

Medical Necessity Guidelines: Urine Drug Testing

Effective: October 21, 2020

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<p>Applies to:</p> <p>COMMERCIAL Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>TUFTS HEALTH PUBLIC PLANS Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 <p>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products</p> <ul style="list-style-type: none"> • Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List • Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List 	

OVERVIEW

Urine drug testing is performed to detect the use of prescription medications and illegal substances of concern for the purpose of medical treatment. Confirmatory testing is an additional test completed to verify the results of the urine drug test. Urine drug testing should not routinely include a panel of all drugs of abuse. The test should be focused on the detection of specific drugs/drug metabolites. The frequency of testing should be at the lowest level to detect the presence of drugs.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may cover urine drug testing when medically necessary.

PRIOR AUTHORIZATION IS NOT REQUIRED

- Documentation Requirements:
 - All documentation must be maintained in the Member’s medical record and available to Tufts Health Plan upon request.
 - Every page of the record must be legible and include appropriate Member identification information [e.g., complete name, dates of service(s)]. The record must include the identity of the physician or non-physician practitioner responsible for and providing the care of the Member.
 - If requested for review, the submitted medical record should support the use of the selected ICD-CM code(s). The submitted CPT/HCPCS code should describe the service performed. Documentation maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative 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 order. Orders which include statements such as “conduct additional testing as needed or custom profile” will not be accepted by Tufts Health Plan.
 - Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative 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 order.

- If the provider of the service is other than the ordering/referring physician, that provider must maintain printed copy documentation of the lab results, along with printed copies of the ordering/referring physician's order for the qualitative drug test. The physician must include the clinical indication/medical necessity in the order for the qualitative drug test.
- A full panel screen should only be considered for initial testing 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).
- Confirmatory Testing: Drug confirmation (G0480-G0483) by a second method is indicated when either of the following has occurred:
 - The result of the screen is positive.
 - The result is negative and the negative finding is inconsistent with the patient's medical history and/or treatment plan.

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.

- Tufts Health Plan may cover urine drug testing for medical conditions, such as those listed below, when medical necessity is demonstrated and when treatment planning by the requesting provider is dependent upon the test results.
 - 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 substance abuse disorders
 - To assess adherence to prescribed medications
- All urine drug testing should be performed at an appropriate frequency based on clinical needs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.

LIMITATIONS

- Quantitative tests in lieu of drug screening services or as a routine supplement to drug screens.
- Tufts Health Plan does not cover urine drug testing in any of the following circumstances:
 - Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.
 - Testing for residential monitoring.
 - Routine urinalysis for confirmation of specimen integrity.

Note: Use of non-contracting labs may have the unintended consequence of subjecting the Member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the non-participating lab that you selected.

For information regarding billing and compensation, refer to the [Laboratory and Pathology Payment Policy](#) on our website.

CODES

Table 1: Covered CPT and HCPCS Codes

CPT/HCPCS 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

CPT/HCPCS Code	Description
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
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
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(s), 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(s), 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(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

REFERENCES

- Center for Medicare & Medicaid Services. Local Coverage Determination 32450. Qualitative drug testing. Accessed on June 7, 2013 at http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/324501/L32450_PATH035060112.pdf.
- Commonwealth of Massachusetts. MassHealth Independent Clinical Laboratory. Bulletin 9. February 2013.

APPROVAL HISTORY

June 18, 2013: Reviewed and approved by Integrated Medical Policy Advisory Committee (IMPAC) for a January 1, 2014 effective date.

Subsequent endorsement date(s) and changes made:

- November 19, 2014: Reviewed by IMPAC, renewed without changes

- December 31, 2014: Coding updated. Per AMA CPT®, effective December 31, 2014 the following code(s) deleted: 80100, 80101, 80102 and 80104; and effective January 1, 2015 the following code(s) added: G6058, 80375, 80376, 80377.
- January 1, 2015: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- August 12, 2015: Reviewed by IMPAC. Renewed with minor language clarifications.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 31, 2015: Coding updated. Per AMA CPT®, effective December 31, 2015 the following code(s) are deleted, G0431, G0434, G6058 the following codes are added, G0477, G0478, G0479, G0480, G0481, G0482, G0483.
- September 14, 2016: Reviewed by IMPAC, renewed without changes
- December 31, 2016: Coding updated. Per AMA CPT®, effective December 31, 2016 the following codes are deleted, G0477, G0478, G0479. Effective January 1, 2017 the following codes are added: 80305, 80306, 80307.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- August 9, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 5, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

[Provider Services](#)