Applicable To:

- Medicaid – All Markets*, excluding Hawaii Behavioral Health
- Medicare – All Markets*, excluding Hawaii Behavioral Health

* Includes State-Specific Criteria for Georgia and South Carolina

Claims Edit Guideline:
Drug Testing

Policy Number: HS-247

Original Effective Date: 12/5/2013

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

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

- For Medicare and 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 may 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.3

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 but 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.4

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 as 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, "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.5

Guidance from Professional Organizations

American Society of Addiction Medicine Policy Statement (ASAM). Drug classes recognized by ASAM include: 6

- Amphetamines – Amphetamines (AMP), Methamphetamines (MET or mAMP), Ecstasy (XTC or MDMA)
- Phencyclidine (PCP)
- Barbiturates (BAR)
- Benzodiazepine (BZD or BZO)

- Propoxyphene (PPX)
- Opiates – Morphine/Opiate (MOR, MOR/OPI or OPI), Oxycodone (OXY)
- Marijuana (THC)
- Cocaine (COC)
- Methadone (MTD)

ASAM recommends the following practices and procedures for the use of drug testing in diagnostic and addiction treatment settings; for monitoring purposes; for the use of drug testing for legal purposes; and for the collection, handling and analysis of specimens used in drug testing. 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.” 8

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.

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POSITION STATEMENT

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. It is otherwise excluded.
- Quantitative testing (or definitive) for negative screening results is excluded without written documentation of medical necessity.

The following services are not medically reasonable or necessary, and therefore are excluded from coverage:

- Blanket orders
- Reflex definitive drug tests when presumptive testing is performed at point of care. The Provider 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 immune assay (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. Physician-defined standing orders for predetermed 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.
- Billing of individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered.
- Direct to Definitive drug test without presumptive positive drug test; this practice encourages excessive and unnecessary testing.
- Confirmation/definitive identification of a presumptive drug test negative result except when a patient on prescribed medication should have had a presumptive positive result.
- Performing presumptive point of care testing (POCT) and ordering presumptive IA testing from a reference laboratory.
- Performing presumptive IA testing and ordering presumptive IA testing from a reference laboratory with or without reflex testing.
- Performing 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 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, 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.
- As a condition for employment, participation in school or community activities (e.g., athletics, extra circular activities), or enrollment in a school or in the military;
- Court ordered drug testing;
- Forensic/criminal situations;
- Required drug testing in the school or work place;
- Administrative, or social service agency investigations, proceedings, or monitoring activities;
- Activities related to testing that do not have a clear role in treatment and decision making (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.

Coverage

Drug testing is categorized into the groups below; the member must meet the criteria listed for each group in order for coverage to be considered.

Group A: Random Testing

• One (1) qualitative (or presumptive) test per day (up to and not exceeding 2 per month or 15 per year in a 365 day period).
• Quantitative (or definitive/confirmatory) tests by HCPCS definition are limited by CPT code based on the number of drug classes to 1 HCPCS code 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\(^3\)

A presumptive drug test should be performed as part of the evaluation and management of a member who presents in an urgent/emergent setting with any one of the following:

• 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 must 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 in a 365 day period). 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
• Clinical documentation supports 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 Use Disorder and Patients on Chronic Opioid Therapy (COT)\(^1,3\)

Substance Disorder

Testing frequency must meet medical necessity requirements 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 in a 365 day period). Specifically:
  o CPT 80305: one unit (1) per day (but not on the same day as utilizing CPT 80306 or 80307), two (2) per month, or 24 per year will be allowed.
  o CPT 80306 or 80307: one (1) unit per day, one (1) per month, and 12 units per year will be allowed
• One (1) **definitive** tests, multiple drug classes per day (up to and not exceeding 1 per month or 12 per year in a 365 day period)

NOTE: For members who are on buprenorphine 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 in the medical record.13

**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 3 per month or 36 per year in a 365 day period)
• One (1) **definitive** test, multiple drug classes per day (up to and not exceeding 1 per month or 12 per year in a 365 day period)

**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 three (3) presumptive and/or three (3) definitive drug tests per month may be allowed 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 each drugs/drug classes to be screened/identified 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; **AND**
• Medical records can be submitted at the initiation of treatment for members undergoing buprenorphine treatment due to the frequency of testing.
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 medical necessity as substantiated by documentation in the medical record. Recommendations for members undergoing COT include:

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

- **COT Monitoring Testing.** Ongoing testing may be medically reasonable and medically 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.

Random UDT should be performed by the clinician at random intervals to properly monitor a patient. UDT testing does not have to be associated with an office visit. Members 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.

Frequency of Presumptive Drug Test for Substance Use 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.

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 exceeded. Documentation can be submitted at the initiation of treatment for members undergoing buprenorphine 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, demonstrating 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 presumptive and/or definitive
drug test. All tests must be ordered in writing by the treating provider and all drugs/drug classes to be tested must be indicated in the Member’s medical record.

- 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 or presumptive 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:
  - The result of the screen is positive and the patient disputes the findings; **OR**
  - 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:
  - Altered mental status;
  - Medical or psychiatric condition where drug toxicity may be a contributing factor;
  - Fetal withdrawal syndrome;
  - Possible exposure of the fetus to illicit drugs taken by the mother;
  - To assess and treat Members with a substance abuse disorders;
  - To assess a Member’s adherence to prescribed medications.

- Drug testing should be performed at an appropriate frequency based on clinical needs. Substance Use Disorder treatment adherence is often best measured through random testing rather than frequent scheduled testing.

- Reports or clinical information derived from the result of laboratory data (e.g., mathematically calculated) – this information is considered part of the test procedure and therefore **not a separately reportable service**.

- Medical records must justify each test ordered and must include the rationale of the ordering provider. This may include, but is not limited to the medical necessity of the test ordered, the justification for the billed CPT or HCPCS Code, and the reason why other appropriate tests were not utilized.

**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 initially denied and a request sent to 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 for medical necessity and proper use of each CPT and HCPCS Code:
• Presumptive Testing: 80300, 80305, 80306, 80307
• Definitive Testing: G0480, G0481, G0482, G0483, G0659

State 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, LDLD, 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, FPIA) 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

Listing not all inclusive. Please reference CMS National and Local Coverage Determinations for specific medical necessity and coverage.

80300 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 NOTE: CPT 80300 is not covered for Medicare

80305 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

80306 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

80307 Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

Confirmatory Drug Testing (see specific coding below)

80320 Alcoholics NOTE: CPT 80320 is not covered for Medicare

80324 Amphetamines; 1 or 2

80325 Amphetamines; 3 or 4

80326 Amphetamines; 5 or more

80332 Antidepressants, serotonergic class; 1 or 2

80333 Antidepressants, serotonergic class; 3-5

80334 Antidepressants, serotonergic class; 6 or more

80335 Antidepressants, tricyclic and other cyclics; 1 or 2

80336 Antidepressants, tricyclic and other cyclics; 3-5

80337 Antidepressants, tricyclic and other cyclics; 6 or more

80338 Antidepressants, not otherwise specified
80339  Antiepileptics, not otherwise specified; 1-3
80340  Antiepileptics, not otherwise specified; 4-6
80341  Antiepileptics, not otherwise specified; 7 or more
80342  Antipsychotics, not otherwise specified; 1-3
80343  Antipsychotics, not otherwise specified; 4-6
80344  Antipsychotics, not otherwise specified; 7 or more
80345  Barbiturates
80346  Benzodiazepines; 1-12*
80347  Benzodiazepines; 13 or more*
80348  Buprenorphine
80349  Cannabinoids, natural
80350  Cannabinoids, synthetic; 1-3
80351  Cannabinoids, synthetic; 4-6
80352  Cannabinoids, synthetic; 7 or more
80353  Cocaine
80354  Fentanyl
80355  Gabapentin, non-blood
80356  Heroin metabolite
80357  Ketamine and norketamine
80358  Methadone
80359  Methyleneoxyamphetamine (MDA, MDEA, MDMA)
80360  Methylphenidate
80361  Opiates, 1 or more
80362  Opioids and opiate analogs; 1 or 2
80363  Opioids and opiate analogs; 3 or 4
80364  Opioids and opiate analogs; 5 or more
80365  Oxycodone
80366  Pregabalin
80367  Propoxyphene
80368  Sedative hypnotics (non-benzodiazepines)
80369  Skeletal muscle relaxants; 1 or 2
80370  Skeletal muscle relaxants; 3 or more
80371  Stimulants, synthetic
80372  Tapentadol
80373  Tramadol
80374  Stereoisomer (enantiomer) analysis, single drug class
80375  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
80376  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377  Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
82542  Column chromatography/mass spectrometry (e.g., GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
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 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)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 23 or more drug class(es), including metabolite(s) if performed.
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 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 Acidosis
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, F11.221, F11.222, F11.229 Opioid dependence with intoxication
F11.23 Opioid dependence with withdrawal
F11.288 Opioid dependence with other opioid-induced disorder
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Claims Edit Guideline

DRUG TESTING

HS-247

Citing information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


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The Claims Edit Guideline (CEG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CEG. When a conflict exists between the two documents, the Member’s Benefit Plan always supersedes the information contained in the CEG. Additionally, CEGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CEG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are not reviewed by wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

 Easy Choice Health Plan – Harmony Health Plan of Illinois – Missouri Care – Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
Oncare (CareFirst Health Plan Arizona, Inc.) – Staywell of Florida – WeCare Prescription Insurance – WellCare Texan Plus (Dallas – Houston markets)
TimeCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

MEDICAL POLICY COMMITTEE HISTORY AND REVISENS

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<tr>
<td>7/12/2018</td>
<td>Approved by MPC. Condensed / revised guideline overall.</td>
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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>
</tr>
<tr>
<td>3/2/2017</td>
<td>Approved by MPC. Additions made due to updated CMS LCD.</td>
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<tr>
<td>3/3/2017</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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