Drugs of Abuse Testing is performed to detect the use of prescription medications and illegal substances of concern for the purpose of medical treatment. A presumptive test is used to determine the presence or absence of one or more drugs or drug classes. Confirmatory testing is an additional test completed to verify the results of the presumptive drug tests through the identification of specific medications, substances or metabolites. CMS has experienced a dramatic increase in reimbursement for Drugs of Abuse Testing and has changed the coding system by which testing and screening is reimbursed for Medicare and Medicaid.

A detailed description of WellCare’s drug screening/testing policy is below. As a general rule:

- Drug testing should not routinely include a panel of all drugs of abuse.
- The test should be focused on the detection of specific drugs.
- The frequency of testing should be at the lowest level to detect the presence of drugs.
- Testing should be based on medical necessity and a complete clinical assessment of the individual’s risk potential for abuse and diversion, using a validated risk assessment interview or questionnaire.
- Periodic monitoring should be performed on a random basis.
- Drug classes tested for in the monitoring phase of patient drug testing should be tailored to the individual and include those drugs that are prescribed and common drugs of abuse. If testing for other drugs/drug classes is ordered, the provider must document the clinical rationale.
- Periodic monitoring addresses proper monitoring of two risk potentials:
  - Abuse and diversion of controlled medications; and
  - Abuse of illicit drugs or drugs not prescribed as part of the treatment plan and obtained from an undisclosed/unsanctioned source.

Frequency should be based in part on the validated risk assessment process and the potential that the patient will engage in medication-aberrant behavior (or illicit drug use behavior). Individuals assessed at a higher risk for medication misuse and illicit drug use may require more frequent testing than those assessed at a lower risk for...
such behavior. In the absence of specific symptoms of medication aberrant behavior or misuse, qualitative drug testing is only reasonable and necessary when titrated to patient risk potential.\(^1\)

**Approximate Detection Time: All Specific Drug Groups (Mayo Clinic, 2011)**

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>LOQ (ng/mL)</th>
<th>Detection Time* up to</th>
<th>LOQ (ng/mL)</th>
<th>Detection Time* up to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine-Type Stimulants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamine</td>
<td>50</td>
<td>3 days</td>
<td>Fentanyl</td>
<td>0.2</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>50</td>
<td>3 days</td>
<td>Norfentanyl</td>
<td>1.0</td>
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<tr>
<td>3,4-Methylenedioxy-amphetamine (MDA)</td>
<td>50</td>
<td>2 days</td>
<td>Ketamine</td>
<td></td>
</tr>
<tr>
<td>Phentermine</td>
<td>50</td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Ephedrine / pseudoephedrine</td>
<td>Not quantitated</td>
<td>5 days</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Barbiturates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butalbital</td>
<td>100</td>
<td>7 days</td>
<td>LSD</td>
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</tr>
<tr>
<td>Amobarbital</td>
<td>100</td>
<td>3 days</td>
<td>2-Oxo-3-hydroxy-LSD</td>
<td>5</td>
</tr>
<tr>
<td>Short-Acting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>100</td>
<td>3 days</td>
<td></td>
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<tr>
<td>Secobarbital</td>
<td>100</td>
<td>3 days</td>
<td>Methadone</td>
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<td>Benzodiazepines</td>
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<tr>
<td>Long-Acting</td>
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<td>Intermediate-Acting</td>
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<tr>
<td>Lorazepam</td>
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<td>Methaqualone</td>
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<tr>
<td>Oxazepam</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
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<td>3 days</td>
<td>Morphine</td>
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<td>Glonazepam</td>
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<td>Codeine</td>
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<td>Flunitrazepam</td>
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<td>Hydrocodone</td>
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<tr>
<td>Short-Acting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine &amp; Metabolite</td>
<td></td>
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<tr>
<td>Cocaine</td>
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<td>&lt;1 day</td>
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<td>Buprenorphine</td>
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<td>Propoxyphene</td>
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<tr>
<td>Norbuprenorphine</td>
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<td>7 days</td>
<td>Norpropoxyphene</td>
<td>100</td>
</tr>
<tr>
<td>CENTERS FOR MEDICARE AND MEDICAID SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As of 2016, multiple payments are not permitted for a multi-drug testing device

- For Medicare/Medicaid – the Provider can only be reimbursed once.
- Devices (such as the Alfa Single Dip Cassette) that contain one strip per test device must be used.
A patient in active treatment for substance use disorder (SUD) or monitoring across different phases of recovery may undergo medical management for a variety of medical conditions. A physician who is writing prescriptions for medications to treat either the SUD or other conditions may need to know if the patient is taking substances which can interact with prescribed medications or taking prescribed medications as expected. The risk of drug-drug interactions is inherent to the patient, and may be compounded by prescribed medications. Drug testing is a medically necessary and useful component of chemical dependency treatment. Results influence treatment and level of care decisions. Ordered tests and testing methods (presumptive and/or definitive) must match the stage of treatment or recovery, documented history, and Diagnostic and Statistical Manual of Mental Disorders V diagnosis.

A qualitative drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used. However, urine is the best specimen for broad qualitative screening, as blood is relatively insensitive for many common drugs. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound. Drugs or classes of drugs are commonly assayed by qualitative testing. A qualitative test may be followed by confirmation with a second method, only if there is a positive or negative finding inconsistent with the setting of a symptomatic patient. Examples of drugs or classes of drugs that are commonly assayed by qualitative tests, followed by confirmation with a second method, are: alcohols, amphetamines, barbiturates/sedatives, benzodiazepines, cocaine and metabolites, methadone, antihistamines, stimulants, opioid analgesics, salicylates, cardiovascular drugs, antipsychotics, and antidepressants. Most toxicological diagnoses and therapeutic decisions are made based on historical or clinical considerations:

1. Laboratory processing turnaround times can often be longer than the critical intervention time course of an overdose;
2. For many toxins there are no established cutoff levels of toxicity, making interpretation of the results difficult.

Qualitative screening panels should be used when the results will alter patient management or disposition. The clinical utility of drug tests in the emergency setting is limited since most therapy for drug poisonings is symptom directed and supportive.

Coverage Indications, Limitations, and/or Medical Necessity

Common methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by qualitative testing. A qualitative test may be followed by confirmation with a second method, when there is a positive inconsistent finding from the qualitative test in the setting of a symptomatic patient, as described below. Typically, the above "spot" chemical tests (referred to above) are urine dipsticks or multiple drug cup devices, whereas there are CPT codes that comprise those chemical analyzers that are designed for office-based use. Techniques in the 80xxx series are most appropriately performed in independent laboratories where there is an adequate quality control infrastructure to guarantee the viability and proficiency of such quantitative confirmation testing.

Examples of drugs or classes of drugs that are commonly assayed by qualitative tests, followed by confirmation with a second method, are: alcohols, amphetamines, barbiturates/sedatives, benzodiazepines, cocaine and metabolites, methadone, antihistamines, stimulants, opioid analgesics, salicylates, cardiovascular drugs, antipsychotics, cyclic antidepressants, and others. Focused drug screens, most commonly for illicit drug use, may be more useful clinically. There is a specific companion LCD on quantitative drug testing, that supports a correlation between those positive findings generated from initial qualitative testing and those requested quantitative tests to specifically confirm such qualitative findings.

Frequency of Testing for Members Undergoing Chronic Opioid Therapy (COT)

National pain organizations, physician societies, and the Federation of State Medical Boards recommend a practical approach to definitive UDT for COT. Frequency of testing beyond the baseline presumptive UDT screen
must be based on individual patient needs substantiated by documentation in the patient’s medical record. Recommendations for the ordering of presumptive and definitive UDT for patients on COT are as follows:

- **COT Baseline Testing.** Initial presumptive and/or definitive COT patient testing may include amphetamine/ methamphetamine, barbiturates, benzodiazepines, cocaine, methadone, oxycodone, tricyclic antidepressants, tetrahydrocannabinoid, opioids, opiates, heroin, and synthetic/analog or “designer” drugs.

- **COT Monitoring Testing.** Ongoing testing may be medically reasonable and necessary based on the patient history, clinical assessment, including medication side effects or inefficacy, suspicious behaviors, self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other clinician documented change in affect or behavioral pattern. The frequency of testing must be based on a complete clinical assessment of the individual’s risk potential for abuse and diversion using a validated risk assessment interview or questionnaire and should include the patient’s response to prescribed medications and the side effects of medications.

The clinician should perform random UDT at random intervals, in order to properly monitor a patient. UDT testing does not have to be associated with an office visit. Patients with specific symptoms of medication aberrant behavior or misuse may be tested in accordance with this document’s guidance for monitoring patient adherence and compliance during active treatment (<90 days) for substance use or dependence.

### GUIDANCE FROM PROFESSIONAL ORGANIZATIONS

**American Society of Addiction Medicine Policy Statement (ASAM).** Drug classes recognized by ASAM include:

- **Amphetamines** – Amphetamines (AMP), Methamphetamines (MET or mAMP), Ecstasy (XTC or MDMA)
- **Opiates** – Morphine/Opiate (MOR, MOR/OPI or OPI), Oxycodone (OXY)
- **Phencyclidine** (PCP)
- **Barbiturates** (BAR)
- **Propoxyphene** (PPX)
- **Benzodiazepine** (BZD or BZO)
- **Marijuana** (THC)
- **Cocaine** (COC)
- **Methadone** (MTD)

ASAM recommends the following practices and procedures:

- The use of drug testing in diagnostic settings.
- The use of drug testing in addiction treatment settings.
- The use of drug testing for monitoring purposes.
- The use of drug testing for legal purposes.
- The collection, handling and analysis of specimens used in drug testing.

In addition, the ASAM policy regarding urine drug testing states:

1. Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care, and should not face undue restrictions.

2. Regarding urine drug testing, the compounds tested for, and the composition of testing panels, should be determined by the ordering physician in order to deliver quality patient care based on the unique clinical presentation of the patient.

**American Pain Society (APS) / American Academy of Pain Medicine (AAPM).** The APS and the AAPM state that drug screening should take place when members are on chronic opioid therapy (COT) and are at high risk or who have engaged in aberrant drug-related behaviors. Further, those on COT but not at high risk and not known to have engaged in aberrant drug-related behaviors should still be considered for periodic urine drug screens as part of their plan of care. Such monitoring of patients is “critical because therapeutic risks and benefits do not remain...
static and can be affected by changes in the underlying pain condition, presence of coexisting disease, or changes in psychological or social circumstances."\(^7\)

American Society of Interventional Pain Physicians (ASIPP). According to the ASIPP, urine drug testing (UDT) must be implemented from initiation along with subsequent adherence monitoring to decrease prescription drug abuse or illicit drug use when patients are in chronic pain management therapy. Physicians should use a screening tool to assess patient risk and monitor patients at different intervals based on risk stratification. Urine is the preferred method of testing (over serum or hair), noting it is the best biologic specimen for detecting the presence or absence of certain drugs due to specificity, sensitivity, ease of administration and the cost. Regular assessment of members is necessary to review the diagnosis, noting that "routine assessment of the “4 As” (analgesia, activity, aberrant behavior and adverse effects) will help to direct therapy and support pharmacologic actions taken."\(^7\)

American College of Occupational and Environmental Medicine (ACOEM). Urine drug screening should be performed in scenarios where a provider may suspect misuse or abuse. The ACOEM recommends the following:\(^9\)
- Conduct an initial test of member prior to treatment.
- Routine urine drug screens for patients on chronic opioid therapy.
- Random monitoring that shall occur at least twice and up to 4 times a year and at termination.

**POSITION STATEMENT**

**Applicable To:**
- Medicaid
- Medicare

**Exclusions**

Any of the following is sufficient criteria for exclusion from coverage:
- Confirmation or Quantitative testing is excluded from coverage if performed for forensic or legal purposes.
- Qualitative and Quantitative testing of blood and urine, saliva and blood or urine, or any multiple source specimens on the same date of service is excluded.
- Quantitative (or definitive) testing requires a positive screening test and shall be performed only for the drug class represented by the positive screening.
- Quantitative testing (or definitive) for negative screening results is excluded without written documentation of medical necessity.

In addition, the following services are excluded from coverage:\(^1,3\)
- Blanket Orders
- Reflex definitive drug tests are not reasonable and necessary when presumptive testing is performed at point of care because the physician may not need to order definitive testing (e.g., the patient admits to a particular drug and the clinician is satisfied that he or she knows everything he or she needs to know, or the IA cut-off is sufficiently low that the physician is comfortable with the test result).
- Routine standing orders for all patients in a physician’s practice are not reasonable and necessary. Physician-defined standing orders for predetermined drug panels according to specific patient profiles for a limited sequential period may be reasonable and necessary and must be documented in the patient’s medical record.
- It is not reasonable and necessary to bill individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered.
- Direct to Definitive drug test without presumptive positive drug test –is not reasonable and necessary because this practice encourages excessive and unnecessary testing.
- Confirmation/definitive identification of a presumptive drug test negative result is not reasonable and necessary except when a patient on prescribed medication should have had a presumptive positive result.
It is not reasonable and necessary for a physician to perform presumptive point of care testing (POCT) and order presumptive IA testing from a reference laboratory.

It is not reasonable and necessary for a physician to perform presumptive IA testing and order presumptive IA testing from a reference laboratory with or without reflex testing.

It is not reasonable and necessary for a reference laboratory to perform IA presumptive screening prior to a definitive testing without a specific physician’s order for the presumptive testing.

IA testing, regardless of whether it is qualitative or semi-quantitative, may not be used to “confirm” or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Semi-quantitative IA testing provides a presumptive test (numerical) result. Definitive UDT provides specific identification and/or quantification by GC-MS or LC-MS/MS.

Drug testing of two different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.

UDT for medico-legal and/or employment purposes or to protect a physician from drug diversion charges.

Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.

In addition, please note the following:

- Drug testing is not covered in any of the following circumstances:
  - Testing ordered by third parties (e.g., schools, courts, or employers) or requested by a provider for the sole purpose of meeting the requirements of a third party, except where required by law.
  - Testing for residential monitoring.
  - Routine urinalysis for confirmation of specimen integrity.

Testing is non-covered for the following non-medical indications:

- As a condition for employment, participation in school or community activities (e.g., athletics, extra circular), or enrollment in a school or in the military;
- Court ordered drug testing;
- Forensic/criminal situations;
- Required drug testing and compliance in the school work place;
- Administrative, or social service agency investigations, proceedings, or monitoring activities;
- Activities related to testing that does not have a clear treatment role and decision making response (negative or positive results);
- Divorce and/or child custody cases;
- Assessment for substances not identified initially;
- For residential monitoring purposes;
- Routine specimen collection and preparation for the purpose of clinical laboratory analysis.
- Reports or clinical information derived from the result of laboratory data that is mathematically calculated which are considered part of the test procedure and therefore not a separately reportable service.

**Coverage**

Drug testing is categorized into the groups below; the member must meet the criteria listed for each group.

**Group A: Random Testing**

- One (1) **qualitative (or presumptive)** test per day (up to and not exceeding 2 per month or 15 per year).
- **Quantitative (or definitive/confirmatory)** tests by CPT definition are limited by CPT code based on the number of drug classes to 1 per day (up to and not exceeding 2 per month, 15 per year

**Group B: Symptomatic Patients, Multiple Drug Ingestion and/or Patients with Unreliable History**

A presumptive drug test should be performed as part of the evaluation and management of a member who presents in an urgent care setting with any one of the following:
DRUG TESTING
HS-247

- Coma; OR
- Altered mental status in the absence of a clinically defined toxic syndrome or toxidrome; OR
- Severe or unexplained cardiovascular instability (cardiotoxicity); OR
- Unexplained metabolic or respiratory acidosis in the absence of a clinically defined toxic syndrome or toxidrome; OR
- Seizures with an undetermined history; OR
- To provide antagonist to specific drug.

NOTE: Presumptive findings, definitive drug tests ordered and reasons for testing are to be documented in the medical record.

For members presenting with the above symptoms/indications, testing is limited to:

One (1) or qualitative (presumptive) test per day (up to and not exceeding 2 per month or 15 per year, 365 days). Quantitative (or definitive/confirmatory) tests by HCPCS definition are limited based on the number of specific medications to be evaluated. One test (HCPCS code) per day, two per month or up to 15 per year will be allowed.

Definitive urine drug testing is considered medically necessary when all of the following criteria are met:

- Presumptive urine drug testing is medically necessary; AND
- Presumptive test was negative for prescribed medications, positive for a prescription drug with abuse potential which was not prescribed, or positive for an illegal drug (e.g., but not limited to methamphetamine or cocaine); AND
- Specific definitive test(s) ordered are supported by documentation specifying the rationale for each definitive test ordered; AND
- Clinical documentation reflects how the results of the test(s) will be used to guide clinical care.

Group C: Treatment for Substance Abuse or Dependence and Patients on Chronic Opioid Therapy (COT)

Substance Abuse or Dependence

SUD is a medically necessary and useful component of chemical dependency diagnosis and treatment. Testing frequency must meet medical necessity and be documented by the Provider in the medical record. This type of testing is limited to the following:

- One (1) qualitative (or presumptive) test per day (up to and not exceeding 3 per month or 36 per year)
- One (1) definitive tests, multiple drug classes per day (up to and not exceeding 3 per month or 12 per year)

NOTE: For members who are on suboxone maintenance therapy, more frequent drug screening early in treatment (up to weekly) may be necessary as members stabilize and establish abstinence. Urine drug testing every 2 to 4 weeks is the standard of care and should be considered on a case-by-case basis (rather than routine). Indication for testing should be documented.

Chronic Opioid Therapy (COT)

A Provider writing prescriptions for medications to treat chronic pain is in a better position to provide care management if the Provider knows whether the Member is consuming another medication or substance. This could suggest the possibility of SUD or lead to drug-drug interactions. COT drug testing identifies absence of prescribed medication and any abuse/misuse by a Member (which could lead to possible diversion), provides objectivity to the treatment plan, reinforces therapeutic compliance with the Member, and provides diagnostic information to help assess individual response to medications.

The testing frequency for COT drug testing must meet medical necessity and documented in the medical record and is limited to the following:

- One (1) qualitative (or presumptive) test per day (up to and not exceeding 1 per month or 12 per year)
- One (1) definitive test, multiple drug classes per day (up to and not exceeding 1 per month or 12 per year)
All Drug Testing MUST be done on distinct days.

Providers may find reason to conduct a drug test on a member who has recently started using Buprenorphine Products such as Suboxone® (buprenorphine and naloxone). The provider may have objective reason to believe the member may be involved in drug diversion or is continuing a pattern of abuse. In such an instance, additional units beyond the stated two (2) presumptive and/or six (6) definitive drug tests per month may be authorized when one or more of the following criteria are met:

- Poor appointment compliance; OR,
- Reports from member’s support network; OR,
- Evidence of intoxication or behavior suggesting recent use; OR,
- Chaotic or deteriorating function despite apparent treatment compliance; OR,
- Member appears deliberately evasive during clinical assessment.

NOTE: The member’s medical record must include an appropriate testing frequency based on the stage of treatment or recovery, the rationale for the drugs/drug classes ordered and the results are documented in the treatment plan.

The member must meet the following criteria for testing:

- Member has been evaluated by a licensed clinician, who has documented appropriate symptomology to support the need for a test and the test panel ordered; AND
- Tests ordered are within the scope of the ordering clinician’s authority; AND
- Rationale for the tests ordered is clearly documented and includes a statement of reasons for the drugs/drug classes to be screened with specific reference to any specialty tests ordered (those not available in CLIA-waived, moderate in-office immunoassay tests); AND
- Test results are used in the management of the patient and documented in the treatment plan.

Frequency of Presumptive Drug Test for Substance Abuse Disorder (SUD)

Random drug testing can occur at various intervals in order to properly monitor the patient and should test for a broad range of commonly abused drugs to screen a patient for SUD. Decisions about screened substances must be based on the following medical necessity guidance criteria:

- Member history, physical examination, and previous laboratory findings; AND
- Stage of treatment or recovery; AND
- Suspected abused substance; AND
- Substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The testing frequency must meet medical necessity and be documented in the clinician’s medical record.

- Presumptive drug testing is expected at a frequency of no more than 1 per day, not to exceed 3 per month

If the threshold is reached and a sentinel event occurs, the clinician may order additional definitive testing with appropriate documentation.

**Required Documentation**

The following documentation is required as part of the member’s medical record once the number of allowable units has been requested. Documentation can be submitted at the initiation of treatment for members undergoing Suboxone treatment due to the frequency of testing. In addition, any additional units required outside of the policy will require medical records to be submitted for justification.
• Pages should be legible and include member identification (e.g., name, dates of service(s)) and any providers (including non-physicians) involved in the member’s care.
• For member files requested for review, the member’s medical record should support the use of the selected code(s). Submitted CPT/HCPCS code should describe the service performed. Also, documentation stating the medical necessity for performing a qualitative and/or quantitative drug test should be included. Tests shall be ordered in writing by the treating provider, indicating drugs and drug classes to be included.
• Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering provider/treating provider must indicate the medical necessity for performing a qualitative and/or quantitative drug test. All tests must be ordered in writing by the treating provider and all drugs/drug classes to be tested must be indicated.
• If the provider of the service is not the ordering/referring provider, the rendering provider must maintain printed copy documentation of the lab results, along with printed copies of the ordering/referring provider’s order for the qualitative drug test. The provider must include the clinical indication/medical necessity in the order for the qualitative and/or quantitative drug test.

Considerations

• A full panel screen should only be considered for initial testing only when appropriate or when the Member’s behavior suggests the use of drugs not identified on the original screening. Medical documentation must support the justification for conducting a full panel screening. Subsequent testing should only be conducted for those substances identified on the Member’s initial profile.
• The preferred method of urine drug testing for a Member with a history of poly-substance abuse during the monitoring period is by utilization of a multi-drug screening kit (qualitative analysis by multiplex method for 2-15 drugs or drug classes).
• Drug confirmation by a second method is indicated when either of the following has occurred:
  o The result of the screen is positive and the patient disputes the findings; OR
  o The result is negative and the negative finding is inconsistent with the patient’s medical history.
    For coverage of confirmatory testing, the test results must be necessary for treatment planning and be requested by the ordering physician. Written orders are required.
• Urine drug testing for medical conditions may be covered. Documentation of medical necessity must be demonstrated and when treatment planning by the requesting provider is dependent upon the test results. Rationale may include, but is not limited to:
  o Altered mental status;
  o Medical or psychiatric condition where drug toxicity may be a contributing factor;
  o Fetal withdrawal syndrome;
  o Possible exposure of the fetus to illicit drugs taken by the mother;
  o To assess and treat Members with substance abuse disorders;
  o To assess a Member’s adherence to prescribed medications.
• Drug testing should be performed at an appropriate frequency based on clinical needs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.

Pre-Pay and Post-Pay Review

WellCare (or its designee) may conduct pre-payment or post-payment reviews of a Provider’s records related to services rendered to WellCare members. When conducting reviews of claims WellCare may request medical records, itemized bills, invoices or other substantiating documentation to support the charges billed. In a pre-pay review, if additional documentation is needed for WellCare to accurately adjudicate the claim, the claim may be
denied initially requesting the provider to submit medical records to support payment of the services billed. For Urine Drug Testing, the following HCPCS Codes may be reviewed on a pre-pay or post-pay basis:

- Presumptive Testing: 80300, 80305, 80306, 80307
- Definitive Testing: G0480, G0481, G0482, G0483, G0659

**Market Specific Criteria**

**GEORGIA**

The State of Georgia’s Medicaid contract with WellCare reads as follows: “Court-Ordered Evaluations and Services (4.11.6). In the event a Member requires Medicaid-covered services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate Utilization Management practices.”

**SOUTH CAROLINA**

Effective for dates of service beginning Jan. 1, 2016, the South Carolina Department of Health and Human Services (SCDHHS) will cover the following presumptive and definitive drug testing classifications. SCDHHS will reimburse for a maximum of one screening per procedure code per date of service, not to exceed 18 screenings per 12-month period. Providers should bill the most appropriate Healthcare Common Procedure Coding System (HCPCS) code for the service rendered.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.

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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FP1A) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.

**CODING**

**Covered CPT Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80300</td>
<td>Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (e.g., dipsticks, cups, cards, cartridges), per date of service</td>
</tr>
<tr>
<td>80305</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service</td>
</tr>
<tr>
<td>80306</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service</td>
</tr>
<tr>
<td>80307</td>
<td>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, FP1A, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service</td>
</tr>
</tbody>
</table>
### Confirmatory Drug Testing

(see specific coding below)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80320</td>
<td>Alcohol(s) NOTE: CPT 80320 is not covered for Medicare</td>
</tr>
<tr>
<td>80324</td>
<td>Amphetamines; 1 or 2</td>
</tr>
<tr>
<td>80325</td>
<td>Amphetamines; 3 or 4</td>
</tr>
<tr>
<td>80326</td>
<td>Amphetamines; 5 or more</td>
</tr>
<tr>
<td>80332</td>
<td>Antidepressants, serotonergic class; 1 or 2</td>
</tr>
<tr>
<td>80333</td>
<td>Antidepressants, serotonergic class; 3-5</td>
</tr>
<tr>
<td>80334</td>
<td>Antidepressants, serotonergic class; 6 or more</td>
</tr>
<tr>
<td>80335</td>
<td>Antidepressants, tricyclic and other cyclics; 1 or 2</td>
</tr>
<tr>
<td>80336</td>
<td>Antidepressants, tricyclic and other cyclics; 3-5</td>
</tr>
<tr>
<td>80337</td>
<td>Antidepressants, tricyclic and other cyclics; 6 or more</td>
</tr>
<tr>
<td>80338</td>
<td>Antidepressants, not otherwise specified</td>
</tr>
<tr>
<td>80339</td>
<td>Antiepileptics, not otherwise specified; 1-3</td>
</tr>
<tr>
<td>80340</td>
<td>Antiepileptics, not otherwise specified; 4-6</td>
</tr>
<tr>
<td>80341</td>
<td>Antiepileptics, not otherwise specified; 7 or more</td>
</tr>
<tr>
<td>80342</td>
<td>Antipsychotics, not otherwise specified; 1-3</td>
</tr>
<tr>
<td>80343</td>
<td>Antipsychotics, not otherwise specified; 4-6</td>
</tr>
<tr>
<td>80344</td>
<td>Antipsychotics, not otherwise specified; 7 or more</td>
</tr>
<tr>
<td>80345</td>
<td>Barbiturates</td>
</tr>
<tr>
<td>80346</td>
<td>Benzodiazepines; 1-12</td>
</tr>
<tr>
<td>80347</td>
<td>Benzodiazepines; 13 or more</td>
</tr>
<tr>
<td>80348</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>80349</td>
<td>Cannabinoids, natural</td>
</tr>
<tr>
<td>80350</td>
<td>Cannabinoids, synthetic; 1-3</td>
</tr>
<tr>
<td>80351</td>
<td>Cannabinoids, synthetic; 4-6</td>
</tr>
<tr>
<td>80352</td>
<td>Cannabinoids, synthetic; 7 or more</td>
</tr>
<tr>
<td>80353</td>
<td>Cocaine</td>
</tr>
<tr>
<td>80354</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>80355</td>
<td>Gabapentin, non-blood</td>
</tr>
<tr>
<td>80356</td>
<td>Heroin metabolite</td>
</tr>
<tr>
<td>80357</td>
<td>Ketamine and norketamine</td>
</tr>
<tr>
<td>80358</td>
<td>Methadone</td>
</tr>
<tr>
<td>80359</td>
<td>Methyleneoxyamphetamine (MDA, MDEA, MDMA)</td>
</tr>
<tr>
<td>80360</td>
<td>Methylphenidate</td>
</tr>
<tr>
<td>80361</td>
<td>Opiates, 1 or more</td>
</tr>
<tr>
<td>80362</td>
<td>Opioids and opiate analogs; 1 or 2</td>
</tr>
<tr>
<td>80363</td>
<td>Opioids and opiate analogs; 3 or 4</td>
</tr>
<tr>
<td>80364</td>
<td>Opioids and opiate analogs; 5 or more</td>
</tr>
<tr>
<td>80365</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>80366</td>
<td>Pregabalin</td>
</tr>
<tr>
<td>80367</td>
<td>Propoxyphene</td>
</tr>
<tr>
<td>80368</td>
<td>Sedative hypnotics (non-benzodiazepines)</td>
</tr>
<tr>
<td>80369</td>
<td>Skeletal muscle relaxants; 1 or 2</td>
</tr>
<tr>
<td>80370</td>
<td>Skeletal muscle relaxants; 3 or more</td>
</tr>
<tr>
<td>80371</td>
<td>Stimulants, synthetic</td>
</tr>
<tr>
<td>80372</td>
<td>Tapentadol</td>
</tr>
<tr>
<td>80373</td>
<td>Tramadol</td>
</tr>
<tr>
<td>80374</td>
<td>Stereoisomer (enantiomer) analysis, single drug class</td>
</tr>
<tr>
<td>80375</td>
<td>Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3</td>
</tr>
<tr>
<td>80376</td>
<td>Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6</td>
</tr>
<tr>
<td>80377</td>
<td>Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more</td>
</tr>
<tr>
<td>82542</td>
<td>Column chromatography/mass spectrometry (e.g., GC/MS, or HPLC/MS), analyte not elsewhere specified</td>
</tr>
</tbody>
</table>
83992  Phencyclidine

Covered HCPCS Codes
NOTE: Listing not all inclusive; reference CMS NCDs/LCDs and/or State Medicaid Manuals for specific medical necessity and coverage.

G0480  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 and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); 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 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)); 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 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)); 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 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)); qualitative or quantitative, all sources, 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 and 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

NOTE: Some codes use QW, a modifier to indicate CLIA Waived. If a CLIA approved facility or physician is using a CLIA-Waived test they must indicate this on the code being used for reimbursement purposes. Physicians must have one of the following to qualify for CLIA status: COW – CLIA Certificate of Waiver or COA – CLIA Certificate of Accreditation.

Covered ICD-10 Codes
NOTE: Listing not all inclusive; reference CMS NCDs/LCDs and/or State Medicaid Manuals for specific medical necessity and coverage.

E87.2 Acetosis
F10.11 Alcohol abuse, in remission
F10.120 Alcohol abuse with intoxication, uncomplicated
F10.20 Alcohol dependence, uncomplicated
F11.11 Opioid abuse, in remission
F11.20 Opioid dependence, uncomplicated
F11.220 Opioid dependence with intoxication, uncomplicated
F11.221 Opioid dependence with intoxication delirium
F11.222 Opioid dependence with intoxication with perceptual disturbance
F11.23 Opioid dependence with withdrawal
F11.24 Opioid dependence with opioid-induced mood disorder

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F11.229 Opioid dependence with intoxication, unspecified
F11.250 Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251 Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259 Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281 Opioid dependence with opioid-induced sexual dysfunction
F11.282 Opioid dependence with opioid-induced sleep disorder
F11.288 Opioid dependence with other opioid-induced disorder
F11.29 Opioid dependence with unspecified opioid-induced disorder
F12.11 Cannabis abuse, in remission
F12.120 Cannabis abuse with intoxication, uncomplicated
F12.220 Cannabis dependence with intoxication, uncomplicated
F13.11 Sedative, hypnotic or anxiolytic abuse, in remission
F13.120 Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F14.11 Cocaine abuse, in remission
F14.120 Cocaine abuse with intoxication, uncomplicated
F14.220 Cocaine dependence with intoxication, uncomplicated
F15.11 Other stimulant abuse, in remission
F15.120 Hallucinogen abuse, in remission
F16.120 Hallucinogen abuse with intoxication, uncomplicated
F18.10 Inhalant abuse, uncomplicated
F18.11 Inhalant abuse, in remission
F18.120 Inhalant abuse with intoxication, uncomplicated
F18.90 Inhalant use, unspecified, uncomplicated
F19.11 Other psychoactive substance abuse, in remission
F19.20 Other psychoactive substance dependence, uncomplicated
F20.0 Paranoid schizophrenia
F20.1 Disorganized schizophrenia
F20.2 Catatonic schizophrenia
F20.89 Other schizophrenia
F55.0 Abuse of antacids
F55.1 Abuse of herbal or folk remedies
F55.2 Abuse of laxatives
F55.3 Abuse of steroids or hormones
F55.4 Abuse of vitamins
F55.8 Abuse of other non-psychoactive substances
G40.301 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.309 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.319 Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.311 Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.401 Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.409 Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.411 Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419 Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.901 Epilepsy, unspecified, not intractable, with status epilepticus
G40.909 Epilepsy, unspecified, not intractable, without status epilepticus
G40.911 Epilepsy, unspecified, intractable, with status epilepticus
G40.919 Epilepsy, unspecified, intractable, without status epilepticus
G89.4 Chronic pain syndrome
I44.0 Atrioventricular block, first degree
I44.1 Atrioventricular block, second degree
I44.30 Unspecified atrioventricular block
I47.0 Re-entry ventricular arrhythmia
I47.1 Supraventricular tachycardia
I47.2  Ventricular tachycardia
I49.2  Junctional premature depolarization
M25.50  Pain in unspecified joint
M47.21  Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22  Other spondylosis with radiculopathy, cervical region
M47.23  Other spondylosis with radiculopathy, cervicothoracic region
M47.26  Other spondylosis with radiculopathy, lumbar region
M47.27  Other spondylosis with radiculopathy, lumbosacral region
M47.28  Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811  Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812  Spondylosis without myelopathy or radiculopathy, cervical region
M47.813  Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.816  Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817  Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818  Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.891  Other spondylosis, occipito-atlanto-axial region
M47.892  Other spondylosis, cervical region
M47.893  Other spondylosis, cervicothoracic region
M47.896  Other spondylosis, lumbar region
M47.897  Other spondylosis, lumbosacral region
M47.898  Other spondylosis, sacral and sacrococcygeal region
M51.14  Intervertebral disc disorders with radiculopathy, thoracic region
M51.15  Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16  Intervertebral disc disorders with radiculopathy, lumbar region
M51.17  Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.36  Other intervertebral disc degeneration, lumbar region
M51.37  Other intervertebral disc degeneration, lumbosacral region
M54.10  Radiculopathy, site unspecified
M54.14  Radiculopathy, thoracic region
M54.15  Radiculopathy, thoracolumbar region
M54.16  Radiculopathy, lumbar region
M54.17  Radiculopathy, lumbosacral region
M54.18  Radiculopathy, sacral and sacrococcygeal region
M54.2  Cervicalgia
M54.5  Low back pain
M60.811  Other myositis, right shoulder
M60.812  Other myositis, left shoulder
M60.821  Other myositis, right upper arm
M60.822  Other myositis, left upper arm
M60.831  Other myositis, right forearm
M60.832  Other myositis, left forearm
M60.841  Other myositis, right hand
M60.842  Other myositis, left hand
M60.851  Other myositis, right thigh
M60.852  Other myositis, left thigh
M60.861  Other myositis, right lower leg
M60.862  Other myositis, left lower leg
M60.871  Other myositis, right ankle and foot
M60.872  Other myositis, left ankle and foot
M60.88  Other myositis, other site
M60.89  Other myositis, multiple sites
M60.9  Myositis, unspecified
M79.1  Myalgia
M79.2  Neuralgia and neuritis, unspecified
M79.7  Fibromyalgia
R40.0  Somnolence
R40.20  Unspecified coma
R40.2110  Coma scale, eyes open, never, unspecified time
R40.2111  Coma scale, eyes open, never, in the field [EMT or ambulance]
R40.2112  Coma scale, eyes open, never, at arrival to emergency department
R40.2114  Coma scale, eyes open, never, 24 hours or more after hospital admission
R40.2120  Coma scale, eyes open, to pain, unspecified time
R40.2121  Coma scale, eyes open, to pain, in the field [EMT or ambulance]
R40.2123  Coma scale, eyes open, to pain, at hospital admission
R40.2124  Coma scale, eyes open, to pain, 24 hours or more after hospital admission
R40.2210  Coma scale, best verbal response, none, unspecified time
R40.2211  Coma scale, best verbal response, none, in the field [EMT or ambulance]
R40.2212  Coma scale, best verbal response, none, at arrival to emergency department
R40.2213  Coma scale, best verbal response, none, at hospital admission
R40.2214  Coma scale, best verbal response, none, 24 hours or more after hospital admission
R40.2220  Coma scale, best verbal response, incomprehensible words, unspecified time
R40.2221  Coma scale, best verbal response, incomprehensible words, in the field [EMT or ambulance]
R40.2222  Coma scale, best verbal response, incomprehensible words, at arrival to emergency department
R40.2223  Coma scale, best verbal response, incomprehensible words, at hospital admission
R40.2224  Coma scale, best verbal response, incomprehensible words, 24 hours or more after hospital admission
R40.2310  Coma scale, best motor response, none, unspecified time
R40.2311  Coma scale, best motor response, none, in the field [EMT or ambulance]
R40.2312  Coma scale, best motor response, none, at arrival to emergency department
R40.2313  Coma scale, best motor response, none, at hospital admission
R40.2314  Coma scale, best motor response, none, 24 hours or more after hospital admission
R40.2320  Coma scale, best motor response, extension, unspecified time
R40.2321  Coma scale, best motor response, extension, in the field [EMT or ambulance]
R40.2322  Coma scale, best motor response, extension, at arrival to emergency department
R40.2323  Coma scale, best motor response, extension, at hospital admission
R40.2324  Coma scale, best motor response, extension, 24 hours or more after hospital admission
R40.2340  Coma scale, best motor response, flexion withdrawal, unspecified time
R40.2341  Coma scale, best motor response, flexion withdrawal, in the field [EMT or ambulance]
R40.2342  Coma scale, best motor response, flexion withdrawal, at arrival to emergency department
R40.2343  Coma scale, best motor response, flexion withdrawal, at hospital admission
R40.2344  Coma scale, best motor response, flexion withdrawal, 24 hours or more after hospital admission
R44.0  Auditory hallucinations
R44.2  Other hallucinations
R44.3  Hallucinations, unspecified
R56.9  Unspecified convulsions
T39.013A  Poisoning by aspirin, assault, initial encounter
T39.014A  Poisoning by aspirin, undetermined, initial encounter
T39.091A  Poisoning by salicylates, accidental (unintentional), initial encounter
T39.092A  Poisoning by salicylates, intentional self-harm, initial encounter
T39.093A  Poisoning by salicylates, assault, initial encounter
T39.094A  Poisoning by salicylates, undetermined, initial encounter
T39.011A  Poisoning by aspirin, accidental (unintentional), initial encounter
T39.012A  Poisoning by aspirin, intentional self-harm, initial encounter
T39.1X1A  Poisoning by 4-Aminophenol derivatives, accidental (unintentional)
T39.1X2A  Poisoning by 4-Aminophenol derivatives, intentional self-harm, initial encounter
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T39.1X3A</td>
<td>Poisoning by 4-Aminophenol derivatives, assault, initial encounter</td>
</tr>
<tr>
<td>T39.1X4A</td>
<td>Poisoning by 4-Aminophenol derivatives, undetermined, initial encounter</td>
</tr>
<tr>
<td>T39.2X2A</td>
<td>Poisoning by pyrazolone derivatives, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T39.2X3A</td>
<td>Poisoning by pyrazolone derivatives, assault, initial encounter</td>
</tr>
<tr>
<td>T39.24A</td>
<td>Poisoning by pyrazolone derivatives, undetermined, initial encounter</td>
</tr>
<tr>
<td>T39.311A</td>
<td>Poisoning by propionic acid derivatives, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T39.312A</td>
<td>Poisoning by propionic acid derivatives, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T39.313A</td>
<td>Poisoning by propionic acid derivatives, assault, initial encounter</td>
</tr>
<tr>
<td>T39.314A</td>
<td>Poisoning by propionic acid derivatives, undetermined, initial encounter</td>
</tr>
<tr>
<td>T39.391A</td>
<td>Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], accidental (unintentional)</td>
</tr>
<tr>
<td>T39.392A</td>
<td>Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T39.393A</td>
<td>Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], assault, initial encounter</td>
</tr>
<tr>
<td>T39.394A</td>
<td>Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.0X1A</td>
<td>Poisoning by opium, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.0X2A</td>
<td>Poisoning by opium, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.0X3A</td>
<td>Poisoning by opium, assault, initial encounter</td>
</tr>
<tr>
<td>T40.0X4A</td>
<td>Poisoning by opium, undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.1X1A</td>
<td>Poisoning by heroin, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.1X2A</td>
<td>Poisoning by heroin, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.1X3A</td>
<td>Poisoning by heroin, assault, initial encounter</td>
</tr>
<tr>
<td>T40.1X4A</td>
<td>Poisoning by heroin, undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.2X1A</td>
<td>Poisoning by other opioids, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.2X2A</td>
<td>Poisoning by other opioids, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.2X3A</td>
<td>Poisoning by other opioids, assault, initial encounter</td>
</tr>
<tr>
<td>T40.2X4A</td>
<td>Poisoning by other opioids, undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.3X1A</td>
<td>Poisoning by methadone, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.3X2A</td>
<td>Poisoning by methadone, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.3X3A</td>
<td>Poisoning by methadone, assault, initial encounter</td>
</tr>
<tr>
<td>T40.3X4A</td>
<td>Poisoning by methadone, undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.4X1A</td>
<td>Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.4X2A</td>
<td>Poisoning by other synthetic narcotics, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.4X3A</td>
<td>Poisoning by other synthetic narcotics, assault, initial encounter</td>
</tr>
<tr>
<td>T40.4X4A</td>
<td>Poisoning by other synthetic narcotics, undetermined, initial encounter</td>
</tr>
<tr>
<td>T40.601A</td>
<td>Poisoning by unspecified narcotics, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td>T40.602A</td>
<td>Poisoning by unspecified narcotics, intentional self-harm, initial encounter</td>
</tr>
<tr>
<td>T40.603A</td>
<td>Poisoning by unspecified narcotics, assault, initial encounter</td>
</tr>
<tr>
<td>T40.604A</td>
<td>Poisoning by unspecified narcotics, undetermined, initial encounter</td>
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<tr>
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REFERENCES


Legal Disclaimer

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Commented [CH1]: Reference SC Medicaid provider manual
### MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<tr>
<td>5/3/2018</td>
<td>Approved by MPC. Added item re: pre-pay and post-pay review.</td>
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<tr>
<td>2/21/2018</td>
<td>Approved by MPC. Updated limits per changes by CMS.</td>
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<tr>
<td>3/2/2017</td>
<td>Approved by MPC. Additions made due to updated CMS LCD.</td>
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<tr>
<td>3/2/2017</td>
<td>Approved by MPC. Additional coding changes.</td>
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<tr>
<td>4/7/2016</td>
<td>Approved by MPC. Additional clarifications re: 2016 codes.</td>
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<tr>
<td>12/16/2015</td>
<td>Approved by MPC. Updates for 2016 per CMS.</td>
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<tr>
<td>8/6/2015</td>
<td>Approved by MPC. Clarification of Georgia specific item.</td>
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<tr>
<td>5/22/2015</td>
<td>Approved by MPC. Updated Position Statement and Coding sections.</td>
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<tr>
<td>5/1/2014</td>
<td>Approved by MPC. Added drug detection chart.</td>
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<tr>
<td>12/5/2013</td>
<td>Approved by MPC. New.</td>
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