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Drug Testing in Pain Management and Substance Use Disorder CorporateMedical Policy

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Description/Summary

Patients in pain management programs and substance use disorder treatment may misuse prescribed opioids and/or may use nonprescribed drugs. Thus, these patients are often assessed before treatment and monitored while receiving treatment. Drug testing 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.

Guidelines with evidence reviews of published peer-reviewed scientific literature suggest that the evidence of benefit on health outcomes for drug testing for both patients in chronic pain using opioids and patients with substance use disorder is limited and usually confounded with drug testing as part of a multifaceted intervention of risk mitigation or contingency management. There is also no clear evidence in the literature regarding the most effective frequency of testing. Notwithstanding the lack of evidence, clinical input and guidelines indicate that drug testing is standard of care.

Various strategies are available to monitor pain management and substance use disorder treatment patients and multicomponent interventions are often used. One strategy for monitoring patients is testing of biologic specimens for the presence or absence of drugs. Currently, urine is the most commonly used biologic substance. Advantages of urine drug testing (UDT) are that it is readily available and standardized techniques for detecting drugs in urine exist.

Policy

Coding Information

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

Attachment I - CPT® and HCPCS Code Table & Instructions

When a service may be considered medically necessary

Pain Management

In outpatient pain management, qualitative/presumptive (i.e., 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; AND
  - Clinicians have knowledge of test interpretation; AND
  - 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).

Substance Use Disorder Treatment

In outpatient substance use disorder treatment, laboratory, in-office or point-of-care qualitative/presumptive (i.e., 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 (i.e., 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; AND
  - Clinicians have knowledge of test interpretation; AND
  - 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 testing once every 1 to 3 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 (i.e., 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 (e.g., 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) beyond 50 units combined (Presumptive Drug Testing & Definitive Drug Testing in the table below) per plan year.
- 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 on Definitive (Confirmatory) Testing

Specific situations for quantitative drug testing may include, but are not limited to the following:

- Need to detect a specific substance not adequately identified by presumptive methods
- Unexpected positive test inadequately explained by the patient (e.g., a positive result on a presumptive test is inconsistent with the history and physical exam)
- Unexpected negative test (suspected medication diversion)
- Need for quantitative levels to compare with established benchmarks for clinical decision making such as treatment transition or changes in medication therapies.

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)

Many 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

Evidence indicates that approximately one-third of patients receiving treatment for chronic pain do not use opioids as prescribed or may abuse them and that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and the use of illicit drugs. An alarming number of deaths has been related to the use of prescription opioids.

Substance use, abuse, and addiction involving numerous prescription and illicit drugs is also a serious social and medical problem. Substance use disorder 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.

Various strategies and multicomponent interventions are available to monitor patients receiving treatment for chronic pain and substance use disorder. Many settings, for example, require patients to sign a contract before they are given a prescription for opioids. The contracts generally involve obtaining patients' agreement on behaviors they will engage in during the treatment period (e.g., taking medication as prescribed) and not engage in (e.g., selling prescribed medication and/or obtaining additional prescriptions from other physicians).

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.

Another strategy for monitoring patients is testing of biologic specimens for the presence or absence of drugs. Currently, urine is the most commonly used biologic substance. Advantages of urine drug testing (UDT) are that it is readily available and standardized techniques for detecting drugs in urine exist. There are two primary categories of UDT: presumptive testing (immunoassay) and confirmatory testing (specific drug identification).

Regulatory Status

Opioid Treatment Programs Screening Guidelines Vermont and resources

https://www.healthvermont.gov/alcohol-drugs/professionals/opioid-prescribing-and-moud
https://www.healthvermont.gov/sites/default/files/documents/pdf/MAT%20Rule.Final%20Adopted.September%202021%20.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 for Opioid Use Disorder (MOUD) (formerly known as Mediation Assisted Treatment or 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

Guidelines with evidence reviews of published peer-reviewed scientific literature suggest that the evidence of benefit on health outcomes for drug testing for both patients in chronic pain using opioids and patients with substance use disorder is limited and usually confounded with drug testing as part of a multifaceted intervention of risk mitigation or contingency management. There is also no clear evidence in the literature regarding the most effective frequency of testing.

Notwithstanding the lack of evidence, clinical input and guidelines indicate that drug testing is standard of care. Therefore, a rigorous study comparing drug testing to no drug testing and following patients for health outcomes is unlikely to be performed.
Thus a traditional evidence review will not be performed and relevant national and regional clinical practice guidelines were sought to inform the review.

The Blue Cross and Blue Shield Association policy was created in February 2014 with a search of the PubMed database. The most recent literature update was performed through September 29, 2022.

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 2022.
2. Vermont Department of Health: Opioid Prescribing and MOUD. Available online at: https://www.healthvermont.gov/alcohol-drugs/professionals/opioid-prescribing-and-moud
3. Vermont Department of Health: Rules Governing Medication-Assisted Treatment for Opioid Use Disorder for: 1. Office-Based Opioid Treatment (OBOT) Providers and 2. Opioid Treatment Programs (OTP) – State Regulations. Available online at: https://www.healthvermont.gov/sites/default/files/documents/pdf/MAT%20Rule.Final%20Adopted.September%202021%20.pdf
4. Federal Guidelines for Opioid Treatment Programs. SAMHSA, January 2015. Accessed January 2023. https://store.samhsa.gov/sites/default/files/d7/priv/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 non-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.

03/2022	Removed superfluous and outdated description/summary content. Updated and streamlined language throughout in description, background, and policy guidelines to better align with BCBSA. Changed Policy name/title to align with Association name and content. Clarified Maintenance Stage testing. Updated references. Minor formatting and grammar changes. Codes 80299, 0011U, 0079U, 0116U re-sequenced in coding table. Codes 82077 & 0007U added as medically necessary. Codes 0143U, 0144U, 0145U, 0146U 0147U, 0148U, 0149U, 0150U added as not medically necessary. Codes 0227U & P2031added as investigational. Codes 80305, 80306, 80307, 0011U, G0480, G0481, G0482, G0483 & G0659 new instructions added to coding table not to exceed (50) units combined limit (Presumptive Drug Testing & Definitive Drug Testing in the table) per plan year.
09/2022	Revised medical policy statement to not exceed beyond (50) units combined (Presumptive Drug Testing & Definitive Drug Testing in the table below) per plan year.
03/2023	Updated references. Minor grammatical changes. No changes to policy statement or intent. Updated coding table instructions for clarification purposes.

Eligible Providers

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

Approved by BCBSVT Medical Directors **Date Approved**

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Attachment I

CPT® and HCPCS Code Table & Instructions

Code	Description	Policy Instructions
Presumptive /Screening/ Qualitative Drug Testing Codes		
The following codes will be considered medically necessary when criteria in the applicable policy statements listed above are met, not to exceed (50) units combined (Presumptive Drug Testing & Definitive Drug Testing in the table below) per plan year.		
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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.

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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.
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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.
Definitive/Confirmatory/ Quantitative Drug Testing Codes		
The following codes will be considered medically necessary when criteria in the applicable policy statements listed above are met, not to exceed (50) units combined (Presumptive Drug Testing & Definitive Drug Testing in the table below) per plan year.		
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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.

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, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.
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); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.

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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.
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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.

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	Not to exceed (1) per date of service and up to (50) units combined (Presumptive Drug Testing & Definitive Drug Testing) per plan year.
The following codes will be considered medically necessary when applicable criteria have been met.		
80299	Quantitation of therapeutic drug, not elsewhere specified	Code will suspend for medical review
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	Refer to instructions at beginning of coding table
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	Refer to instructions at beginning of coding table

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	Refer to instructions at beginning of coding table
80320	Alcohols	
80321	Alcohol biomarkers; 1 or 2	
80322	Alcohol biomarkers; 3 or more	
80323	Alkaloids, not otherwise specified	
80324	Amphetamines; 1 or 2	
80325	Amphetamines; 3 or 4	
80326	Amphetamines; 5 or more	
80327	Anabolic steroids; 1 or 2	
80328	Anabolic steroids; 3 or more	
80329	Analgesics, non-opioid; 1 or 2	
80330	Analgesics, non-opioid; 3-5	
80331	Analgesics, non-opioid; 6 or more	
80332	Antidepressants, serotonergic class; 1 or 2	
80333	Antidepressants, serotonergic class; 3-5	
80334	Antidepressants, serotonergic class; 6 or more	
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	
80336	Antidepressants, tricyclic and other cyclicals; 3-5	
80337	Antidepressants, tricyclic and other cyclicals; 6 or more	
80338	Antidepressants, not otherwise specified	
80339	Antiepileptics, not otherwise specified; 1-3	
80340	Antiepileptics, not otherwise specified; 4-6	
80341	Antiepileptics, not otherwise specified; 7 or more	
80342	Antipsychotics, not otherwise specified; 1-3	
80343	Antipsychotics, not otherwise specified; 4-6	
80344	Antipsychotics, not otherwise specified; 7 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	
80355	Gabapentin, non-blood	
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	
80364	Opioids and opiate analogs; 5 or more	
80365	Oxycodone	
80366	Pregabalin	
80367	Propoxyphene	
80368	Sedative hypnotics (non-benzodiazepines)	
80369	Skeletal muscle relaxants; 1 or 2	
80370	Skeletal muscle relaxants; 3 or more	
80371	Stimulants, synthetic	
80372	Tapentadol	
80373	Tramadol	
80374	Stereoisomer (enantiomer) analysis, single drug class	
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	
82077	Alcohol (ethanol); any specimen except urine and breath, immunoassay (eg, IA, EIA, ELISA, RIA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)	
83992	Phencyclidine (PCP)	

0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service	
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	Refer to instructions at beginning of coding table
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected	Requires Prior Approval
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	
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	

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, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed	Refer to instructions at beginning of coding table
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); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed	Refer to instructions at beginning of coding table

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	Refer to instructions at beginning of coding table
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	Refer to instructions at beginning of coding table

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	Refer to instructions at beginning of coding table
The following codes will be denied as Not Medically Necessary, Contract Exclusion or Investigational		
0051U	Prescription drug monitoring, evaluation of drugs present by liquid chromatography tandem mass spectrommetry (LC-MS/MS), urine or blood, 31 drug panel, reported as quantitative results, detected or not detected, per date of service	Investigational
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
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

0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary

0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service	Not Medically Necessary
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation	Investigational
P2031	Hair analysis (excluding arsenic)	Investigational