MEDICAL COVERAGE POLICY

SERVICE:	**Urine Drug Monitoring in Pain Management and Substance Abuse**
Policy Number:	**252**
Effective Date:	**05/01/2024**
Last Review:	**04/08/2024**
Next Review:	**04/08/2025**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business.*
Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.

SERVICE: Urine Drug Monitoring in Pain Management and Substance Abuse

PRIOR AUTHORIZATION: Not required.

POLICY:

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

The frequency of urine drug testing (UDT) should be based on the risk of aberrant medication-taking behaviors as determined and documented in the medical record. There are several tools available that can assist the provider in determining risk. In addition, prescription drug monitoring program (PDMP) reports may impact risk status.

1. Perform UDT at baseline for all members receiving opioids for chronic pain.
2. UDT should be performed no more that two times each year for members documented to be at low-risk.
3. UDT should be performed no more that four times each year for members at moderate-risk.
4. UDT may need to be performed as often as monthly (12 times each year) for members at high-risk.
5. In members with drug addiction being treated for substance use disorders, it may be medically necessary for UDT's to be performed weekly for the first month.

Testing performed more frequently will be subject to medical review.

The method used for testing depends somewhat on the drug(s) being tested for. Qualitative (presumptive) UDT is appropriate most of the time. Definitive testing may be appropriate in the following situations:

1. Qualitative (presumptive) UDT is positive for a prescription drug that is NOT prescribed to the member
2. Qualitative (presumptive) UDT was negative for a prescription drug that IS prescribed to the member
3. Qualitative (presumptive) UDT was positive for an ILLICIT drug
4. A qualitative (presumptive) UDT for the relevant drug is not commercially available.
5. Other special circumstances that are supported by medical documentation.

Routine screening, either presumptive or definitive performed as part of a clinician's protocol for treatment, WITHOUT documented individual patient assessment, is considered NOT medically necessary

Documentation Requirements: Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the patient's medical history or current clinical presentation, and without duplication. Each drug or drug class being tested for, must be indicated by the referring clinician in a written order and so reflected in the patient's medical record. Additionally, the clinician's documentation must be patient specific and accurately reflect the need for each test.

BACKGROUND:

Patients in pain management programs and substance abuse treatment may misuse prescribed opioids and/or may use non-prescribed drugs. Thus, patients are often assessed before treatment and monitored while they are 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 benefit contracts.

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. Results are generally reported qualitatively as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). These tests generally have a rapid turnaround time, from minutes to a few hours.

Confirmatory tests are always performed in a laboratory. Gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/mass spectrometry (LC/MS) are considered the "gold" standard for confirmatory testing. 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. Situations for quantitative (definitive) drug testing may include, but are not limited to the following:

1. Unexpected positive test inadequately explained by the patient.
2. Unexpected negative test (suspected medication diversion).
3. Need for quantitative levels to compare with established benchmarks for clinical decision making.

MANDATES: None

CODES:

Important note: *Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.*

CPT Codes	
CPT Codes Not Covered	
ICD-10 Codes	
ICD-10 Codes Not Covered	

POLICY HISTORY:

Status	Date	Action
New	05/22/2019	New policy
Reviewed	07/30/2020	No changes
Reviewed	07/22/2021	No changes
Reviewed	07/28/2022	No changes
Reviewed	11/29/2023	Formatting changes, beginning and ending note sections updated to align with CMS requirements and business entity changes
Reviewed	01/20/2024	Incorrect policy number in header corrected to correct policy number
Reviewed	04/08/2024	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. Charles E. Argoff, et al. Pain Medicine 2018; 19: 97–117, doi: 10.1093/pm/pnx285