Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: WA.UM.29
Effective Date: 12/14
Last Review Date: 2/18

Coding Implications
Revision Log

Subject

Outpatient testing for drugs of abuse (DOA)

Description

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

Policy/Criteria

I. It is the policy of Coordinated Care that outpatient quantitative 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/presumptive drug test has been previously performed; *and*
2. The findings from that preliminary/presumptive (qualitative) test (either positive or negative) are either:
   a. Inconsistent with the expected results as suggested by the member's medical history, clinical presentation, and/or member's own statement after a detailed discussion about their recent medication and drug use, or
   b. The qualitative test yields 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)
2. Participation in school or community athletic activities or programs
3. Participation in school or community extra circular 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.

Coding Information

G0480- quantitative drug testing of 1-7 different drug classes
G0481- quantitative drug testing of 8-14 different drug classes
G0482- quantitative drug testing of 15-21 different drug classes
G0483- quantitative drug testing of 22+ different drug classes

Drug Screening for medication assisted treatment (MAT)
Per the Health Care Authority, drug assay tests are covered for members receiving medication assisted treatment (MAT) for substance use disorders under the following conditions:

G0480 and G0481 are used for definitive testing
1 code may be billed per day and up to 24 units billed in a 12 month period.

Authorization Protocols

Outpatient confirmatory/definitive for DOA requires prior authorization EXCEPT when performed for children < 6 years of age.

Requests for PA will be accepted up to 30 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.

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 claim for a service for which a prior-authorization has not been provided may be subject to denial. 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.

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 2015, 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.

CPT®* Codes	Description
80184	Phenobarbital
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
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80371	Stimulants, synthetic
83992	Phencyclidine (PCP)

HCPCS Codes	Description
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects,

HCPCS Codes	Description
	interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
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); 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, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

References

1. American Society of Addiction Medicine. Public Policy Statement on Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in Other Clinical Settings. Revised October 2010.Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.)
2. Becker W, Starrels JL. Prescription drug misuse: Epidemiology, prevention, identification, and management. In: UpToDate, Saxon AJ (Ed), UpToDate, Waltham, MA. Accessed 09/23/16.
3. Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.
4. Christo PJ, Manchikanti L, Ruan X, et al. Urine Drug Testing in Chronic Pain. Pain Physician 2011;14:123-143.
5. Gourlay DL, Heit HA, Caplan YH. Urine Drug Testing in Clinical Practice. The Art and Science of Patient Care. Edition 5. Presented by the Johns Hopkins University School of Medicine. 2012.
6. Hoffman RJ. Testing for drugs of abuse (DOA). In: UpToDate, Traub SJ (Ed), UpToDate, Waltham, MA. Accessed 08/23/2017.

7. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials. June 2015.
8. Manchikanti L, Malla Y, Wargo BW, et al. Comparative Evaluation of the Accuracy of Immunoassay with Liquid Chromatography Tandem Mass Spectrometry (LC/MS/MS) of Urine Drug Testing (UDT) Opioids and Illicit Drugs in Chronic Pain Patients. Pain Physician 2011;14:175-187.
9. Moeller KE, Lee KC, Kissack JC. Urine Drug Screening: Practical Guide for Clinicians. Mayo Clin Proc 2008;83(1):66-76.
10. Wilfong A. Seizures and epilepsy in children: Initial treatment and monitoring. In: UpToDate, Nordli DR (Ed), UpToDate, Waltham, MA. Accessed 09/23/2016.
11. Hurford M, et al American Society of Addiction Medicine Consensus Statement. Appropriate Use of Drug Testing in Clinical Addiction Medicine. Adopted by the ASAM Board of Directors April 5, 2017. Endorsed by the American College of Medical Toxicology. Journal of Addiction Medicine. May/June 2017
12. Gourlay DL, Heit HA, Caplan YH. Urine Drug Testing in Clinical Practice. The Art and Science of Patient Care. Edition 6. Presented by the Center for Independent Healthcare Education. Aug 2015
13. Dasgupta A. Challenges in Laboratory Detection of Unusual Substance Abuse: Issues with Magic Mushroom, Peyote Cactus, Khat, and Solvent Abuse. Adv Clin Chem. 2017;78:163-186.
14. Snyder ML, Fantz CR, Melanson S. Immunoassay-Based Drug Tests Are Inadequately Sensitive for Medication Compliance Monitoring in Patients Treated for Chronic Pain. Pain Physician. 2017 Feb;20(2S):SE1-SE9.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Revision Log	Date
Added under Criteria: A.2.b option for concordant test results but specific quantitative analysis needed to identify specific drug	12/15
Updated coding to reflect 2016 HCPCS	1/16
Updated Description section, moved to new clinical policy template, included HCA language regarding MAT treatment limitations, updated background section	2/17
Added term “presumptive” and “qualitative” to preliminary drug testing. Codes reviewed and updated. Reviewed by neurology/pain management specialist. References reviewed and updated.	2/18