determinations:

L34645 Drug Testing.

L35006 Controlled Substance Monitoring and Drugs of Abuse Testing.

L35724 Lab: Controlled Substance Monitoring and Drugs of Abuse Testing.

L36037 Urine Drug Testing.

L36393 Controlled Substance Monitoring and Drugs of Abuse Testing.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

CPT Code	Description	Comments
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service	
80324-80326	Amphetamines	
80345	Barbiturates	
80346-80347	Benzodiazepines	
80348	Buprenorphine	
80349-80352	Cannabinoids	
80353	Cocaine	
80354	Fentanyl	
80356	Heroin metabolite	
80357	Ketamine and norketamine	
80358	Methadone	
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	
80360	Methylphenidate	
80361-80364	Opiates and opioids	
80365	Oxycodone	

ICD-10 Code	Description	Comments
F10.10-F10.229	Alcohol abuse/Dependence	
F11.10-F11.90	Opioid abuse	
F12.10-F12.90	Cannabis abuse	
F13.10-F13.90	Sedative, hypnotic or anxiolytic abuse	
F14.10-F14.90	Cocaine abuse	
F15.10-F15.90	Other stimulant abuse	
F16.10-F16.90	Hallucinogen abuse	
F18.10-F18.90	Inhalant abuse	
F19.10-F19.90	Other psychoactive substance abuse	
F55.8	Abuse of other non-psychoactive substances	

HCPCS Level II Code	Description	Comments
G0479	Drug(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service	
G0480	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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA)and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), including specimen validity testing, per day 1-7 drug class(es), including metabolites if performed.	
G0481	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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA)and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), including specimen validity testing, per day 8-14 drug class(es), including metabolites if performed.	
G0482	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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA)and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), including specimen validity testing, per day 15-21 drug class(es), including metabolites if performed.	
G0483	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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA)and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), including specimen validity testing, per day 22 or more drug class(es), including metabolites if performed.	