



**EFFECTIVE DATE:** 07|01|2011

**POLICY LAST UPDATED:** 05|05|2015

## OVERVIEW

This policy documents the criteria and documentation requirements for Immunoassay Testing (i.e., Qualitative Testing, Screening) and Quantitative Testing (i.e., Confirmatory Testing) urine drug toxicology tests.

## MEDICAL CRITERIA

Not applicable

## PRIOR AUTHORIZATION

Prior authorization review is not required.

## POLICY STATEMENT

### BlueCHiP for Medicare and Commercial Products

Immunoassay Testing (i.e., Qualitative Testing, Screening) and Quantitative Testing (i.e., Confirmatory Testing) urine drug toxicology tests are covered.

Medical records must document the medical necessity of billed services and must be made available to BCBSRI upon request. See the Background section of this policy for documentation requirements.

Qualitative testing is not eligible for reimbursement as described below:

- Testing as required for or as part of participation in a substance abuse program with an all-inclusive bundled rate
- Routine testing (i.e., testing at every visit)
- Testing ordered by or for third parties for the sole purpose of meeting the requirements of a third party

Quantitative testing is not eligible for reimbursement as described below:

- Routine quantitative drug testing (i.e., testing at each visit)
- Quantitative testing when qualitative testing is clinically appropriate and meets clinical needs
- Routine confirmatory testing in the absence of an unexpected positive finding or an unexpected negative finding
- Testing ordered by or for third parties for the sole purpose of meeting the requirements of a third party

### Drug testing limits applied to CLIA non-waived independent laboratories:

Payments are limited to five (5) tests/units per date of service. Tests will process in the sequence of claim filed; therefore, providers are requested to file for services in the order of the highest reimbursement per test/units for each claim. However, if the provider does not bill in this manner, claims will process at the first five (5) tests/units submitted regardless of allowance.

Any tests billed over and above five (5) tests/units per date of service will deny as inclusive in the allowance previously paid for the first five (5) tests/units. In this case, the testing will be considered not separately reimbursed and may not be billed to the member.

## **COVERAGE**

Benefits may vary. Please refer to the appropriate member Evidence of Coverage or Subscriber Agreement for applicable laboratory benefits/coverage.

## **BACKGROUND**

### **Immunoassay Testing (i.e., Qualitative Testing, Screening)**

These tests can be performed either in a laboratory or at the point of service. Immunoassay tests are based on the principle of competitive binding and 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.

Immunoassay 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 immunoassays identify only classes of drugs and thus results cannot be used to determine which drug a patient is taking. For example, a positive result to an opiate immunoassay can be due to morphine or hydromorphone. The degree of cross-reactivity, i.e., an antibody's reactivity with a compound other than the target of the test, varies widely among immunoassays.

Immunoassay findings are generally reported qualitatively as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). 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.

Immunoassays generally have a rapid turnaround time, within minutes for onsite tests and 1 to 4 hours for laboratory-based tests.

Qualitative urine drug testing to verify compliance with treatment or identify disclosed drug use or abuse is considered medically necessary as part of a routine monitoring program. Qualitative urine drug testing is considered medically necessary under the following conditions:

- An individual is receiving treatment for chronic pain with prescription opioid or other potentially abused medications; or
- An individual is undergoing treatment for or monitoring for relapse of opioid addiction or substance abuse; or
- Abuse of non-prescribed medications or illegal substances is suspected; or
- An individual is beginning a pain management program or substance abuse recovery program.

**Medical records must document the medical necessity of billed services.**

### **Specific Drug Identification (i.e., Quantitative Testing, Confirmatory Testing)**

Confirmatory tests are always performed in a laboratory. Gas chromatography/mass spectrometry (GC/MS) is considered to be the criterion standard for confirmatory testing. This technique involves using GC to separate the analytes in a specimen and MS to identify the specific molecular structures of the drug and its metabolites. The tests are able to quantify the amount of drug or metabolite present in the urine sample.

Quantitative tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS generally requires specification of the drug or drugs to be identified. Alternatively, "broad spectrum screens" can be conducted. There is a several day turnaround time for GC/MS testing.

An issue with both types of UDT 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 UDT 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 UDS into pain management and substance abuse treatment settings. Most commonly, patients undergo UDS before beginning treatment to verify current drug use. Some clinicians believe that UDS 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 healthcare 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 use selective confirmation of positive qualitative tests, such as when an unexpected immunoassay 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 immunoassays.

#### **Guidance regarding quantitative, i.e., confirmatory testing**

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

- Unexpected positive test inadequately explained by the patient
- Unexpected negative test (suspected medication diversion)
- Need for quantitative levels to compare with established benchmarks for clinical decision making

Quantitative or confirmatory testing must be ordered on an individual basis by a medical provider directly caring for a member at the time of order and may not be ordered from “standing” orders, i.e. orders that provide for routine testing. Quantitative testing must be ordered with an indication of the specific drug being confirmed, not as a comprehensive confirmatory panel.

According to Medicare instructions, drug testing providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed. Testing to confirm that a urine specimen is unadulterated is an internal control process that is not separately reportable.

#### **Regulatory Status**

GC/MS tests and some immunoassays are performed in laboratory settings. Clinical laboratories may develop and validate in house (i.e., laboratory-developed) tests and market them as a service Laboratory developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Act (CLIA).

A CLIA waiver is available for use of certain point-of-care immunoassays. Tests eligible for a CLIA waiver are those considered to be simple, with low risk of error and low potential for harm. The U.S. Food and Drug Administration is tasked with approving manufacturers' applications for test system waivers. There are commercially available CLIA-waived tests for drugs such as cocaine, methadone, morphine/opiates, and oxycodone.

## **CODING**

### **BlueCHiP for Medicare and Commercial Products**

The following codes effective January 1, 2015 are covered:

**G0431**

**G0434**

**G6030 - G6058 Definitive Drug Code Range**

Claims filed using the CPT code range 80300 through 80377 with dates of service after January 1, 2015 will be denied as "use alternate code."

The following codes are subject to the payment limitation of five (5) tests/units per date of service:

<b>G0431</b>	<b>G6031</b>	<b>G6040</b>	<b>G6042</b>	<b>G6043</b>	<b>G6044</b>
<b>G6052</b>	<b>G6053</b>	<b>G6056</b>	<b>G6058</b>		
<b>80184</b>	<b>80299</b>	<b>82541</b>	<b>82542</b>	<b>83788</b>	<b>83789 83992</b>

## **RELATED POLICIES**

None

## **PUBLISHED**

Provider Update, July 2015

Provider Update, November 2013

Provider Update, June 2011

Provider Update, July 2008

## **REFERENCES**

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