MASSACHUSETTS

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Medical Policy

Drug Testing in Pain Management and Substance Use Disorder Treatment

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Policy Number: 674

BCBSA Reference Number: 2.04.98
NCD/LCD: Local Coverage Determination (LCD): Urine Drug Testing (L36037)

Related Policies

- Biofeedback as a Treatment of Chronic Pain, #210
- Methadone Treatment and Intensive Detoxification or Ultra-Rapid Detoxification for Opiate Addiction, #274
- Intravenous Anesthetics for the Treatment of Chronic Pain, #291

Policy[1]

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

In outpatient pain management, presumptive (ie, immunoassay) urine drug testing (using HCPCS codes listed below) 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
  - Urine drug testing is ordered by a clinician during an office visit.

In the outpatient substance abuse treatment setting, in-office or point-of-care presumptive (ie, immunoassay) urine drug testing (using HCPCS codes listed below) may be considered **MEDICALLY NECESSARY** under the following conditions when ordered by a clinician during an office visit:

- Baseline screening before initiating treatment or at the time treatment is initiated (ie, 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;
  - 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
- Maintenance phase – targeted presumptive screening once every 1 to 3 months.

Blue Cross Blue Shield of Massachusetts compliance may authorize Urine Drug Testing (UDT) up to 20 presumptive (immunoassay) or definitive (ie, confirmatory) drug screen services per member per 365 days. The presumptive testing (Immunoassays) should be the initial test and screen, done to provide data on compliance with treatment or for monitoring of drug use. Clinics should be using the HCPCS codes listed below. No standing orders.

Definitive (ie, confirmatory) urine drug testing, in outpatient pain management or substance abuse treatment, may be considered **MEDICALLY NECESSARY** when ordered by a clinician during an office visit, under the following circumstances (using HCPCS codes listed below:

- 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 and would significantly change a treatment plan.

Guidance on Definitive (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.

Urine drug testing in the following settings may be considered **MEDICALLY NECESSARY** and will not count toward the 20 lab per year limit:

- Emergency rooms
- Ambulatory surgery
- Inpatient Services
- If you are receiving Methadone Maintenance for Substance Use Disorders
- An abrupt change in mental status (to rule out substance intoxication or delirium)
- Drug or alcohol exposure during pregnancy
- To rule out a fetal withdrawal syndrome by testing the mother for drug use.

Urine drug testing is considered **NOT MEDICALLY NECESSARY** when performed more than 20 services per member per 365 days.

Any tests ordered by third parties such as supportive housing (i.e. halfway house), courts, employers or school drug testing are considered **NOT MEDICALLY NECESSARY**. Urine drug testing should be ordered by a clinician during an office visit.

In the outpatient pain management setting and the outpatient substance abuse treatment setting, urine drug testing is considered **NOT MEDICALLY NECESSARY** when the above criteria are not met including but not limited to routine presumptive or definitive urine drug testing (eg, testing at every visit, without consideration for specific patient risk factors or without consideration for whether definitive testing is required for clinical decision making).

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

Medicare HMO Blue[SM] and Medicare PPO Blue[SM] Members

Medical necessity criteria and coding guidance for **Medicare Advantage members living in Massachusetts** can be found through the link(s) below.

Local Coverage Determinations (LCDs) for National Government Services, Inc.

Local Coverage Determination (LCD): Urine Drug Testing (L36037)

Note: To review the specific LCD, please remember to click "accept" on the CMS licensing agreement at the bottom of the CMS webpage.

For medical necessity criteria and coding guidance for **Medicare Advantage members living outside of Massachusetts**, please see the Centers for Medicare and Medicaid Services website at https://www.cms.gov for information regarding your specific jurisdiction.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **not required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.
Medicare HMO Blue℠	Prior authorization is **not required**.
Medicare PPO Blue℠	Prior authorization is **not required**.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, 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 (eg, immunoassay); read by instrument assisted direct optical observation (eg, 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 (eg, 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

HCPCS Codes

HCPCS codes:	Code Description
G0480	Drug tests(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 (eg, (IA, EIA, ELISA, EMIT,FPIA) and enzymatic methods (eg, 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 tests(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 (eg, (IA, EIA, ELISA, EMIT,FPIA) and enzymatic methods (eg, 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 tests(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 (eg, (IA, EIA, ELISA, EMIT,FPIA) and enzymatic methods (eg, 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 tests(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 (eg, (IA, EIA, ELISA, EMIT,FPIA) and enzymatic methods (eg, 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), excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, 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

The following CPT codes should not be used for urine drug testing for the following products: Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	Alcohol biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamines; 3 or 4
80326	Amphetamines; 5 or more
80327	Anabolic steroids; 1 or 2

80328	Anabolic steroids; 3 or more
80329	Analgesics, non-opioid; 1 or 2
80330	Analgesics, non-opioid; 3-5
80331	Analgesics, non-opioid; 6 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 cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 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
80359	Methylenedioxyamphetamines (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
83992	Phencyclidine (PCP)

Description

OPIOIDS

According to a 2012 evidence assessment by the American Society of Interventional Pain Physicians, approximately one-third of chronic pain patients do not use opioids as prescribed or may abuse them.[1] In 2016, the International Narcotics Control Board reported that between 1999 and 2010, the number of deaths related to the use of prescription opioid painkillers increased 5-fold among United States women and increased by a factor of 3.6 among United States men.[2] Additionally, studies have found that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and use of illicit drugs.[3]

Monitoring Strategies

Various strategies are available to monitor pain management and substance use disorder 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 (eg, taking medication as prescribed) and not engage in (eg, 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, and the Opioid Risk Tool, 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.

Testing Strategies

Another strategy for monitoring patients is testing of biologic specimens for the presence or absence of drugs. Currently, urine is the most commonly used biologic substance. Advantages of urine drug testing (UDT) are that it is readily available and standardized techniques for detecting drugs in urine exist. Other biologic specimens (eg, blood, oral fluids, hair, sweat) can also be tested and may gain in popularity over time as techniques for collecting and analyzing these specimens become more standardized. In addition to urine testing, this review will address testing for oral fluids and hair.

Urine Drug Testing

There are 2 primary categories of UDT: immunotherapy and specific drug identification.

Immunoassay Testing

Immunoassay testing (also called presumptive testing or qualitative testing or screening) can be performed 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 an opiate immunoassay can be due to morphine or hydromorphone. The degree of crossreactivity (ie, an antibody's reactivity with a compound other than the target of the test) varies widely among immunoassays.

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

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

Specific Drug Identification
Confirmatory tests are always performed in a laboratory. Gas chromatography/mass spectrometry (GC/MS) and liquid-chromatography/mass spectrometry (LC/MS) are considered to be the criterion standard for confirmatory testing. These techniques involve using GC or LC to separate the analytes in a specimen and for 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 quantitative tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS and LC/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 and LC/MS testing.[5]

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

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

There are various approaches to incorporating UDT into pain management and substance use disorder treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use. Some clinicians believe that UDT 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 health care 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 the use of presumptive vs definitive tests. Some involve conducting routine confirmation of positive presumptive tests with definitive quantitative testing. Others use selective confirmation of positive presumptive 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.

Full informed consent is a requirement before UDT. 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 a factor in the overall assessment of patients’ ability to adhere to treatment.[6]

Oral Fluid Drug Testing

Oral fluid (liquid samples obtained from the oral cavity) can potentially be used to test for drug use. Oral fluid contains secretions from several different sources, including secretions from the 3 pairs of major salivary glands (parotid, sublingual, and submandibular), secretions from the minor salivary glands, oro-naso-pharyngeal secretions, and cellular debris. The mixture of fluids obtained varies depending on the collection method used (eg, spitting, suctioning, draining, or collection on some type of absorbent material). Drug concentrations can be affected by the collection method and by the use of saliva stimulation methods. Several collection devices are commercially available in the United States, and they generally involve collection on an absorbent material, such as foam pads; pads are then placed in a container with a stabilizing buffer solution. Drug concentrations may also depend on how the oral fluid is recovered from the collection device (eg, by centrifugation or by applying pressure). Drug concentrations may not reflect blood levels because of residual amounts of drug (specifically those ingested or smoked) remaining in the oral cavity after recent use.

Analysis techniques must be able to detect drugs present in low concentration and in a small volume of fluid (often <1 mL). Immunoassay techniques are available to detect drugs in oral fluid; they require a small sample volume (≈25 µL). Immunoassays tend to be relatively sensitive techniques, but they have low specificity. Confirmation analysis is generally performed using MS-based methods. In recent years, advancements have been made in MS analysis techniques, including the development of multianalyte LC-MS methods.

A practical advantage of oral fluid collection compared with urine collection is that samples can be obtained under direct supervision and without loss of privacy. It has been used in situations where urine sampling is impractical, such as testing drivers during traffic stops. Oral fluid sampling also has the potential to be useful in the pain management or substance use disorder treatment settings, particularly when substitution or tampering with urine drug samples is suspected.

Hair Testing

Hair is composed of protein that traps chemicals in the blood at the time the hair develops in the follicle. Hair on the human head grows at approximately 0.5 inch per month. Thus, a 1.5-inch hair sample could be used to detect drug use during the previous 90 days. Potential advantages of hair as a drug testing source include: noninvasive collection; ease of collection, storage, and shipping; availability of samples for testing and retesting; and difficulty in tampering. Potential disadvantages include: recent drug use (ie, within past 7 days) cannot be detected; difficulty in detecting very light drug use (eg, a single episode); and drug levels can be affected by environmental exposure. In addition, variation in hair texture as well as cosmetic hair treatments can affect drug incorporation into hair and the accuracy of drug tests on hair samples. As with other types of samples, hair can be initially tested using immunoassay techniques, with confirmation by MS-based methods. Hair testing has been used in a variety of situations where detection of drug use during the previous several months is desired (eg, pre-employment screening, post-drug-treatment verification of relapse).

Summary

Patients in pain management programs and substance use disorder treatment may misuse prescribed opioids and/or may use nonprescribed drugs. Thus, these patients are often assessed before treatment and monitored while receiving treatment. Urine drug testing (UDT) 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.

For individuals who have chronic pain treated with opioids who receive UDT, the evidence includes nonrandomized comparative studies and systematic reviews. Relevant outcomes are test accuracy and validity, health status measures, and resource utilization. The evidence on the diagnostic accuracy of urine immunoassay tests, as confirmed by gas- or liquid-chromatography/mass spectrometry, shows sensitivities ranging from about 80% to 93% for both opiates and oxycodone. No randomized controlled trials (RCTs) evaluating clinical utility were identified. Several nonrandomized comparative studies have been conducted, though interventions and outcomes have varied across the studies. Most interventions included patient contracts along with UDT, and therefore, the effect of UDT alone could not be determined. Most studies did not provide details on the frequency of UDTs and whether the testing was

random or scheduled. As a result, these studies provided inconclusive evidence on whether UDT in the pain management setting improves patient outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a drug addiction who are in substance use disorder treatment who receive UDT, the evidence includes 2 RCTs. Relevant outcomes are test accuracy and validity, health status measures, and resource utilization. No studies were identified that evaluated the accuracy of UDT compared with a valid reference standard in individuals undergoing substance use disorder treatment. One small RCT focused specifically on UDT to determine eligibility for take-home methadone. The second RCT found that UDT identified drug use in a substantial number of patients who denied illicit usage; the impact on treatment success was not addressed. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2014 indicated that UDT is standard of care, and supported the medical necessity of UDT under certain circumstances. Guidelines from Department of Veterans Affairs and Department of Defense, American College of Occupational and Environmental Health, American Society of Interventional Pain Physicians, and the National Opioid Use Guideline Group have recommended UDT at baseline, and periodic random UDT thereafter. The guidelines consider the frequency of testing to be at the discretion of the health care provider, based on an assessment of the patient's risk for misuse or addiction. Thus, UDT may be considered medically necessary in selected situations.

For individuals who have chronic pain treated with opioids or with a drug addiction in substance use disorder treatment who receive oral fluid drug testing, the evidence includes diagnostic accuracy studies using UDT as the reference standard. Relevant outcomes are test accuracy and validity, health status measures, and resource utilization. The limited number of studies on the diagnostic accuracy of oral fluid testing compared with UDT have varied findings. No studies were identified assessing the impact of oral fluid testing on health outcomes compared with UDT or no drug testing. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have chronic pain treated with opioids or with a drug addiction in substance use disorder treatment who receive hair drug testing, the evidence includes a diagnostic accuracy study in the psychiatric treatment setting. Relevant outcomes are test accuracy and validity, health status measures, and resource utilization. Hair testing cannot detect recent drug use (ie, in the past few days), and thus has limited applicability to pain management or substance use disorder treatment settings, except, perhaps, for initial intake. There are no studies comparing the diagnostic accuracy of hair testing with UDT in either setting. One relatively small study tested the hair and urine of known drug users recruited from a psychiatric clinic. The study looked for drug use over the past several months rather than the shorter timeframe generally needed in pain management or drug treatment settings. No studies were identified on the clinical utility of hair testing in pain management or substance use disorder treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

Date	Action
3/2018	BCBSA National medical policy review. The term "abuse" replaced with "substance use" to align text with title change.
3/2017	Policy clarified.
2/2017	BCBSA National medical policy review. Policy statements clarified, "qualitative" changed to "presumptive" and "quantitative" changed to "definitive." New references added.
1/2017	Clarified coding information for the 2017 code changes.
10/2016	BCBSA National medical policy review. Statement added that, in outpatient pain management and substance abuse treatment, hair drug testing and oral fluid drug testing are considered investigational. "Urine" deleted from title. Clarified coding information. Effective 10/1/2016.
1/2016	Clarified coding information.

1/2016	Urine drug testing clarified from 20 times per calendar year to 20 services per member per 365 days.
6/2015	Policy implementation date corrected from 1/1/2015 to 6/1/2015. CPT and HCPCS codes for methadone removed. Effective 6/1/2015.
3/2015	New references added from BCBSA National medical policy.
1/2015	Added the total number of encounters for urine drug testing related to any diagnosis category shall not exceed more than 20 dates of service per member per 365 days is considered investigational. Clarified coding information. Effective 1/1/2015.
9/2014	Medicare local coverage determination for Qualitative Drug Screening (L28145) added.
7/2014	New medical policy describing medically necessary and not medically necessary indications. Effective 7/1/2014.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

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Endnotes

[1] Based on expert opinion and BCBSA National policy