



## Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: HNCA.CP.MP542

Effective Date: 09/12

Last Review Date: 08/19

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

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

This policy is applicable to specific levels of care including Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Recovery Support Group (RSG), Residential Treatment Center (RTC) and Subacute Detoxification and testing as a part of office-based treatment. It is not applicable to INPATIENT Treatment.

### Policy/Criteria

- I. It is the policy of Health Net of California that outpatient drug testing for drugs of abuse (DOA) is **medically necessary** for confirmatory/definitive testing for a specific drug(s) when members meet the criteria in A or B:
  - A. Member has a documented history or suspicion of illicit or prescription drug use or noncompliance or a high probability of non-adherence to a prescribed drug regimen documented in the medical record; *and all of the following*:
    1. A preliminary/presumptive drug test has been previously performed, unless no reliable test is available; *and*
    2. The findings from that preliminary test (either positive or negative) are either:
      - a. Inconsistent with the expected results as suggested by the member's medical history, clinical presentation, and/or member's own statement after a detailed discussion about their recent medication and drug use, or
      - b. The test yielded results consistent with the clinical scenario but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result. *and*
    3. Resolving the inconsistency is essential to the ongoing care of the member, *and*
    4. The requested confirmatory/definitive test is only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results. OR
  - B. The provider expects the presumptive test to be positive (e.g. the member reports recent use), information regarding specific substance and/or quantity is desired, and there are established benchmarks for clinical decision making based on quantitative levels. OR
  - C. 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:



## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

- 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 or extracurricular activities or programs
  - B. Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations).
  - C. Screening in asymptomatic patients except as listed in section I.
  - D. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.).
  - E. As a component of a medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.).
  - F. Same-day screening of drug metabolites in both a blood and urine specimen by either preliminary or confirmatory/definitive analyses.
  - G. Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.
- III.** It is the policy of Health Net of California that outpatient drug testing for drugs of abuse (DOA) is considered not **medically necessary** unless all components of the panel have been determined to be medically necessary based on the criteria above. A full panel screen should only be considered for initial testing when appropriate or when the behavior suggests the use of drugs not identified on the original screening. Medical documentation must support the justification for conducting a full panel screening.
- IV.** It is the policy of Health Net of California that the outpatient urine drug testing for drugs of abuse (DOA) should be performed at an appropriate frequency based on clinical needs. The frequency of testing should be at the lowest level to detect the presence of drugs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.
- A. Presumptive testing for substance use (80305-80307) must be medically necessary and documented in the medical record.
    - 1. For patients with 0 to 30 consecutive days of abstinence, presumptive testing may be performed randomly but no more often than 3 presumptive tests per week.
    - 2. For patients with 31 to 90 consecutive days of abstinence, presumptive tests may be performed randomly but no more often than weekly.
    - 3. For patients with > 90 consecutive days of abstinence, presumptive testing may be performed randomly but no more often than twice per month.
  - B. Confirmatory/Definitive testing for substance use (G0480-G0483) must be medically necessary and the medical record must include an appropriate testing frequency based on the stage of screening, treatment, or recovery; the rationale for the drugs/drug classes ordered; and the results must be documented in the medical record and used to direct care.



## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

1. For patients with 0 to 30 consecutive days of abstinence, confirmatory /definitive testing may be performed no more often than 1 physician-directed testing profile in one week.
2. For patients with 31 to 90 consecutive days of abstinence, confirmatory/definitive testing may be performed no more often than 3 physician-directed testing profiles in one month.
3. For patients with > 90 consecutive days of abstinence, confirmatory/definitive testing may be performed no more often than 1 physician-directed testing profile in one month

### Authorization Protocols

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

### *Request Requirements*

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

### Background

A drug of abuse is defined as a drug, chemical, or plant product known to be misused for recreational purposes. In the United States, the basic screening test for DOA includes five drugs: amphetamine, cocaine, marijuana, opioids, and phencyclidine. Other common drugs tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamine. These tests can vary by region based on epidemiologic trends. There currently is no uniformity for what is included in extended DOA assay testing, or what cutoff values should be used for detection of drugs that are not covered by workplace testing laws.

The three methods of drug assays include immunoassay, chromatography, and gas-chromatography/mass spectrometry (GC/MS). Immunoassay is the most widely used method for initial testing for DOA and offers results within minutes. They are able to detect low concentrations of a drug with a high degree of specificity. This can be most easily performed using point-of-care test kits such as a urine drug cup. Unfortunately, in the clinical setting point-of-care testing does not perform to manufacturers' claims and untrained staff can improperly interpret test results.

Chromatography and GC/MS require highly trained lab staff and instruments to provide a highly sensitive and specific technique for detecting drugs or metabolites. It often takes many hours to obtain results, thus these methods are generally not used for initial screening in the clinical setting. The mass spectrometer is capable of detecting even minute amounts of a given substance and is considered to have the highest specificity of all lab detection methods. It is most commonly used for confirmatory test results that are primarily of forensic importance.



## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

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.

ICD-10 <sup>®*</sup> Codes	Description
	May not be an all inclusive list
F11	Opioid dependence
F12	Cannabis dependence
F13	Sedative, hypnotic or anxiolytic dependence
F14	Cocaine dependence
F15	Other stimulant dependence
F16	Hallucinogen dependence
F18	Inhalant dependence
F19	Other psychoactive substance dependence



**CLINICAL POLICY**  
**Outpatient Testing for Drugs of Abuse**

CPT® Codes	Description
80305	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) read by instrumented assisted direct optical observation (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, by instrument chemistry and analyzers (e.g., utilizing immunoassay [EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (DAT, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

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HCPCS Codes	Description
G0480	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per



**CLINICAL POLICY**  
**Outpatient Testing for Drugs of Abuse**

HCPCS Codes	Description
	specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

Reviews, Revisions, and Approvals	Date	Approval Date
Added language to allow for 5 days post specimen collection to request PA	07/14	
Added background information	10/14	10/14
CPT codes updated per 2015 code changes	01/15	
Added temporary HCPCS codes to code list	07/15	
Added under Criteria: A.2.b option for concordant test results but specific quantitative analysis needed to identify specific drug	10/15	10/15
Health Net Policy developed based on Centene policy CP.MP. 50 (January 2016). Added new 2016 G codes for definitive drug testing, clarified in criteria the addition of definitive testing. Frequency testing included	02/16	
Added same day urine/blood screening and sample validity testing limitations to the not medically necessary section. Replaced “qualitative” language with “preliminary,” and “quantitative” with “confirmatory/definitive.”	09/16	10/16
Updated Codes to note that G0477 – G0479 have been deleted as of 2017 and added new codes 80305 – 80307 and G0659	2/17	2/17
Health Net Update: Clarified policy to note that it applies to medical, surgical and behavioral health, removed definitive prior authorization requirements, added references Corporate Update: Added term “presumptive” and “qualitative” to preliminary drug testing. Codes reviewed and updated. Reviewed by neurology/pain management specialist. References reviewed and updated	9/17	10/17
Made the following changes based on the Centene Corporate policy: Modified criteria in I.A.1 that a presumptive test must be performed before a definitive test unless no reliable test is available. I.B. -Added an indication for testing when the presumptive test is assumed to be positive based on patient history, but quantitative levels are required. Modified II.C. to state that screening in asymptomatic patients is medically unnecessary, unless otherwise stated in section I.	08/18	08/18
Reviewed by MHN, no changes	8/19	8/19



## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

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## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

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16. Centers for Medicare and Medicaid Services: Noridian Health Care Solutions : Local Coverage Determination (LCD) L36668. Controlled Substance Monitoring and Drugs of Abuse Testing

### **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



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## CLINICAL POLICY

### Outpatient Testing for Drugs of Abuse

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.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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