Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: MS.CP.MP.50
Last Review Date: 4/24/19

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 medical, surgical or behavioral health 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.

This policy is applicable to testing as a part of office-based treatment. It is not applicable to INPATIENT Treatment.

Policy/Criteria

I. Magnolia Health Plan does not require prior authorization for presumptive drug testing (80305-80307). It is the policy of Magnolia Health Plan that outpatient drug testing for drugs of abuse (DOA) is **medically necessary** for confirmatory/definitive testing for a specific drug(s) when members meet the criteria in A or B:

A. Member 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 drug test has been previously performed; *and*
2. The findings from that preliminary test (either positive or negative) are either:
   a. Inconsistent with the expected results as suggested by the member's medical history, clinical presentation, and/or member's own statement after a detailed discussion about their recent medication and drug use, or
   b. The test yielded results 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. *and*
3. Resolving the inconsistency is essential to the ongoing care of the member, *and*
4. The requested confirmatory/definitive test is only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results. OR

B. 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).

II. Urine drug testing is considered **not medically necessary** if provided for reasons that include, but are not limited to, the following:

A. 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

B. Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations).

C. Screening in asymptomatic patients.

D. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.).
E. 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.).
F. Same-day screening of drug metabolites in both a blood and urine specimen by either preliminary or confirmatory/definitive analyses.
G. Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.

III. It is the policy of Magnolia Health Plan that outpatient drug testing for drugs of abuse (DOA) is considered **not medically necessary** unless all components of the panel have been determined to be medically necessary based on the criteria above. A full panel screen should only be considered for initial testing when appropriate or when the behavior suggests the use of drugs not identified on the original screening. Medical documentation must support the justification for conducting a full panel screening. If the full panel screen is determined to be **not medically necessary**, a request for CPT code G0659 or G0480 may be submitted and reviewed for medical necessity.

IV. It is the policy of Magnolia Health Plan that the outpatient urine drug testing for drugs of abuse (DOA) should be performed at an appropriate frequency based on clinical needs. The frequency of testing should be at the lowest level to detect the presence of drugs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.

A. Presumptive testing for substance use (80305-80307) must be medically necessary and documented in the medical record.
1. For patients with 0 to 30 consecutive days of abstinence, presumptive testing may be performed randomly but no more often than 3 presumptive tests per week.
2. For patients with 31 to 90 consecutive days of abstinence, presumptive tests may be performed randomly but no more often than weekly.
3. For patients with > 90 consecutive days of abstinence, presumptive testing may be performed randomly but no more often than twice per month.

Authorization Protocols
Outpatient confirmatory/definitive testing for DOA may be subject to prior authorization **except** when performed for children < 6 years of age.

Request Requirements
A clinical laboratory may not bill for a service unless it has received a written request to perform that specific service from an authorized prescriber who is treating the member and will use the test for the purpose of diagnosis, treatment, or an otherwise medically necessary reason as defined in this policy. Any clinical laboratory billing for a service must maintain such request in its records, and make such records available upon request.

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 gas-chromatography/mass spectrometry (GC/MS). 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 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.

Chromatography 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.

All other procedures not specifically addressed in this policy will be submitted for secondary medical review.

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 2018, 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. 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. The following codes will be considered and may require prior authorization. Please check the Pre-Auth Tool on the health plan website.

CPT®* Codes	Description
80184	Phenobarbital
80305	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) read by instrumented assisted direct optical observation (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, by instrument chemistry and analyzers (e.g., utilizing immunoassay [EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (DAT, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
80324	Amphetamines; 1 or 2
80325	Amphetamine; 3 or 4
80326	Amphetamines; 5 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids; synthetic; 7 or more
80353	Cocaine
80354	Fentanyl
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4

CPT®* Codes	Description
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80367	Propoxyphene
80368	Sedative Hypnotics
80369	Skeletal muscle relaxants; 1 or 2
80370	Stimulants, synthetic
80371	Stimulants, synthetic
80372	Tapentadol
80373	Tramadol
83992	Phencyclidine (PCP)

HCPCS Codes	Description
G0480	Drug test(s), definitive, 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, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed
G0659	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), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	3/15/19	3/16/19
Updated CPT code listing per Corporate policy update.	4/24/19	6/10/19
Policy review by Mississippi Division of Medicaid	4/25/19	6/10/19

References

1. Abdi S. Etiology, clinical manifestations, and diagnosis of complex regional pain syndrome in adults. In: UptoDate, Rosenquist E WK, Shefner JM (Ed), UpToDate. Waltham, MA. Accessed 08/20/2015.
2. American College of Occupational and Environmental Medicine Guidelines: Chronic Pain. ACOEM 2008.

3. Canoso JJ. Greater trochanteric pain syndrome. In: UpToDate, Isaac Z (Ed), UpToDate, Waltham, MA. Accessed 8/20/2015.
4. Chou R, Hashimoto R, Friedly J, Fu Rochelle, Dana T, Sullivan S, Bougatsos C, Jarvik J. Pain Management Injection Therapies for Low Back Pain. Technology Assessment Report ESIB0813. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. HHSA 290-2012-00014-I.) Rockville, MD: Agency for Healthcare Research and Quality; March 2015.
5. Chou R. Subacute and chronic low back pain: Nonsurgical interventional treatment. In: UpToDate, Atlas SJ (Ed), UpToDate, Waltham, MA. Accessed 8/17/2015.
6. Chou R, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American college of physicians and the American pain society. Ann Intern Med. 2007;147:478-491.
7. Chou R et al. Diagnostic imaging for low back pain: advice for high-value health care from the American College of Physicians. Ann Intern Med 2011; 154:181-189.
8. Chou R et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain. An evidence-based clinical practice guideline from the American Pain Society. Spine 2009; 34: 1066-1077.
9. Fernandez-del Castillo C, Jimenez RE. Supportive care of the patient with advanced exocrine pancreatic cancer. In: UpToDate, LaMont JT, Goldberg RM (Ed), UpToDate, Waltham, MA, 2013.
10. Freedman SD. Treatment of chronic pancreatitis. In: UpToDate, Whitcomb DC (Ed), Waltham, MA. Accessed 8/20/2015.
11. Hayes Health Technology Brief. Endoscopic epidural adhesiolysis for chronic back pain. 12/23/2013.
12. Hayes Health Technology Brief. Percutaneous epidural adhesiolysis for chronic back pain. 12/27/2013.
13. Hayes Medical Technology Directory. Spinal cord stimulation for relief of neuropathic pain. 1/19/2012.
14. Heggeness MH. AAOS endorses back pain guidelines. AAOS Now. Sept 2010.
15. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines for Interventional Techniques: Part 1. Diagnostic Interventions. Pain Physician 2010; 13:E141-E174.
16. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines For Interventional Techniques: Part 2. Therapeutic Interventions. Pain Physician 2010; 13:E215-E264.
17. Novak S, Nemeth WC. The basis for recommending repeating epidural steroid injections for radicular low back pain: a literature review. Arch Phys Med Rehabil 2008: 89:543-552.
18. Salahadin A. Prevention and management of complex regional pain syndrome in adults. In: UpToDate, Goldenberg DL (Ed), UpToDate, Waltham, MA, 2013.
19. Todd DJ. Bursitis: An overview of clinical manifestations, diagnosis, and management. In: UpToDate, Isaac Z, (Ed), UpToDate, Waltham, MA. Accessed 8/20/2015.
20. Simmons M, Laham RJ. New therapies for angina pectoris. In: UpToDate, Kaski JC (Ed), UpToDate, Waltham, MA. Accessed 8/20/2015.
21. Soloman M, Mekhail MN, Mekhail N. Radiofrequency treatment in chronic pain. Expert Rev Neurother. 2010;10(3):469-474. Accessed online at: http://www.medscape.com/viewarticle/718292_1

22. Staal JB et al. Injection therapy for subacute and chronic low-back pain. Cochrane Database of Systematic Reviews 2008, Issue 3. Art. No. CD001824. DOI: 10.1002/14651858.CD001824.pub3.
23. Hayes Medical Technology Directory. Local Injections Therapy and Neurosurgery for Cervicogenic Headache and Occipital Neuralgia. September 30, 2011. http://www.hayesinc.com/hayes/
24. Hayes Medical Technology Directory. Nerve Blocks for the Treatment of Chronic Nonmalignant Pain. September 22, 2011
25. Ullrich PF. Injections for back pain management: Selective nerve root block (SNRB) for diagnosis and back pain management. Access online at: http://www.spine-health.com/treatment/injections/injections-back-pain-management
26. Work Loss Data Institute. Low back – lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2011. Various p.

Important Reminder

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This policy is current at the time of approval, may be updated and therefore is subject to change. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.