MEDICAL POLICY

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MEDICAL POLICY DETAILS	
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Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based on our criteria and assessment of the peer-reviewed literature, *presumptive* (immunoassay) urine drug testing, in office or at point-of-care, for outpatient pain management, is considered **medically appropriate** for:
   A. Baseline screening before initiating treatment or at the time treatment is initiated when the following conditions are met:
      1. An adequate clinical assessment of patient history and risk of substance use disorder is performed; and
      2. Clinicians have knowledge of test interpretation; and
      3. There is a plan in place regarding how to use test findings clinically; or
   B. Subsequent monitoring of treatment at a frequency appropriate for the risk level of the individual patient (*please refer to Policy Guidelines*).

II. Based on our criteria and assessment of the peer-reviewed literature, *presumptive* (immunoassay) urine drug testing, in office or at point-of-care, for outpatient substance use treatment, is considered **medically appropriate** for:
   A. Baseline screening before initiating treatment or at the time treatment is initiated, one time per program entry when the following conditions are met:
      1. An adequate clinical assessment of patient history and risk of substance use disorder is performed; and
      2. Clinicians have knowledge of test interpretation; and
      3. There is a plan in place regarding how to use test findings clinically; or
   B. Subsequent monitoring of treatment, either during a stabilization or maintenance phase at a frequency appropriate for the risk level of the individual patient (*please refer to Policy Guidelines*).

III. Based on our criteria and assessment of the peer-reviewed literature, *definitive* urine drug testing, in outpatient pain management or substance use treatment, is considered **medically appropriate** in the following circumstances:
   A. When presumptive urine drug testing is unable to identify the following:
      1. A specific substance or metabolite; or
      2. Specific drugs in a large family of drugs; or

3. A specific substance or metabolite that is not detectable by qualitative urine drug testing (e.g., fentanyl, meperidine, synthetic cannabinoids); or
4. A negative qualitative urine drug test result (or to confirm a positive result) that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan; or
5. A non-prescribed medication or illicit use, to ensure the safe ongoing prescription of controlled substances; or

B. When a definitive concentration of a drug is needed to guide management (e.g., discontinuance of THC use according to a treatment plan); or
C. To rule out an error as the cause of a qualitative urine drug testing result; or
D. When used as part of a differential assessment of medication efficacy, side effects, or drug-drug- interactions.

This medical policy addresses urine drug testing only and does not address drug testing using blood, hair or oral fluid.

POLICY GUIDELINES

I. Testing frequency is dependent on the stability of the patient, the type of treatment, the treatment setting and the half-life of drugs in the matrix being tested.

II. Testing should be performed randomly and/or selectively based on patient history.

III. Testing should not be performed as part of standard protocols (e.g., routine standing orders).

IV. Testing should be supported by both an order for the test and rationale for the testing.

V. The medical record should include documentation that the results were reviewed and will impact patient care.

VI. Presumptive urine drug testing for opioid pain management should be part of the pain management strategy and may be performed as follows:
   A. Prior to initiating opioid therapy.
   B. Every three months to assess effectiveness of the prescribed dose and decisions regarding tapering or increasing the dose are planned.
   C. At least annually.

VII. For end-of-life pain management with opioids, testing is indicated if there is any reason to consider diversion of the drug (lost scripts, lost pills, enormous escalation of utilization without member appearing to have consumed this amount of opioids).

VIII. Frequency of presumptive urine drug testing for substance use disorder is based on the consecutive days of abstinence as follows:
   A. 0 to 30 days consecutive abstinence: 1 to 3 presumptive urine drug tests per week. Requests for coverage of more than three presumptive urine drug tests per week must be accompanied by clinical documentation to support additional testing.
   B. 31 to 90 consecutive days of abstinence: 1 to 3 presumptive urine drug tests per week. Requests for coverage of more than three presumptive urine drug tests per week must be accompanied by clinical documentation to support additional testing.
   C. Greater than 90 consecutive days of abstinence: 1 to 3 presumptive urine drug tests per month. Requests for coverage of more than three physician-directed presumptive urine drug tests in one month must be accompanied by clinical documentation to support additional testing.

IX. Definitive urine drug testing for opioid pain management may be performed to detect specific opioids that cannot be identified on standard immunoassays or in the event of unexpected urine drug test results.

X. Frequency of definitive urine drug testing and the rationale for testing must be documented in the patient's medical record. Frequency is based on the following consecutive days of abstinence, as follows:

   A. 0 to 30 days consecutive days of abstinence: 1 physician-directed testing profile per week. Requests for coverage of more frequent definitive urine drug tests in one week must be accompanied by clinical documentation to support additional testing.

B. 31 to 90 consecutive days of abstinence: 1 to 3 physician-directed testing profile(s) per month. Requests for coverage of more than three definitive urine drug tests in one month must be accompanied by clinical documentation to support additional testing.
C. Greater than 90 consecutive days of abstinence: 1 to 3 physician-directed testing profile(s) per three month period. Requests for more than three definitive urine drug tests in a three-month period must be accompanied by clinical documentation to support additional testing.

XI. Frequency of urine drug testing for individuals on chronic opioid therapy depends on the risk of opioid misuse and/or the existence of an opioid disorder. Frequency of testing ranges from 1 to 2 times per 12 months (low-risk), 1 to 2 times per six months (moderate-risk), and 1 to 3 times per three month period for prescribed medications, non-prescribed medications that may pose a safety risk if mixed with prescribed medications, and illicit substances based on patient history, clinical presentation and/or community usage.

DESCRIPTION

Drug testing should be a key component of assessment and treatment planning, especially when integrated with other clinical information gathering, such as substance use history, physical and mental status examinations, withdrawal severity scores, and standardized laboratory assessments of metabolic, neurologic, and psychiatric status (ASAM, 2013 White Paper). A knowledgeable clinician can use drug testing to verify self-reports, confirm diagnoses, identify denial and minimization of drug and alcohol use, enhance motivation for treatment, measure biological adaptation, assist in development of treatment planning, monitor treatment response, document treatment effectiveness and outcomes, support patient advocacy by validating abstinence from alcohol and drug use, and validate adherence in taking prescribed controlled substances.

Urine drug testing is used in the initial, often intensive, phase of addiction treatment, sometimes referred to as “primary treatment.” Primary treatment includes intensive psychosocial services to assist patients in establishing abstinence; psychoeducational activities to assist patients in understanding their disease; psychotherapeutic interventions to help patients overcome shame and guilt and to accept their circumstances without minimization, denial, or bargaining; and cognitive-behavioral interventions to help patients manage cravings and identify drug-use triggers. Random and frequent urine drug testing should always be an important component of primary addiction treatment.

The monitoring phase after formal addiction treatment has been completed can last for varying lengths of time; however, at the center of this phase is continued random drug and alcohol testing. After primary addiction treatment, patients should be followed using models of chronic disease management, with the treatment goal of long-term, even lifetime, recovery that includes abstinence from alcohol and drug use.

When drug testing is used in addiction treatment settings, it is best to use random, rather than scheduled, testing and to set the frequency of the random testing higher at the start of treatment, when patients are known to more frequently engage in continued drug use. When the patient has attained a substantial period of stable abstinence from drug use, the frequency of random drug testing can be lowered. It is important that the testing be unpredictable, even if it is infrequent, so the patient can be tested at any time, even the day after the prior test. It is also wise to vary the drug testing panels and the matrix used for the testing. These should be as unpredictable to the participant as the date and time of the test itself.

There are two primary categories of urine drug testing.

Presumptive drug testing

Presumptive drug testing is used to determine the presence or absence of drugs or drug classes in a urine sample, when immediate test results are necessary for the immediate management of the patient. Types of presumptive/qualitative drug tests include competitive immunoassays (IA) and thin layer chromatography (TLC). IAs can be performed either in a laboratory or at point-of-service (e.g., a physician’s office). IA tests are based on the principle of competitive binding; they use antibodies to detect a particular drug or drug metabolite in a urine sample. With competitive binding, a fixed amount of a labeled drug is added to the urine sample, and the drug or metabolite in the sample competes with the labeled drug for binding sites on the antibody. The amount of labeled antigen that binds with the antibody is inversely

proportional to the amount of the drug or metabolite in the sample. The IA platform consists of cups, dipsticks, cassettes, or strips that are read by the human eye, or by an instrument assisted, direct-optical observation.

IA tests vary in the type of compounds they can detect. Some detect specific drugs and may fail to recognize similarly structured drugs within the same class. Other IAs identify only classes of drugs, and thus, results cannot be used to determine which drug a patient is taking. All IA tests are vulnerable to cross-reactivity from prescription, over-the-counter, and herbal medications, although such cross-reactivity is far less common today, now that the more-specific antibodies are in use. The most common IA drug test panel includes the SAMHSA-5: amphetamines (various stimulant drugs as a drug class), marijuana metabolites (THC), cocaine metabolites, opiates (natural opiates such as codeine and morphine), a metabolite of heroin but *not* other opioids such as oxycodone, hydrocodone, buprenorphine and methadone, and phencyclidine (PCP). Most commercially available IA drug test panels can be extended beyond this standard panel, often to include benzodiazepines, some of the semi-synthetic opioids such as buprenorphine, hydrocodone, oxycodone, and some of the synthetic opioids such as meperidine and methadone.

IA findings are generally reported qualitatively, as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). Thus, raising or lowering the threshold thus changes the proportion of positive tests. A negative test is interpreted as a level below the threshold and does not necessarily mean that the drug or metabolite is absent.

IAs generally have a rapid turnaround time, to within minutes for onsite tests, and within one to four hours for laboratory-based tests.

Definitive testing

Definitive testing is able to identify the specific molecular structures of a drug and its metabolites. It can be used to confirm the presence of a specific drug or metabolite identified by a screening test, as well as to identify drugs that cannot be isolated by currently available IAs. The tests are able to quantify the amount of drug or metabolite present in the urine sample and results are reported as the specific levels of substances detected. These tests are always performed in a laboratory. Types of definitive/quantitative tests include gas chromatography mass spectrometry (GC-MS) and liquid chromatography mass spectrometry (LC-MS). GC-MS is considered to be the criterion standard for definitive/confirmatory testing. This technique involves using gas chromatography (GC) to separate the analytes in a specimen and mass spectrometry (MS) to identify the specific molecular structures of the drug and its metabolites. GC-MS generally requires specification of the drug or drugs to be identified, and broad-spectrum screens can be conducted. Turnaround time for GC-MS is several days. LC-MS/MS, like GC-MS, can confirm IA results. LC-MS/MS uses the separation technique, with two mass spectrometers placed in tandem to detect a drug's unique ions secondary to fragmentation of characteristic precursor ions. The two-stage mass fragmentation process significantly improves identification of drugs and metabolites, when coupled with liquid chromatographic separation. As a confirmatory test of IA presumptive positive results, LC-MS/MS is easier and quicker to perform than GC-MS, as it does not necessarily require derivatization prior to analysis. Quantitative or confirmation testing can be performed as a reflex test which is performed after an initial test result to identify further diagnostic information that is essential to patient care.

An issue with both types of urine drug tests is the possibility of sample tampering to mask the presence of illegal drugs. A variety of products and techniques are available to patients, and can be as simple as drinking a large amount of water to dilute the sample. There are also commercial dilution and cleaning products, additives, and urine substitutes. Some of these techniques can be detected by visual inspection of the sample (e.g., color) or by onsite testing of sample characteristics including urine temperature, creatinine concentration, and specific gravity.

In addition, correct interpretation of urine drug test results is very important. Knowledge of drug metabolites is essential for accurate interpretation. Accurate interpretation of test results also requires knowledge of the drug manufacturing process. For example, due to manufacturing impurities, a small amount of hydrocodone may be present in urine samples from patients prescribed oxycodone. Thus, it would be acceptable to have this degree of hydrocodone if high amounts of oxycodone were also present.

There are various approaches to incorporating urine drug tests into pain management and substance use disorder treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use.

Some clinicians believe that urine drug testing should be routinely used to establish baseline information about substance use, but the optimal frequency and interval of testing remains uncertain. A universal approach to screening may uncover more inappropriate use and may reduce patients' sense that testing is being performed due to a lack of trust. However, routine universal screening may place an unnecessary burden on the health care system and on the doctor-patient relationship. An alternative approach is selective testing of patients who are judged to be at increased risk for drug misuse. Existing protocols vary for use of qualitative versus quantitative tests. Some of these involve conducting routine confirmation of positive qualitative tests with quantitative testing. Others involve selective confirmation of positive qualitative tests, such as when an unexpected IA result is not adequately explained by the patient. There is also a mixed approach, with routine confirmation of qualitative tests only for drugs with poor-performing IAs.

Full informed consent is a requirement before urine drug testing. Patients should be informed of the specific drug testing protocol before treatment and should provide written agreement with the plan for monitoring. As stated in a joint U.S. Veterans Affairs/Department of Defense guideline, patients' refusal to consent to urine testing should be considered as one factor in the overall assessment of patients' ability to adhere to treatment.

RATIONALE

A white paper on Drug Testing published by the American Society for Addiction Medicine (ASAM) (2013) encourages wider and "smarter" use of drug testing within the practice of medicine and, beyond that, broadly within American society. Smarter drug testing means increased use of random testing rather than the more common scheduled testing, and it means testing not only urine but also other matrices such as blood, oral fluid (saliva), hair, nails, sweat and breath when those matrices match the intended assessment process. Smarter testing means improved sample collection and detection technologies to decrease sample adulteration and substitution. Designing appropriate steps to respond to the efforts of individuals trying to subvert the testing process must be considered when evaluating the costs/benefit ratio of different testing matrices, recognizing that such countermeasures may have a dramatic impact on the usefulness of testing. Smarter drug testing means careful consideration of the financial costs of testing in relationship to the value and in many cases, medical necessity, of the test results as well as consideration of the advantages and limitations of the many testing technologies available today.

The American Society for Addiction Medicine (ASAM) updated its guidelines on Appropriate Use of Drug Testing in Clinical Addiction (2017). The guidelines include the following recommendations:
Drug testing should be used widely in addiction treatment settings because evidence suggests that drug testing assists with monitoring adherence and abstinence in treatment and can improve patient outcomes and should be used in combination with a patient's self-reported information about substance use. Providers should understand that drug tests are designed to measure whether a substance has been used within a particular window of time and drug testing panels should be based on the patient's drug of choice, prescribed medications, and drugs commonly used in the patient's geographic location and peer group.

Presumptive testing should be a routine part of initial and ongoing patient assessment, as it can provide more immediate (albeit less accurate) results. Definitive testing techniques should be used whenever a provider wants to detect specific substances not identified by presumptive methods, to quantify levels of the substance present, and to refine the accuracy of the results; and the results inform clinical decisions that have major clinical or non-clinical implications for the patient (e.g. treatment transition, changes in medication therapies, changes in legal status). For people in addiction treatment, frequency of testing should be dictated by patient acuity and level of care, and providers should look to tests' detection capabilities and windows of detection to determine the frequency of testing. Providers should understand that increasing the frequency of testing increases the likelihood of detection of substance use, but there is insufficient evidence that increasing the frequency of drug testing has an effect on substance use, itself. Drug testing should be scheduled more frequently (at least weekly) at the beginning of treatment, and the frequency should be decreased to monthly as recovery progresses and is stable. Testing should occur on a random schedule in outpatient services following weekends, holidays, and paydays, when feasible because the patient's opportunity for substance use is greater relative to residential treatment. Additional drug testing should be considered if a patient is experiencing stressful psychological events.

There is insufficient evidence in the published, peer-reviewed, scientific literature to establish the clinical utility or effectiveness of presumptive or definitive drug testing at a specific frequency. In addition, no professional society or

organization has published consensus guidelines regarding the frequency of drug testing. However, parameters regarding the principles of testing in a substance use disorder treatment program have been published which recommend testing more frequently at the start of treatment and after initial baseline testing; drug-test monitoring can progress to once per week, then to once per month, as long-term abstinence/sobriety is achieved.

In 2017, the American Society of Interventional Pain Physicians updated guidelines for responsible opioid prescribing for chronic noncancer pain. The guidelines make recommendations for urine drug testing, including undertaking a comprehensive assessment and documentation before initiating opioid therapy, screening for opioid use, to assist with identifying opioid abuses (Evidence: limited) and to reduce opioid abuse; and implementing of urine drug testing from initiation, including subsequent adherence monitoring, in an in-office setting with IA and confirmation for accuracy with chromatography in select cases. The goal is to identify patients who are non-compliant or abusing prescription drugs or illicit drugs, and urine drug testing may decrease prescription drug abuse or illicit drug use when patients are in chronic pain management therapy (Evidence: good). The evidence behind these recommendations was not clearly described in either the guidance document or the accompanying evidence assessment document.

In 2014, the American College of Occupational and Environmental Medicine updated its guidelines on the chronic use of opioids and recommended the routine use of urine drug screening for patients on chronic opioids, stating that there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise may not be apparent to the treating physician (Evidence: C). The guidelines noted that there is limited evidence that the urine drug screen may improve important health and functional benefits. Screening is recommended for all patients at baseline, and then randomly at least twice and up to four times per year, and at termination, as well as when the provider suspects abuse of prescribed medication.

Interagency guidelines on opioid dosing for chronic noncancer pain were updated in 2015 by the Washington State Agency Medical Directors' Group. The guidelines included recommendations on urine drug testing and on testing frequency which differed depending on patient risk of opioid addiction and opioid disease. For low-risk patients, testing frequency was recommended once per year. For moderate-risk patients, testing frequency was recommended twice per year. For high-risk patients, or patients whose opioid dose is over 120 mg MED/d, testing is recommended at a frequency of three to four times per year. Urine drug testing is recommended with each visit for aberrant behavior.

The American Pain Society and American Academy of Pain Medicine (2009) clinical guideline on the use of opioid therapy in chronic noncancer pain recommends the use of urine drug screens or other information to confirm adherence to the chronic opioid therapy plan of care, for in patients on chronic opioid therapy who are at high risk or who have engaged in aberrant drug-related behaviors (Evidence: low-quality, recommendation: strong). Periodic urine drug screens or other information to confirm adherence to the chronic opioid plan of care should be considered for patients who are on chronic opioid therapy, who are not at high risk and not known to have engaged in aberrant drug-related behaviors (Evidence: low quality, recommendation: weak). The recommendations suggest that random urine drug screening may be more informative than scheduled or routine testing and is likely to result in a higher yield in patients with risk factors for substance use disorder or diversion. Although evidence on accuracy of urine drug screening to identify aberrant drug-related behaviors or diversion is lacking, and no evidence exists that demonstrates that screening improves clinical outcomes, absence of prescribed opioids or presence of unprescribed opioids or illicit drugs can be a marker for problematic issues that would not be apparent without urine drug screening.

A 2010 Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain guideline recommended that, if using urine drug screening to establish a baseline measure of risk or to monitor compliance, physicians should be aware of benefits and limitations, undertake appropriate test ordering and interpretation, and have a plan to use results. (Grade C)." The guideline also stated that there is no "compelling evidence" to guide physicians on identifying patients who should have urine drug screening, or on how often they should be tested. Urine drug screening should be performed in patients at risk for opioid misuse and addiction and patients with aberrant drug-related behaviors.

The Centers for Disease and Control Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (2016) recommend that, when prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually, to assess for prescribed medications, as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type 4). Experts agreed that, prior to starting

opioids for chronic pain, and periodically during opioid therapy, clinicians should use urine drug testing to assess for prescribed opioids, as well as other controlled substances and illicit drugs that increase the risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, and heroin. While experts agreed that clinicians should use urine drug testing before initiating opioid therapy for chronic pain, they disagreed on how frequently urine drug testing should be conducted during long-term opioid therapy. Most experts agreed that urine drug testing at least annually for all patients was reasonable. Some experts noted that this interval might be too long in some cases and too short in others, and that the follow-up intervals should be left to the discretion of the clinician. In most situations, initial urine drug testing can be performed with a relatively inexpensive IA panel for commonly prescribed opioids and illicit drugs. Patients who are prescribed less-commonly-used opioids might require specific testing for those agents. The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard IAs or on the presence of unexpected urine drug test results. Clinicians should be familiar with the drugs included in urine drug testing panels used in their practice and should understand how to interpret results for these drugs. Before ordering urine drug testing, clinicians should have a plan for responding to unexpected results. Clinicians should explain to patients that urine drug testing is intended to improve their safety, they should also explain expected results (e.g., presence of prescribed medication and absence of drugs, including illicit drugs, not reported by the patient). Clinicians should ask patients about use of prescribed and other drugs and ask whether there might be unexpected results. This will provide an opportunity for patients to provide information about changes in their use of prescribed opioids or other drugs. Clinicians should use unexpected results to improve patient safety (e.g., changing in pain management, tapering or discontinuing opioids, re-evaluating more frequently, offering naloxone, or referring for treatment for substance use disorder, all as appropriate). If tests for prescribed opioids are repeatedly negative, confirming that the patient is not taking the prescribed opioid, clinicians can discontinue the prescription without a taper. Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety.

No studies were identified regarding the management of patients with routine urine drug testing, compared to selective urine drug testing or managing patients with routine confirmation of positive qualitative tests, compared to selective confirmation of positive qualitative tests.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassays), capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) including samples validation when performed, per date of service
80306	read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service

Code	Description
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography (e.g., DART, DESI, GC-MS, GCMS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
80320-80373	Definitive drug testing (code range)
80375-80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified (code range), per date of service (e.g., 1 unit per date of service allowed)
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 (ToxProtect, Genotox Laboratories, Ltd)
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 (UCompliDx by Elite Medical Laboratory Solutions, LLC)
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 (NextGen Precision™ Testing, Precision Diagnostics LBN Precision Toxicology, LLC.)
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected (ComplyRX; Claro Labs)
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 (Foundation PISM℠ by Ethos Laboratories)
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

HCPCS Codes

Code	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, 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, 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.
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
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.

Code	Description
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 (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, 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.

ICD10 Codes

Code	Description
F11.10-F11.99	Opioid related disorders (code range)
F14.10-F14.99	Cocaine related disorders (code range)
F16.10-F16.99	Hallucinogen related disorders (code range)
F45.42	Pain disorder with related psychological factors
G89.21-G89.4	Chronic pain (code range)

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*Key Article

KEY WORDS

Urine drug testing, immunoassay, presumptive testing, confirmatory testing.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a Local Coverage Determination (LCD) for Urine Drug Testing. Please refer to the following LCD website for Medicare Members: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=36037&ver=46