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Substance Use Disorder Treatment and Pain Management: Urine Drug Testing CorporateMedical Policy

File Name: Substance Use Disorder Treatment and Pain Management: Urine Drug Testing
File Code: 2.04.VT98
Last Review: 02/2021
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Description/Summary

Patients in pain management programs and those receiving substance use disorder treatment may misuse prescribed opioids and/or may use non-prescribed drugs. Thus, these patients are often assessed before treatment and monitored while they are receiving treatment. Urine drug testing (UDT) can be part of this monitoring strategy; it is most often used as part of a multifaceted intervention that includes other components such as patient contracts, Prescription Drug Monitoring Programs, etc.

For individuals who have chronic pain treated with opioids who receive UDT, the evidence includes nonrandomized comparative studies and systematic reviews. Relevant outcomes are test validity, health status measures, and resource utilization. The evidence on the diagnostic accuracy of urine immunoassay tests, as confirmed by gas- or liquid- chromatography/mass spectrometry, shows sensitivities ranging from about 80% to 93% for both opiates and oxycodone. No randomized controlled trials (RCTs) evaluating clinical utility were identified. Several nonrandomized comparative studies have been conducted, though interventions and outcomes have varied across the studies. Most interventions included patient contracts along with UDT, and therefore, the effect of UDT alone could not be determined. Most studies did not provide details on the frequency of UDTs and whether the testing was random or scheduled. As a result, these studies provided inconclusive evidence on whether UDT in the pain management setting improves patient outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a substance use disorder and are in substance use disorder treatment who receive UDT, the evidence includes 2 RCTs. Relevant outcomes are test accuracy and validity, health status measures, and resource utilization. No studies were identified that evaluated the accuracy of UDT compared with a valid reference standard in individuals undergoing substance use

disorder treatment. One small RCT focused specifically on UDT to determine eligibility for take-home methadone. The second RCT found that UDT identified drug use in a substantial number of patients who denied illicit usage; the impact on treatment success was not addressed. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2014 indicated that UDT is standard of care and supported the medical necessity of UDT under certain circumstances. Guidelines from Department of Veterans Affairs and Department of Defense, American College of Occupational and Environmental Health, American Society of Interventional Pain Physicians, and the National Opioid Use Guideline Group have recommended UDT at baseline, and periodic random UDT thereafter. The guidelines consider the frequency of testing to be at the discretion of the health care provider, based on an assessment of the patient's risk for misuse or addiction. Thus, UDT may be considered medically necessary in selected situations.

For individuals who have chronic pain treated with opioids or with a substance use disorder and are in substance use disorder treatment who receive oral fluid drug testing, the evidence includes diagnostic accuracy studies using UDT as the reference standard. Relevant outcomes are test validity, health status measures, and resource utilization. The limited number of studies on the diagnostic accuracy of oral fluid testing compared with UDT have varied findings. No studies were identified assessing the impact of oral fluid testing on health outcomes compared with UDT or no drug testing. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have chronic pain treated with opioids or with a substance use disorder and are in substance use disorder treatment who receive hair drug testing, the evidence includes a diagnostic accuracy study in the psychiatric treatment setting. Relevant outcomes are test validity, health status measures, and resource utilization. Hair testing cannot detect recent drug use (ie, in the past few days), and thus has limited applicability to pain management or substance use disorder treatment settings, except, potentially, for initial intake. There are no studies comparing the diagnostic accuracy of hair testing with UDT in either setting. One relatively small study tested the hair and urine of known drug users recruited from a psychiatric clinic. The study looked for drug use over the past several months rather than the shorter timeframe generally needed in pain management or drug treatment settings. No studies were identified on the clinical utility of hair testing in pain management or substance use disorder treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I - CPT® and HCPCS Code Table & Instructions

Attachment II – ICD-10-CM Code Table & Instructions

When a service may be considered medically necessary

Pain Management

In outpatient pain management, qualitative/presumptive (ie, immunoassay) urine drug testing may be considered medically necessary for:

- Baseline screening before initiating treatment or at the time treatment is initiated, when all of the following conditions are met:
  - An adequate clinical assessment of patient history and risk of substance use disorder is performed;
  - Clinicians have knowledge of test interpretation;
  - There is a plan in place regarding how to use test findings clinically
- Subsequent monitoring of treatment at a frequency appropriate for the risk- level of the individual patient (see Policy Guidelines sections).

Opiate and other Substance Use Disorders

In outpatient substance use disorder treatment, laboratory, in-office or point-of-care qualitative/presumptive (ie, immunoassay) urine drug testing may be considered **medically necessary** for the following circumstances:

- Baseline screening before initiating treatment or at the time treatment is initiated (ie, induction phase), one time per program entry, when all of the following conditions are met:
  - An adequate clinical assessment of patient history and risk of substance use disorder is performed;
  - Clinicians have knowledge of test interpretation;
  - There is a plan in place regarding how to use test findings clinically
- Stabilization phase – targeted weekly qualitative screening for a maximum of four weeks
- Maintenance phase – targeted qualitative screening everyone to three months
- At least eight random drug tests per year as per federal treatment guidelines (https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP)

Quantitative/definitive (ie, confirmatory) urine drug testing, in outpatient pain management or substance use disorder treatment, may be considered **medically necessary** under the following circumstances:

- When immunoassays for the relevant drug(s) are not commercially available.
- In specific situations for which quantitative drug levels are required for clinical decision making. For example: when there is a positive finding (e.g., presence of a substance not prescribed); OR a negative finding when a positive result is expected (see Policy Guidelines section)
- There is an indication of the specific drug being confirmed (e.g., order the individual substance(s) at question instead of a comprehensive confirmatory panel).

When a service is considered not medically necessary

In outpatient pain management and outpatient substance use disorder treatment, urine drug testing is considered **not medically necessary** when the above criteria are not met including but not limited to routine qualitative/presumptive or quantitative/definitive urine drug testing (eg, testing at every visit, without consideration for specific patient risk factors or without consideration for whether quantitative testing is required for clinical decision making).

Testing performed as described below is not medically necessary:

- Routine qualitative/presumptive or quantitative/definitive or confirmatory urine drug testing (e.g., testing at every visit)
- Unbundled tests when using a multi-test kit screening (e.g. strip, dip card, or cassette)
- Quantitative/definitive or confirmatory testing instead of qualitative/presumptive drug screening other than as outlined above, or as a routine supplement to drug screens
- Qualitative/presumptive, quantitative/definitive or confirmatory testing orders for "custom profile" or "conduct additional testing as needed"
- Quantitative/definitive or confirmatory testing that is indiscriminately carried out without a positive or unexpected negative result
- Quantitative/definitive or confirmatory testing of negative point-of -care results, and expected positive results (i.e., known prescribed drugs)

  "Standing orders" or routine orders given to a population of patients that may result in testing that is not individualized, and not used in the management of the patient's specific medical condition.

When a service is considered investigational

In outpatient pain management and substance use disorder treatment, hair drug testing and oral fluid drug testing are considered **investigational**.

When a service is considered a benefit exclusion and therefore not covered

Testing ordered by or for third parties (such as courts, schools, military or employers) or ordered for the sole purpose of meeting the requirements of a third party.

Policy Guidelines

Guidance regarding quantitative/definitive, ie, confirmatory testing:

- Specific situations for quantitative drug testing may include, but are not limited to the following:
  - Unexpected positive test inadequately explained by the patient
  - Unexpected negative test results, unless positive results are expected (eg, known prescribed drugs).

- Need for quantitative levels to compare with established benchmarks for clinical decision making subsequent monitoring of treatment for chronic non-cancer pain:

The Washington State Agency Medical Directors' Group (2015) updated its interagency guidelines on opioid dosing for chronic non-cancer pain. The guidelines included recommendations on UDT. Recommendations on testing frequency differed depending on the patient risk of opioid addiction and opioid dosage, as listed below:

Low risk: Once per year Moderate risk:

Twice per year

High risk or opioid dose over 120 mg MED/d: 3-4 times per year

Aberrant behavior: Each visit.

There may not be commercially available tests for certain synthetic or semisynthetic opioids.

The following information on immunoassay availability and diagnostic capacity is included in the Washington State Inter-Agency Guideline[1]:

Natural opioids (e.g., codeine, morphine)

"Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone."

Semisynthetic opioids (e.g., hydrocodone, hydromorphone, oxycodone, oxymorphone)

"Opiates" immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS [liquid chromatography tandem mass spectrometry]) is required to verify compliance with the prescribed semisynthetic opioid(s).

Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively."

Synthetic opioids (e.g., fentanyl, meperidine, methadone, propoxyphene)

"Current "opiates" immunoassays do not detect synthetic opioids. Thus, confirmatory testing

(GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified."

The following table on interpreting unexpected results of urine drug tests was adapted from one developed by the Canadian National Opioid Use Guideline Group that was cited by ASIPP in their guideline on prescribing opioids for chronic non-cancer pain:

Unexpected Result	Possible Explanation	Possible Actions for the Physician
Test is Negative for Prescribed Opioid	●False Negative ●Non-compliance ●Diversion	●Conduct Confirmatory Testing specifying the drug of interest (e.g., Oxycodone often missed by immunoassay); ●Take a detailed history of the patient's medication use for the preceding 7 d (e.g., could learn that the patient ran out several days prior to the test; ●Ask patient if they have given the drug to others; ●Monitor compliance with pill counts.
Test is Positive for Non Prescribed Opioid or Benzodiazepines	●False Positive ●Patient acquired Opioids from Other Sources (double-doctoring, "street")	●Repeat Urine Drug Testing regularly; ●Ask patients if they accessed Opioids from other sources; ●Assess for Opioid misuse / addiction; ●Review / Revise Treatment Agreement.
UDS Positive for Illicit Drugs (e.g., Cocaine, Cannabis)	●False Positive ●Patient is Occasional User or Addicted to the Illicit Drug ●Cannabis is Positive for Patients taking Certain Medications (e.g., Dronabinol)	●Repeat Urine Drug Testing regularly; ●Assess for Abuse / Addiction & Refer for Addiction Treatment as Appropriate

Background

Substance use, abuse, and dependence involving numerous prescription and illicit drugs is also a serious social and medical problem. Substance dependence is a primary, chronic disease of brain reward, motivation, memory, and related circuitry and is manifested by individual pathologic pursuit of reward and/or relief by substance use and other behaviors.

Confirming whether patients follow these behavioral guidelines can be a challenge. Risk assessment screening instruments can aid in the assessment of patients' risk for inappropriate drug use. In addition, the presence of "aberrant behaviors" can be used as a marker for patients who are at high risk for deviating from treatment protocols.

Aberrant behaviors include multiple lost prescriptions, obtaining prescriptions from other practitioners, and displaying evidence of acute intoxication during office visits.

Regulatory Status

Opioid Treatment Programs Screening Guidelines Vermont and resources

https://www.healthvermont.gov/alcohol-drugs/professionals/medication-assisted-treatment-resources

https://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-medication-assisted-therapy-for-dependence.pdf

The primary goal of medication assisted therapy is to improve overall individual functioning of the patient. A necessary component in reaching this goal is the monitoring of illicit substance use and ensuring programmatic compliance. Urine toxicology testing is consistent with the reasonable standard of practice and is a requirement for medication assisted therapy programs in the State of Vermont for providers governed by the Medication Assisted Therapy (MAT) rules. Current federal and state regulations, however, are not prescriptive of which substances must be tested for in urine toxicology panels. It is recommended that a comprehensive screening for drugs of abuse shall be done at admission into Opioid Treatment Programs (OTPs) and should reflect the prevailing use patterns in the community.

Vermont Board of Medical Practice Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

http://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Opioid%20Pain%20Policy%2004022014.pdf

Rationale/Scientific Background

The Blue Cross and Blue Shield Association policy was created in 2014 with a search of the MEDLINE database and updated with a literature review through December 30, 2020.

Clinical Input Received From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received through five physician specialty societies and eight academic medical centers while this policy was under review in 2014. There was near consensus among reviewers that, in the outpatient pain management, qualitative urine drug testing may be considered medically necessary for patients who meet the stated criteria and that the frequency of repeat drug testing should be dependent on the risk level of the individual. There was also near

consensus among reviewers that, in substance use disorder treatment, baseline qualitative drug testing may be considered medically necessary for patients who meet the stated criteria and that targeted weekly qualitative screening for a maximum of four weeks may be considered medically necessary during the stabilization phase. There was mixed input on the frequency of qualitative drug testing that may be considered medically necessary during the maintenance phase of substance use disorder treatment. In addition, clinical input was mixed on confirmatory quantitative drug testing and particularly on the issue of whether quantitative drug testing should only be performed on a drug-specific basis.

Reference Resources

1. Blue Cross and Blue Shield Association medical policy "Drug Testing in Pain Management and Substance Use Disorder Treatment" MPRM 2.04.98 Last review December 2020
2. Vermont Department of Health Vermont 2013 Opioid Treatment Programs Screening Guidelines. Available on line at: http://www.healthvermont.gov/sites/default/files/documents/2016/12/adap_opioid_treatment_programs_screening_guidelines.pdf
3. Vermont Department of Health, Medication Assisted Therapy for Opioid Dependence Rule. Available on line at: http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-medication-assisted-therapy-for-dependence.pdf management of opioid therapy for chronic pain.www.guideline.gov. Accessed December 30, 2019
4. Federal Guidelines for Opioid Treatment Programs. SAMHSA, January 2015. https://store.samhsa.gov/system/files/pep15-fedguideotp.pdf

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

06/2015	New Policy
07/2016	Language adopted from BCBSA # 2.04.98. HCPCS codes updated.
06/2017	Aligned to BCBSA MPRM 2.04.98. Updated references. Added investigational language for hair and oral fluid drug testing. Minor grammatical and formatting changes. Added CPT® Codes 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659. Deleted CPT® Codes 80300, 80301, 80302, 80303,80304, G6030-G6058, G0477, G0478, G0479.
12/2018	Updated to continue to align with BCBSA MPRM 2.04.98. No change to policy statements.
01/2020	Updated to continue to align with BCBSA MPRM 2.04.98. No change to policy statements. Added section for medical criteria for subsequent monitoring of treatment for chronic mon-cancer pain. Updated Vermont guidelines and references updated.
02/2021	Updated references minor language changes. Removed unit designation in coding table and added the following codes to the policy table: 0082U, 0051U, 0054U, 0117U as investigational. 0093U requires prior approval. Codes 0011U, 0117U, 0079U, 0116U medically necessary if criteria has been met. No changes to policy statements.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors **Date Approved**

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Kate McIntosh, MD, MBA, FAAP
Senior Medical Director

Attachment I
CPT® and HCPCS Code Table & Instructions

Code Table	Number	Brief Description	
The following codes may be considered as medically necessary when applicable criteria have been met.			
CPT®	80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service	
CPT®	80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	

CPT®	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	
CPT®	80299	Quantitation of therapeutic drug, not elsewhere specified.	Suspend for medical review
CPT®	80320	Alcohols	
CPT®	80321	Alcohol biomarkers; 1 or 2	
CPT®	80322	Alcohol biomarkers; 3 or more	
CPT®	80323	Alkaloids, not otherwise specified	
CPT®	80324	Amphetamines; 1 or 2	
CPT®	80325	Amphetamines; 3 or 4	
CPT®	80326	Amphetamines; 5 or more	
CPT®	80327	Anabolic steroids; 1 or 2	
CPT®	80328	Anabolic steroids; 3 or more	
CPT®	80329	Analgesics, non-opioid; 1 or 2	
CPT®	80330	Analgesics, non-opioid; 3-5	
CPT®	80331	Analgesics, non-opioid; 6 or more	
CPT®	80332	Antidepressants, serotonergic class; 1 or 2	
CPT®	80333	Antidepressants, serotonergic class; 3-5	
CPT®	80334	Antidepressants, serotonergic class; 6 or more	
CPT®	80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	
CPT®	80336	Antidepressants, tricyclic and other cyclicals; 3-5	
CPT®	80337	Antidepressants, tricyclic and other cyclics 6 or more	
CPT®	80338	Antidepressants, not otherwise specified	

CPT®	80339	Antiepileptics, not otherwise specified; 1-3	
CPT®	80340	Antiepileptics, not otherwise specified; 4-6	
CPT®	80341	Antiepileptics, not otherwise specified; 7 or more	
CPT®	80342	Antipsychotics, not otherwise specified; 1-3	
CPT®	80343	Antipsychotics, not otherwise specified; 4-6	
CPT®	80344	Antipsychotics, not otherwise specified; 7 or more	
CPT®	80345	Barbiturates	
CPT®	80346	Benzodiazepines; 1-12	
CPT®	80347	Benzodiazepines; 13 or more	
CPT®	80348	Buprenorphine	
CPT®	80349	Cannabinoids, natural	
CPT®	80350	Cannabinoids, synthetic; 1-3	
CPT®	80351	Cannabinoids, synthetic; 4-6	
CPT®	80352	Cannabinoids, synthetic; 7 or more	
CPT®	80353	Cocaine	
CPT®	80354	Fentanyl	
CPT®	80355	Gabapentin, non-blood	
CPT®	80356	Heroin metabolite	
CPT®	80357	Ketamine and norketamine	
CPT®	80358	Methadone	
CPT®	80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	
CPT®	80360	Methylphenidate	
CPT®	80361	Opiates, 1 or more	
CPT®	80362	Opioids and opiate analogs; 1 or 2	
CPT®	80363	Opioids and opiate analogs; 3 or 4	
CPT®	80364	Opioids and opiate analogs; 5 or more	
CPT®	80365	Oxycodone	
CPT®	80366	Pregabalin	

CPT®	80367	Propoxyphene	
CPT®	80368	Sedative hypnotics (non-benzodiazepines)	
CPT®	80369	Skeletal muscle relaxants; 1 or 2	
CPT®	80370	Skeletal muscle relaxants; 3 or more	
CPT®	80371	Stimulants, synthetic	
CPT®	80372	Tapentadol	
CPT®	80373	Tramadol	
CPT®	80374	Stereoisomer (enantiomer) analysis, single drug class	
CPT®	80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	
CPT®	80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	
CPT®	80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	
CPT®	83992	Phencyclidine (PCP)	
CPT®	0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected	Requires Prior Approval
CPT®	0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites	
CPT®	0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain	
CPT®	0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	

CPT®	0116U	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications	
HCPCS	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), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.	
HCPCS	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 source(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.	
HCPCS	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), includes specimen validity testing, per day,15- 21drug class(es), including metabolite(s) if performed	

HCPCS	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), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed	
HCPCS	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.	
The following codes will be denied and Not Medically Necessary, Non-Covered, Contract Exclusions or Investigational			
CPT®	0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service	Investigational
CPT®	0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service	Investigational

CPT®	0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service	Investigational
CPT®	0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain	Investigational

Attachment II
ICD-10-CM Diagnosis Code Table & Instructions

Code Type	Number	Description
Any of a large number of diagnosis codes might apply to this policy, the following are just examples		
ICD-10-CM	F11.10- F11.99	Opioid related disorders, code range
ICD-10-CM	F14.10- F14.99	Cocaine related disorders, code range
ICD-10-CM	F16.10- F16.99	Hallucinogen related disorders, code range
ICD-10-CM	F45.42	Pain disorder with related psychological factors
ICD-10-CM	G89.21-G89.4	Chronic pain not otherwise specified code range