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Corporate Medical Policy

Drug Testing in Pain Management and Substance Abuse Treatment

Description of Procedure or Service

According to an evidence assessment by the American Society of Interventional Pain Physicians (ASIPP), approximately one-third of chronic pain patients do not use opioids as prescribed or may abuse them. Moreover, studies report that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and use of illicit drugs.

Various strategies are available to monitor pain management and substance abuse treatment patients, and multicomponent interventions are often used. Many settings require patients to sign a contract before they are given a prescription for opioids. The contracts generally involve obtaining patients’ agreement on behaviors they will engage in during the treatment period (e.g., taking medication as prescribed) and not engage in (e.g., selling prescribed medication and/or obtaining additional prescriptions from other physicians).

Confirming whether patients follow these behavioral guidelines can be a challenge. Risk-assessment screening instruments, such as the Screener and Opioid Assessment for Patients with Pain-Revisited (SOAPP-R), and the Opioid Risk Tool (ORT), can aid in the assessment of patients’ risk for inappropriate drug use. In addition, the presence of “aberrant behaviors” can be used as a marker for patients who are at high risk for deviating from treatment protocols. Aberrant behaviors include multiple lost prescriptions, obtaining prescriptions from other practitioners, and displaying evidence of acute intoxication during office visits.

Another strategy for monitoring patients is testing of biological specimens for the presence or absence of drugs. Currently, urine is the most commonly used biological substance. Advantages of urine sampling are that it is readily available, and standardized techniques for detecting drugs in urine exist. Other biological specimens e.g., blood, oral fluids, hair and sweat, can also be tested and may gain in popularity over time as techniques for collecting and analyzing these specimens become more standardized.

Urine drug testing

There are 2 primary categories of urine drug testing:

1. **Immunoassay testing (i.e., presumptive testing, qualitative testing, screening)**
   These tests can be performed either in a laboratory or at point of service. Immunoassay tests are based on the principle of competitive binding and use antibodies to detect a particular drug or drug metabolite in a urine sample. With competitive binding, a fixed amount of a labeled drug is added to the urine sample, and the drug or metabolite in the sample competes with the labeled drug for binding sites on the antibody. The amount of labeled antigen that binds with the antibody is inversely proportional to the amount of the drug or metabolite in the sample.

   Immunoassay tests vary in the type of compounds they can detect. Some detect specific drugs and may fail to recognize similarly structured drugs within the same class. Other immunoassays identify only classes of drugs and thus results cannot be used to determine which drug a patient is taking. For example, a positive result to
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an opiate immunoassay can be due to morphine or hydromorphone. The degree of cross reactivity, i.e., an antibody’s reactivity with a compound other than the target of the test, varies widely among immunoassays.

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

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

Mass Spectrometry and Liquid Chromatography: These newer techniques used by some offices and most commercial laboratories will combine the Presumptive and Definitive testing in a single step. This testing may include up to 50 tests from a single sample. This testing, when done for screening purposes, is considered to be Presumptive testing.

2. Specific drug identification (i.e., definitive testing, quantitative testing, confirmatory testing)

Confirmatory tests are always performed in a laboratory. Gas chromatography/mass spectrometry (GC/MS) is considered to be the criterion standard for confirmatory testing. This technique involves using GC to separate the analytes in a specimen and MS to identify the specific molecular structures of the drug and its metabolites. The tests are able to quantify the amount of drug or metabolite present in the urine sample. Definitive tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS generally requires specification of the drug or drugs to be identified. Alternatively, “broad spectrum screens” can be conducted. There is a several day turnaround time for GC/MS testing.

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

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

There are various approaches to incorporating urine drug screening into pain management and substance abuse treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use. Some clinicians believe that urine drug screening should be routinely used to establish baseline information about substance use, but the optimal frequency and interval of testing remains uncertain. A universal approach to screening may uncover more inappropriate use, and may reduce patients’ sense that testing is being performed due to a lack of trust. However, routine universal screening may place an unnecessary burden on the healthcare system and on the doctor-patient relationship. An alternative approach is selective testing of patients who are judged to be at increased risk for drug misuse.

Existing protocols vary for use of presumptive versus definitive tests. Some of these involve conducting routine confirmation of positive presumptive tests with definitive testing. Others use selective confirmation of positive qualitative tests, such as when an unexpected immunoassay result is not adequately explained by the patient. There is also a mixed approach, with routine confirmation of presumptive tests only for drugs with poor-performing immunoassays.
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Full informed consent is a requirement before urine drug testing. Patients should be informed of the specific drug testing protocol before treatment and should provide written agreement with the plan for monitoring. As stated in a joint U.S. Veterans Affairs/Department of Defense guideline, patients’ refusal to consent to urine testing should be considered as one factor in the overall assessment of patients’ ability to adhere to treatment.

This policy applies to all biologic specimens used for drug testing in pain management and substance abuse treatment.

This policy does not address the use of biologic specimen testing in the following circumstances: Emergency department testing, including for the detection of potential overdose or poisoning; Federally regulated testing; Non-forensic testing for commercial drivers licensing or any other job-related testing; and State/legally mandated drug testing.

Related Policies:
Maximum Units of Service
Residential Treatment

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for drug testing in pain management and substance abuse treatment when it is considered to be medically necessary because the medical criteria and guidelines below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Drug Testing in Pain Management and Substance Abuse Treatment is covered

In outpatient pain management, presumptive (i.e., immunoassay, mass spectrophotometric and liquid chromatography) drug testing may be considered medically necessary for:

- Baseline screening before initiating treatment or at the time treatment is initiated, when the following conditions are met:
  - An adequate clinical assessment of patient history and risk of substance abuse is performed;
  - Clinicians have knowledge of test interpretation;
  - There is a plan in place regarding how to use test findings clinically

- Subsequent monitoring of treatment at a frequency appropriate for the risk-level of the individual patient. (See Policy Guidelines sections).

In outpatient substance abuse treatment, in-office or point-of-care qualitative (i.e., immunoassay) drug testing may be considered medically necessary under the following conditions:

- Baseline screening before initiating treatment or at the time treatment is initiated (i.e., induction phase), 1 time per program entry, when the following conditions are met:
  - An adequate clinical assessment of patient history and risk of substance abuse is performed;
  - Clinicians have knowledge of test interpretation;
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- There is a plan in place regarding how to use test findings clinically
  - Stabilization phase - targeted weekly presumptive screening for a maximum of 4 weeks (see Policy Guidelines section)
  - Maintenance phase – targeted presumptive screening once every 1 to 3 months (see Policy Guidelines section)

Definitive (i.e., confirmatory) drug testing, in outpatient pain management or substance abuse treatment, may be considered medically necessary under the following circumstances:

- When immunoassays for the relevant drug(s) are not commercially available.
- In specific situations for which quantitative drug levels are required for clinical decision making (see Policy Guidelines).

When Drug Testing in Pain Management and Substance Abuse Treatment is not covered

In outpatient pain management and outpatient substance abuse treatment, drug testing is considered not medically necessary when the above criteria are not met, including but not limited to, routine presumptive or definitive drug testing (e.g., testing at every visit, without consideration for specific patient risk factors or without consideration for whether quantitative testing is required for clinical decision making).

Documentation is required to support the necessity of the confirmatory (definitive) testing as outlined above.

Routine confirmation of presumptive tests with definitive testing is considered not medically necessary.

In outpatient pain management and substance abuse treatment, hair drug testing and oral fluid drug testing are considered investigational.

Policy Guidelines

Pain management

The risk-level for an individual patient should include a global assessment of risk factors, and monitoring for the presence of aberrant behavior. Standardized risk assessment tools are available, such as the 5-item opioid risk tool (ORT). Another screening instrument is the SOAPP-R, a 24-item tool.

Aberrant behavior is defined by one or more of the following:

- multiple lost prescriptions,
- multiple requests for early refill,
- obtained opioids from multiple provider,
- unauthorized dose escalation,
- apparent intoxication during previous visits.

Opinions vary on the optimal frequency of drug screening to monitor patients on opioid therapy for chronic pain. Frequency of screening using a risk-based approach, as recommended by the Washington State Inter-Agency Guideline, is as follows:

- Low risk by Opioid Risk Tool (ORT): Up to 1 per year
- Moderate risk by ORT: Up to 2 per year
- High risk or opioid dose >120 MED/d: Up to 3 to 4 per year
- Recent history of aberrant behavior: Each visit.

Note that the ORT is a copyrighted instrument.
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The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain does not include specific screening frequencies but states that an individual patient’s risk for opioid misuse and addiction should be considered when deciding when to order a urine drug screen.

**Substance Abuse**

Stabilization phase: Most patients are expected to be on a stable dose of opioid medication within 4 weeks of initiating treatment. In some complicated patients, the stabilization phase may last longer than 4 weeks.

Maintenance phase: For most patients, targeted presumptive screening once every 1 to 3 months is sufficient during the maintenance phase of treatment. More frequent testing may be appropriate for some complicated patients.

**Guidance regarding definitive, ie, confirmatory testing**

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

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

There may not be commercially available screening tests for certain synthetic or semi synthetic opioids.

The following information on immunoassay availability and diagnostic capacity is included in the Washington State Inter-Agency Guideline:

**Natural opioids (e.g., codeine, morphine)**

“Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.”

**Semi synthetic opioids (e.g., hydrocodone, hydromorphone, oxycodone, oxymorphone)**

“Opiates” immunoassays may also detect semi synthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semi synthetic opioids. Confirmatory testing (GC/MS or LC-MS/MS [liquid chromatography followed by tandem mass spectrometry]) is required to verify compliance with the prescribed semi synthetic opioid(s).

Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.”

**Synthetic opioids (e.g., fentanyl, meperidine, methadone, propoxyphene)**

Current “opiates” immunoassays do not detect synthetic opioids. Thus confirmatory testing (GC/MS or LC-MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.”

The following table on interpreting unexpected results of urine drug tests was adapted from one developed by the Canadian National Opioid Use Guideline Group that was cited by ASIPP in their guideline on prescribing opioids for chronic noncancer pain:

<table>
<thead>
<tr>
<th>Unexpected Result</th>
<th>Possible Explanations</th>
<th>Possible Actions for the Physician</th>
</tr>
</thead>
</table>
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| Test is negative for prescribed opioid | False negative  | Noncompliance  | Diversion  | Conduct confirmatory testing, specifying the drug of interest (e.g., oxycodone often missed by immunoassay)  
|                                       |                  |               |           | Take a detailed history of the patient’s medication use for the preceding 7 d (e.g., could learn that patient ran out several days prior to test)  
|                                       |                  |               |           | Ask patient if they’ve given the drug to others  
|                                       |                  |               |           | Monitor compliance with pill counts  |

| Test is positive for nonprescribed opioid or benzodiazepines | False positive  | Patient acquired opioids from other sources (double-doctoring, "street")  
|                                                               |                  |               |           | Repeat drug testing regularly  
|                                                               |                  |               |           | Ask patients if they accessed opioids from other sources  
|                                                               |                  |               |           | Assess for opioid use/addiction  
|                                                               |                  |               |           | Review/revise treatment agreement  |

| UDS positive for illicit drugs (e.g., cocaine, cannabis) | False positive  | Patient is occasional user or addicted to the illicit drug  
|                                                         |                  | Cannabis is positive for patients taking certain medications (e.g., dronabinol)  
|                                                         |                  |               | Repeat drug test regularly  
|                                                         |                  |               | Assess for abuse/addiction and refer for addiction treatment as appropriate  |

(UDS: urine drug screen)

Summary:
Patients in pain management programs and substance abuse treatment may misuse prescribed opioids and/or may use non prescribed drugs. Thus, these patients are often assessed before treatment and monitored while they are receiving treatment. Urine drug screening can be part of this monitoring strategy; it is most often used as part of a multifaceted intervention that includes other components such as patient contracts. There is limited published evidence on the diagnostic accuracy and clinical utility of urine drug testing in pain management and substance abuse treatment. For pain management patients, there are no randomized controlled trials (RCTs) that isolate the potential effect of urine drug testing on patient management/health outcomes. One RCT was identified on urine drug testing of patients in substance abuse treatment; that trial focused on the specific situation of testing to determine eligibility for take-home methadone. Based on the available evidence and clinical input, urine drug testing may be considered medically necessary under specific conditions listed in the policy statements.

Another strategy for monitoring patients is testing of biological specimens for the presence or absence of drugs. Currently, urine is the most commonly used biological substance. Advantages of urine sampling are that it is readily available, and standardized techniques for detecting drugs in urine exist. Other biological specimens, e.g., blood, oral fluids, hair and sweat, can also be tested and may gain in popularity over time as techniques for collecting and analyzing these specimens become more standardized. Blood or serum is used regularly for testing in some institutions, and in some circumstances and institutions hair, feces, sweat, or saliva may be used to detect drug of abuse.

This policy applies to all biologic specimens used for drug testing in pain management and substance abuse treatment.

Practice Guidelines and Position Statements:

Pain Management
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In 2014, Nuckols et al published a systematic review of guidelines that addressed management of opioid use for chronic pain. The authors included guidelines from national organizations and specialty societies, as well as guidelines from state agencies and specific health systems. The authors identified 9 guidelines with recommendations on UDT. The recommendations varied widely; 2 guidelines recommended mandatory testing for all patients, 1 recommended testing only patients at increased risk of medication abuse, and 2 stated that testing patients at low risk of abuse is not cost-effective. If UDT is used, the recommended frequency of follow-up testing was at least quarterly in 1 guideline, at least yearly in 1 guideline and randomly in 2 guidelines.

American Society of Interventional Pain Physicians
In 2012, the American Society of Interventional Pain Physicians issued guidelines on responsible opioid prescribing for chronic noncancer pain. The guidelines include the following recommendations on UDT:

- “Comprehensive assessment and documentation is recommended before initiating opioid therapy...” (Evidence: good)
- “Despite limited evidence for reliability and accuracy, screening for opioid use is recommended, as it will identify opioid abusers and reduce opioid abuse.” (Evidence: limited)
- “Urine drug testing must be implemented from initiation along with subsequent adherence monitoring, in an in-office setting with immunoassay and confirmation for accuracy with chromatography in select cases, to identify patients who are non-compliant or abusing prescription drugs or illicit drugs, and urine drug testing may decrease prescription drug abuse or illicit drug use when patients are in chronic pain management therapy.” (Evidence: good)

The evidence behind these recommendations was not clearly described in either the guidance document or the accompanying evidence assessment document.

American Pain Society and American Academy of Pain Medicine Opioids Guidelines Panel
In 2009, the American Pain Society and American Academy of Pain Medicine jointly published clinical guidelines on use of opioid therapy in chronic noncancer pain. The guidelines do not address UDT or other forms of monitoring adherence.

American College of Occupational and Environmental Medicine
In 2011, the American College of Occupational and Environmental Medicine issued guidelines on the chronic use of opioids which contained the following recommendations on UDT:

“Routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician.” Evidence (C): “The intervention is recommended for appropriate patients. There is limited evidence that the intervention may improve important health and functional benefits.”

Screening is recommended for all patients at baseline and then randomly at least twice and up to 4 times a year and at termination. Screening should also be performed if the provider suspects abuse of prescribed medication.

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
Guidelines were issued in 2010 and they include the following recommendation on urine drug screening (UDS): “When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C).”

The guideline also states that there is no “compelling evidence” to guide physicians on identifying patients who should have UDS, or on how often they should be tested. The document states that the following factors should be considered when deciding whether to order a urine drug screen:

- patient’s risk for opioid misuse and addiction
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- aberrant drug-related behaviors
- testing availability (note: this may be a Canadian-specific issue)

**Veterans Affairs and Department of Defense Management of Opioid Therapy for Chronic Pain Working Group**

In 2010, the Department of Veterans Affairs and Department of Defense issued clinical practice guidelines for managing opioid therapy for chronic pain treatment. The recommendations on assessing adherence to prescribed opioids includes, with patient consent, obtaining a urine drug test before initiating opioid therapy and randomly at follow-up to confirm appropriate use. Other strategies recommended include clinical assessment and screening aids such as random pill counts, adherence checklists and standardized instruments such as the Screener and Opioid Assessment for Patients with Pain.

The guideline included the following specific recommendations on UDT:

1. Inform patients that drug testing is a routine procedure for all patients starting or on opioid therapy, and is an important tool for monitoring the safety of their treatment.
2. With patient consent, obtain a UDT in all patients prior to initiation of opioid treatment.
3. With patient consent monitor all patients on OT with periodic random UDTs to confirm adherence to the treatment plan. Increase the frequency of UDTs based on risk level for aberrant drug related behaviors and following each dose increase.
4. Take into consideration a patient’s refusal to take a UDT as part of the ongoing assessment of the patient’s ability to adhere to the treatment plan and the level of risk for adverse outcomes.
5. When interpreting UDT results take into account other clinical information (e.g., past substance abuse, other risk factors, aberrant drug-related behaviors, and other conditions indicating risk.)
6. Understanding of lab methods for drug testing and reporting are necessary to interpret UDT results (i.e., screen versus confirmatory test, substances tested, cut-off levels for tests). Maintain a close working relationship with the clinical laboratory to answer any questions about the UDT or for confirming the results.

**Washington State Agency Medical Directors’ Group**

In 2010, the Washington State Agency Medical Directors' Group issued interagency guidelines on opioid dosing for chronic noncancer pain. The guideline included recommendations on UDT. Recommendations on testing frequency differed depending on patient risk of opioid addiction and opioid dosage, and are summarized next (also see Policy Guidelines section):

- Low risk: Periodic screening (up to once per year)
- Moderate risk: Regular screening (up to twice per year)
- High risk or opioid dose over 120 mg MED/d
- Aberrant behavior: Each visit

**Substance Abuse Treatment**

**American Society of Addiction Medicine**

In 2010, the American Society of Addiction Medicine (ASAM) issued a statement on drug testing in the substance abuse treatment programs. As stated in this document, the policy of ASAM is: “Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring 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.”

**Billing/Coding/Physician Documentation Information**
Drug Testing in Pain Management and Substance Abuse Treatment

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 80305, 80306, 80307, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376, 80377, G0480, G0481, G0482, G0483, G0659

Only one unit of a Confirmatory UDT will be paid per patient encounter, if the study is done with automated equipment.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

For policy titled, “Urine Drug Testing in Pain Management and Substance Abuse Treatment”


Medical Director Review 6/2015


Drug Testing in Pain Management and Substance Abuse Treatment


Specialty Matched Consultant Advisory Panel review 8/2015

For policy titled, “Drug Testing in Pain Management and Substance Abuse Treatment”

Hoffman, Robert J. Testing for drugs of abuse (DOA). In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on October 1, 2015.)


Policy Implementation/Update Information

For policy titled, “Urine Drug Testing in Pain Management and Substance Abuse Treatment”

7/1/15 Original policy issued with Policy Statement as follows, “BCBSNC will provide coverage for Urine Drug Testing in pain management and substance abuse treatment when it is considered to be medically necessary because the medical criteria and guidelines below are met.” Medical Director reviewed 6/2015. Notification given 7/1/15 for effective date of 9/1/15. (td)


For policy titled, “Drug Testing in Pain Management and Substance Abuse Treatment”

10/30/15 Policy title changed to Drug Testing in Pain Management and Substance Abuse Treatment. Description section updated to provide additional detail regarding biologic specimens addressed in this policy. Policy Guidelines section updated to include position statements and practice guidelines. References updated. (td)
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12/30/15  Billing/Coding section updated to delete codes: G0431, G0434, G6030, G6031, G6032, G6034, G6035, G6036, G6037, G6038, G6039, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6047, G6048, G6049, G6050, G6051, G6052, G6053, G6054, G6055, G6056, G6057, G6058 and add codes: G0477, G0478, G0479, G0480, G0481, G0482, G0483; effective 1/1/16. (td)

8/30/2016  Statement regarding specific situations for quantitative drug testing moved from the “when covered” section to “policy guidelines” section. Specialty Matched Consultant Advisory Panel review 7/27/2016. (an)

12/30/16  2017 code update. Codes 80300, 80301, 80302, 80303, 80304 deleted and codes 80305, 80306, 80307, G0659 added to Billing/Coding section. (an)

6/30/17  “Qualitative” changed to “presumptive” and “quantitative” changed to “definitive” throughout the policy for consistency with the language in the code descriptions. The following statement added to the Non-Covered section: “In outpatient pain management and substance abuse treatment, hair drug testing and oral fluid drug testing are considered investigational.” References added. Specialty Matched Consultant Advisory Panel review 4/26/2017. (an)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.