

MEDICAL POLICY – 2.04.513

Drug Testing in Pain Management and Substance Use Disorder Treatment Settings

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RELATED MEDICAL POLICY:

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5.01.643 Prescription Digital Therapeutics for Substance Use Disorders

Replaces: N/A

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Introduction

Urine drug testing is generally done for people in a pain management program or in substance use disorder treatment. Pain management programs work to control pain and improve function while minimizing the use of potentially addictive medications. In substance use disorder treatment, the goal is to stop using, and remain free of addictive prescribed or illegal drugs. Usually, an individual may be tested for drug use as treatment begins. Testing may also be done intermittently during treatment. After a urine sample is provided, the urine is tested to detect if a particular drug has been used within a set time frame. Results can also show the absence of specific substances. This policy describes when urine drug testing as part of pain management and substance use disorder treatment programs may be considered medically necessary. Drug testing from body sources other than urine is usually considered investigational and therefore not covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

| Testing | Medical Necessity |
|---|--|
| Presumptive (i.e., screening) urine drug testing | <p>Presumptive urine drug testing is testing that uses a method with low sensitivity and/or specificity (usually immunoassay), which establishes preliminary evidence regarding the presence or absence of drugs, metabolites, or a class of drugs.</p> <p>In the outpatient pain management setting, presumptive urine drug testing is considered medically necessary for any of the following reasons:</p> <ul style="list-style-type: none"> • As part of the initial evaluation upon admission to the program • At any time that there is suspicion of non-compliance with prescribed treatment • At any time that there is suspicion of unreported drug use or abuse • At any time that interval history or symptoms suggest use of non-prescribed medications or illegal substances • At any time that there is a report of, suspicion of, or evidence of aberrant behavior such as: <ul style="list-style-type: none"> ○ Lost prescriptions ○ Repeated requests for early refills ○ Prescriptions from multiple providers ○ Unauthorized dose escalation ○ Apparent intoxication ○ Other unusual findings • For periodic monitoring to check treatment compliance and to check for unauthorized drug use: <ul style="list-style-type: none"> ○ The frequency is determined by risk stratification according to a standard risk assessment tool such as the Opioid Risk Tool (ORT) or the Screener and Opioid Assessment for Individuals with Pain-Revised (SOAPP-R), or based on clinical risk factors (e.g., history of or current substance use disorder, history of overdose, use of high opioid doses, concurrent benzodiazepine use): <ul style="list-style-type: none"> ▪ Low risk: every 12 months ▪ Moderate risk: every 6 months |



| Testing | Medical Necessity |
|---------|--|
| | <ul style="list-style-type: none"> ▪ High risk or opioid dose >120 MED/day: every 3 months <p>In substance use disorder treatment settings, presumptive urine drug testing is considered medically necessary for any of the following reasons:</p> <ul style="list-style-type: none"> • As part of the initial evaluation upon admission to the program • Intermittently while in ambulatory (outpatient, intensive outpatient, partial hospitalization) substance use disorder or dual disorders (substance use and mental health) treatment: <ul style="list-style-type: none"> ◦ One to two times/week during the stabilization phase of treatment ◦ One time/month during the maintenance phase of treatment ◦ One time/week during the maintenance phase of treatment for individuals residing in a recovery residence ◦ One time/month for individuals in office-based medication-assisted treatment (MAT) ◦ At any time that there is a report of, suspicion of, or evidence of use or abuse of non-prescribed drugs, illicit drugs, or drugs that have not been authorized or agreed to by the treatment program ◦ At any time that there is a report of, suspicion of, or evidence of relapse ◦ Repeat testing following a positive test for non-prescribed controlled medications(s) or illicit drug(s), until test is no longer positive, or individual is dismissed from the program • Intermittently while in inpatient or residential substance use disorder or dual disorders (substance use and mental health) treatment: <ul style="list-style-type: none"> ◦ One time only, as part of the initial admission evaluation (because the individual is then in a 24/7 contained setting) ◦ At any time that there is reason to suspect that the individual has taken a non-prescribed or illicit drug that the individual or someone else smuggled in |



| Testing | Medical Necessity |
|---------|--|
| | <ul style="list-style-type: none"> ○ At any time that there is reason to suspect that the individual has taken a non-prescribed or illicit drug while out of the facility on a pass <p>Presumptive urine drug testing is considered not medically necessary when the criteria above are not met.</p> <p>Alcohol breath testing (breathalyzer) may be considered medically necessary in lieu of urine testing only when there is reason (documented in the medical record) to suspect alcohol ingestion within the past 24 hours and there are no obvious clinical signs or symptoms of alcohol ingestion or intoxication.</p> <p>The use of presumptive testing panels is considered not medically necessary unless all components of the panel meet the medically necessary criteria listed above.</p> <p>Note: A specific individual component of a panel may be considered medically necessary when criteria above are met, and when only the specific individual component is tested for.</p> |

Medical Record Documentation Necessary for Presumptive Testing

- The medical record documents the clinical necessity for presumptive testing based on the criteria above and documents the medical necessity for each drug or drug class tested, based on the individual's clinical needs, and documents the information that is expected to be obtained from the testing. Testing that is a program's or facility's or provider's routine or standard testing that is not based on individual clinical needs is considered not medically necessary.

AND

- Urine drug testing is done at no more than the frequencies indicated above for presumptive testing. For urine drug testing that exceeds the indicated frequencies, the medical record documents the specific clinical need for the additional testing based on individual clinical needs and documents the information that is expected to be obtained from the testing. Additional testing that is a program's or facility's or provider's routine or standard testing that is not based on individual clinical needs is considered not medically necessary.



| Testing | Medical Necessity |
|---|---|
| Definitive (i.e., confirmatory) urine drug testing | <p>Definitive urine drug testing is testing that uses a method with high sensitivity and specificity (usually gas or liquid chromatography combined with mass spectrometry), that can identify specific drugs, their metabolites, and/or drug quantities.</p> <p>Definitive urine drug testing is considered medically necessary in the following situations:</p> <ul style="list-style-type: none"> • Presumptive urine drug testing was previously done for a medically necessary reason and the presumptive test result was concerning for one or more of the following reasons: <ul style="list-style-type: none"> ◦ Negative for prescribed medications (indicating possible non-compliance and/or diversion; or may indicate that the individual's drug level was below the threshold detected by the presumptive testing) ◦ Positive for a prescription drug with abuse/addiction potential (controlled medication) that is not being prescribed for the individual ◦ Positive for an illicit drug ◦ There is reason (documented in the medical record) to suspect that a presumptive testing result is erroneous (false positive or false negative) ◦ The individual disputes the results of the presumptive testing ◦ There is clinical need (documented in the medical record) to quantify the level of substance that is present |

OR

- Presumptive testing identified a class of drugs but not a specific drug or drugs, and the individual will not disclose the unauthorized or illicit specific drug or drugs, or, the specific drug or drugs need confirmation to verify compliance

OR

- There is reason (documented in the medical record) to suspect use of a substance that is inadequately detected or inconsistently detected or not detected by presumptive testing, such as:
 - heroin



| Testing | Medical Necessity |
|---------|---|
| | <ul style="list-style-type: none"> ○ synthetic opioids: <ul style="list-style-type: none"> ▪ fentanyl, methadone, meperidine, propoxyphene ○ semi-synthetic opioids: <ul style="list-style-type: none"> ▪ oxycodone, oxymorphone, hydrocodone, hydromorphone, buprenorphine <p>AND</p> <ul style="list-style-type: none"> • The medical record documents the clinical necessity for testing for each drug tested, based on individual clinical needs, documents the information that is expected to be obtained from the testing, and documents how test results will guide clinical management <p>Repeating definitive urine drug testing for the same presumptive testing result is considered not medically necessary.</p> <p>Definitive urine drug testing is considered not medically necessary when the criteria above are not met.</p> <p>Definitive urine drug testing that is a program's or facility's or provider's routine or standard testing that is not based on individual clinical needs and is not done for one of the specific reasons noted above, is considered not medically necessary.</p> <p>The use of definitive testing panels is considered not medically necessary unless all components of the panel meet the medically necessary criteria listed above.</p> <p>Note: A specific individual component of a panel may be considered medically necessary when criteria above are met, and when only the specific individual component is tested for.</p> |



| Other Testing | Investigational |
|--|--|
| Hair / oral fluid / nail / sweat drug testing | Hair drug testing, oral fluid drug testing, nail drug testing, and sweat drug testing are considered investigational in all clinical settings due to insufficient current evidence to support their usefulness in treatment settings. |

Coding

| Code | Description |
|------------|--|
| CPT | |
| 0007U | Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service Note: Proprietary Laboratory Analysis Code (PLA) for the test ToxProtect from Genotox Laboratories LTD |
| 0051U | Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service Note: Proprietary Laboratory Analysis Code (PLA) for the test UCompliDx from Elite Medical Laboratory Solutions |
| 0082U | Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service |
| 0227U | Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation |
| 0603U | Drug assay, presumptive, 77 drugs or metabolites, urine, liquid, chromatography with tandem mass spectrometry (LC-MS/MS), results reported as positive or negative (new code effective 01/01/26) |
| 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 |



| Code | Description |
|--------------|--|
| | (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 [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LTD, MALDI, TOF) includes sample validation when performed, per date of service |
| HCPCS | |
| G0480 | Drug test(s), definitive, utilizing (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); 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 (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); 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 (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed |



| Code | Description |
|-------|---|
| G0483 | Drug test(s), definitive, utilizing (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); 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 (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: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Related Information

Pain Management

The risk level for an individual should include both 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 Screener and Opioid Assessment for Patients in Pain, a 24-item tool.

Aberrant behavior during treatment of pain with opioids is defined by one or more of the following:

- Multiple lost or stolen prescriptions
- Multiple requests for early refills



- Obtaining opioids from multiple providers
- Unauthorized dose escalation
- Apparent intoxication during office visits
- Reports of apparent intoxication during ER visits
- Reports of intoxication from other reliable sources
- Arrests or citations by law enforcement for intoxication
- Diversion of prescribed opioids to other persons

Opinions vary on the optimal frequency of urine drug screening to monitor individuals on opioid therapy for chronic pain. Screening frequency using a risk-based approach, as recommended by the Washington State interagency guideline (Washington State Agency Medical Directors' Group, 2015) is as follows:

- Low risk by ORT: Once a year
- Moderate risk by ORT: Twice a year
- High risk or opioid dose >120 morphine milligram equivalents/day: 3 to 4 times a year
- Recent history of aberrant behavior: Each visit

Note that the ORT is a copyrighted instrument. 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's risk for opioid misuse and addiction should be considered when deciding when to order a urine drug screen.

Substance Use Disorder Treatment

Stabilization Phase

The stabilization phase (also referred to as the initial phase or early in recovery) is the initial period of substance use disorder treatment during which treatment generally focuses on the following:

- Eliminating use of the substance(s) for which substance use disorder is diagnosed



- Ameliorating any remaining withdrawal symptoms (as distinct from post-acute withdrawal symptoms or PAWS, which can persist for days to months)
- Eliminating use of any other illicit and non-prescribed substances
- Eliminating inappropriate use or abuse of any prescribed psychoactive substances
- Reducing the intensity of cravings
- Evaluating and decreasing the intensity of any co-occurring mental and medical disorders
- Developing a plan to address social, legal, family, employment, and other problems associated with substance use
- Satisfying basic needs for food, clothing, shelter, and safety (when in ambulatory levels of treatment)
- Initiating and stabilizing the dose of medication-assisted treatment (MAT) when MAT is utilized

If an individual re-enters treatment for substance use after a period of abstinence, treatment re-starts with the stabilization phase.

Maintenance Phase

The maintenance phase (also referred to as stable in treatment or stable in recovery) is the period of substance use disorder treatment following the stabilization phase during which treatment generally focuses on the following:

- Further reducing the intensity of cravings
- Recognizing and developing skills to deal with relapse triggers
- Developing a relapse prevention plan
- Developing a support system
- Involving family when available and amenable in relapse prevention planning
- Developing skills for coping with, and initiating plans for addressing, major life problems, e.g., medical, social, legal, family, employment, and other problems



- Assisting with or providing referrals for help with legal, educational, employment, medical, financial, or other problems that could interfere with treatment retention
- Promoting participation in constructive activities such as employment, education, vocational training, increased parenting activities, volunteer work
- Promoting and assisting with obtaining a sponsor when appropriate
- Providing information about, promoting participation in, and assisting with engagement with, outside/community support groups such as AA, NA, other 12-Step groups, or other similar groups
- Adjusting the dose of medication-assisted treatment (MAT) as needed

Immunoassay Availability and Diagnostic Capacity

The following information on immunoassay availability and diagnostic capacity is included in the Washington Agency Medical Directors Group (AMDG) Inter-Agency Guideline on Prescribing Opioids for Pain (2015):

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."

Semisynthetic Opioids (e.g., hydrocodone, hydromorphone, oxycodone, oxymorphone)

"Opiates' immunoassays may also detect semisynthetic opioids depending on their crossreactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS [liquid chromatography tandem mass spectrometry]) is required to verify compliance with the prescribed semisynthetic 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."

Interpreting Unexpected Urine Drug Tests Results

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 in the American Society of Interventional Pain Physicians guideline on prescribing opioids for chronic noncancer pain.

| Unexpected Results | Possible Explanations | Possible Actions For the Physician |
|---|--|--|
| Test is negative for prescribed opioid | <ul style="list-style-type: none">• False negative• Noncompliance• Diversion | <ul style="list-style-type: none">• Conduct confirmatory testing, specifying the drug of interest (e.g., oxycodone often missed by immunoassay)• Take a detailed history of an individual's medication use for the predicting 7 days (e.g., could learn that the individual ran out several days before test)• Ask individuals if they've given the drug to others• Monitor compliance with pill counts |
| Test is positive for non-prescribed opioid or benzodiazepines | <ul style="list-style-type: none">• False positive• Individual acquired opioids from other sources (double doctoring, "street") | <ul style="list-style-type: none">• Repeat urine drug testing regularly• Ask individuals if they accessed opioids from other sources• Assess for opioid misuse/addiction• Review/revise treatment agreement |



| Unexpected Results | Possible Explanations | Possible Actions For the Physician |
|--|---|--|
| UDS positive for illicit drugs (e.g., cocaine, cannabis) | <ul style="list-style-type: none"> False positive Individual is occasional user or addicted to the illicit drug Cannabis is positive for individuals taking certain medications (e.g., dronabinol) | <ul style="list-style-type: none"> Repeat urine drug test regularly Assess for abuse/addiction and refer for addiction treatment as appropriate. |

UDS: urine drug screen.

Benefit Application

Drug testing or screening for employment issues may be addressed in the member contract. Please refer to the member's benefits for further information.

Evidence Review

Pain Management

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 As far as age groups, the INCB reported the rates of drug overdose deaths increased over the period from 1999 to 2017 for all age groups, however in 2017, rates were significantly higher for those 25 to 64 years of age (31.4 per 100,000) than for those age 65 and over (6.9 per 100,000)³ Additionally, studies have found that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and use of illicit drugs.⁵



Substance Use Disorder

Substance use, abuse, and addiction involving numerous prescription and illicit drugs is also a serious social and medical problem. Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry and is manifested by the individual pathologic pursuit of reward and/or relief by substance use and other behaviors.

Monitoring Strategies

Various strategies are available to monitor individuals in pain management and substance use disorder treatment, and multicomponent interventions are often used. Many settings require individuals to sign a contract before they are given a prescription for opioids. The contracts generally involve obtaining individuals' 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 individuals 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 individuals' risk for inappropriate drug use. In addition, the presence of "aberrant behaviors" can be used as a marker for individuals 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 Matrices

Another strategy for monitoring individuals is testing of biological specimens for the presence or absence of drugs. Currently, urine is the most commonly used biological substance. Advantages of urine drug testing (UDT) 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. All matrices have advantages and disadvantages with respect to sensitivity and specificity over different time windows, time to obtain results, different susceptibility to sample tampering, and ease of collection.



Urine Drug Testing

There are two primary categories of UDT:

- Presumptive testing (immunoassay)
- Confirmatory testing (specific drug identification).

Presumptive (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 an individual is taking. For example, a positive result to an opiate immunoassay can be due to morphine or hydromorphone. The degree of crossreactivity, 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 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, within minutes for onsite tests and 1 to 4 hours for laboratory-based tests.⁶



Confirmatory (Specific Drug Identification) (i.e., Quantitative Testing, Confirmatory Testing, Definitive Testing)

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. This technique involves using GC or LC 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 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 require the 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.⁷

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 individuals, 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.

The 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 individuals 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 use disorder treatment settings. Most commonly, individuals 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 individuals' 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-individual relationship. An alternative approach is selective testing of individuals who are judged to be at increased risk for drug misuse.



Existing protocols vary for use of presumptive versus 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 individual. There is also a mixed approach, with routine conformation of presumptive tests only for drugs with poor-performing immunoassays.

Full informed consent is a requirement before urine drug testing. Individuals 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 US Veterans Affairs/Department of Defense guideline, individuals' refusal to consent to urine testing should be considered a factor in the overall assessment of individuals' ability to adhere to treatment.⁷

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-nasopharyngeal secretions and cellular debris. The mixture of fluids obtained varies depending on the collection method used (e.g. spitting, suctioning, draining or collection on some type of absorbent material). In addition, 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 these generally involve collection on absorbent material (e.g., foam pads). Pads are then placed in a container with a stabilizing buffer solution. Drug concentrations may also vary depending on how the oral fluid is recovered from the collection device (e.g., by centrifugation or by applying pressure). Another issue is that 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; these require a small sample volume ($\approx 25 \mu\text{L}$). Immunoassays tend to be relatively sensitive techniques, but they tend to have low specificity. Confirmation analysis is generally performed using mass spectrometry (MS) based methods. In recent years, advancements have been made in MS analysis techniques, including the development of multianalyte liquid chromatography-mass spectrometry (LC/MS) methods.

A practical advantage of oral fluid collection compared with urine is that samples can be obtained under direct supervision and without loss of privacy. It has been used in forensic



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. However, it is not yet practical in these settings because of inconsistency of results for reasons noted above.

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 the rate of approximately one-half inch per month. Thus, a 1.5-inch hair sample could be used to reveal drug use during the previous 90 days. Potential advantages of hair as a drug testing source include noninvasive collection, it is easy to collect, store and ship, sufficient samples are generally available for testing and retesting and it is difficult to substitute or adulterate. Potential disadvantages are that hair analysis cannot detect recent drug use (i.e., within past 7 days), it is difficult to detect very light drug use (e.g., a single episode), drug levels can be due to environmental exposure as well as use. In addition, variation in hair texture as well as cosmetic hair treatments can affect drug incorporation in 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 sought, such as pre-employment screening or post-drug-treatment verification of relapse. However, it is not yet practical in treatment settings for reasons noted above.

Summary of Evidence

Urine Drug Testing

For individuals who have chronic pain treated with opioids who receive drug testing, there is limited peer-reviewed scientific literature to guide drug testing strategies; however, guidelines indicate that drug testing is standard of care. Guidelines from the Centers for Disease Control and Prevention, American Society of Interventional Pain Physicians, American Pain Society and American Academy of Pain Medicine, American College of Occupational and Environmental Medicine, Department of Veterans Affairs, and Department of Defense have recommended drug testing and 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.



For individuals who have a drug addiction who are in substance use disorder treatment who receive drug testing, there is limited peer-reviewed scientific literature to guide drug testing strategies; however, guidelines indicate that drug testing is standard of care. Guidelines from the American Society of Addiction Medicine have recommended drug testing and consider the frequency of testing to be at the discretion of the health care provider, based on an assessment of the patient's risk and substance(s) used.

Based on the available evidence and clinical input, urine drug testing may be considered medically necessary under specific conditions listed in the policy statements.

Oral Fluid Drug Testing

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.

Hair Drug Testing

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 (i.e., in the past few days), and thus has limited applicability to pain management or substance abuse 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 abuse.



Ongoing and Unpublished Clinical Trials

There are currently no clinical trials that might influence this policy.

Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2014 Input

In response to requests, input was received from 5 physician specialty societies and 8 academic medical centers while this policy was under review in 2014. There was near-consensus among reviewers that, in outpatient pain management, presumptive (i.e., qualitative) urine drug testing may be considered medically necessary for individuals who meet the stated criteria and that the frequency of repeat drug testing should depend on the risk level of the individual. There was also near-consensus among reviewers that, in substance abuse treatment, baseline presumptive drug testing may be considered medically necessary for individuals who meet the stated criteria and that targeted weekly qualitative screening for a maximum number of weeks (most experts indicated 4 weeks) may be considered medically necessary during the stabilization phase for individuals in ambulatory treatment. There was mixed input on the frequency of presumptive drug testing that may be considered medically necessary during the maintenance phase of substance abuse treatment. In addition, clinical input was mixed on confirmatory definitive (i.e., quantitative) drug testing and particularly on whether definitive drug testing should only be performed on a drug-specific basis. The specific conditions and frequencies listed in the policy statements derive to a significant extent from the guidelines of the Washington State Agency Medical Directors' Group (AMDG) and of the American Society of Addiction Medicine (ASAM), which have emerged as pre-eminent authoritative guidelines.



Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Pain Management Treatment

In 2014, Nuckols et al. published a systematic review of guidelines that addressed management opioid use for chronic pain.¹⁰ Reviewers included guidelines from national organizations and specialty societies, as well as guidelines from state agencies and specific health systems. The reviewers identified nine guidelines with recommendations on urine drug testing (UDT). The recommendations varied widely; two guidelines recommended mandatory testing for all individuals, one recommended testing only individuals at increased risk of medication abuse, and two stated that testing individuals 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 one guideline, at least yearly in one guideline and randomly in two guidelines.

American Academy of Pain Medicine

In 2018, the American Academy of Pain Medicine (AAPM) published consensus recommendations on urine drug monitoring in patients receiving opioids for chronic pain.¹¹ The AAPM recommended definitive testing at baseline for patients prescribed opioids for chronic pain unless presumptive testing is required by institutional or payer policy. The AAPM also recommended that the choice of substances to be analyzed should be based on considerations that are specific to each patient and related to illicit drug availability. Baseline risk assessment for aberrant medication-taking behavior, misuse, and opioid use disorder should be conducted using patient history, validated risk assessment tools, prescription drug monitoring program data, previous urine drug monitoring results, and evaluation of behaviors indicative of risk. The recommended frequency of urine drug monitoring was based on risk assessment: at least annually for patients at low risk, 2 or more times per year for those at moderate risk, and 3 or more times per year for those at high risk.



American Society of Interventional Pain Physicians (ASIPP)

In 2017, the American Society of Interventional Pain Physicians issued guidelines for responsible, safe, and effective opioid prescribing for chronic non-cancer pain.¹² The guidelines included the following recommendations on UDT (see **Table 2**).

Table 2. Recommendations on Urine Drug Testing for Chronic Non-Cancer Pain

| Recommendation | LOE | SOE |
|--|--------|----------|
| "Comprehensive assessment and documentation is recommended before initiating opioid therapy, with documentation of comprehensive history, general medical condition, psychosocial history, psychiatric status, and substance use history." | I | Strong |
| "Screening for opioid abuse is recommended, as it will potentially identify opioid abusers and reduce opioid abuse." | II-III | Moderate |
| "Presumptive UDT is implemented at initiation of opioid therapy, along with subsequent use as adherence monitoring, using in-office point of service testing, followed by confirmation with chromatography/mass spectrometry for accuracy in select cases, to identify patients who are not compliant or abusing prescription drugs or illicit drugs. UDT may decrease prescription drugs abuse of illicit drug use when patients are in chronic pain management therapy." | III | Moderate |

LOE: level of evidence. SOE: strength of evidence; UDT: urine drug testing

Centers for Disease Control and Prevention

In 2016, the Centers for Disease Control and Prevention (CDC) published guidelines on opioids for chronic pain.¹³ In 2022, these guidelines were updated and expanded to include management of pain of a shorter duration, and to clarify that they are not applicable to sickle cell disease- or cancer-related pain or patients receiving palliative or end-of-life care.¹⁴ The updated guidelines recommend the following regarding drug testing: "When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances." The authors note that such testing should not be used punitively, including as a basis for dismissing patients from care, and that clinicians should consider the benefits and risks of toxicology testing prior to initiation and at least annually during opioid therapy. The guideline authors further note that restricting definitive confirmatory testing to situations and substances for which results are expected to affect management (e.g.,



results will influence decisions with major clinical or non-clinical implications, there is a need to detect specific agents or agents that cannot be identified in standard immunoassays, or to confirm unexpected screening test results) can reduce costs.

Department of Veterans Affairs and Department of Defense

In 2022, the Department of Veterans Affairs and Department of Defense updated clinical practice guidelines for managing opioid therapy for the treatment of chronic pain.⁸ The recommendations on risk mitigation to prescribed opioids include obtaining a UDT (with patient consent) before initiating opioid therapy, and then randomly at a follow-up to confirm appropriate use. Other strategies recommended include clinical assessment such as random pill counts and use of prescription drug monitoring programs.

The guidelines included the following specific recommendations on UDT as part of risk mitigation:

"We recommend implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include:

- Ongoing, random urine drug testing (including appropriate confirmatory testing)
- Checking state prescription drug monitoring programs
- Monitoring for overdose potential and suicidality
- Providing overdose education
- Prescribing of naloxone rescue and accompanying education"

The guideline states that gaining consent is required prior to a UDT; if a patient declines consent, "providers should factor that declination into their consideration about whether it is safe to continue opioids. Urine drug testing is required if long-term opioids are to be initiated or continued."



Washington State Agency Medical Directors' Group

In 2015, the Washington State Agency Medical Directors' Group updated its interagency guidelines on opioid dosing for chronic non-cancer pain.¹⁵ The guidelines included recommendations on UDT. Recommendations on testing frequency differed depending on the patient risk of opioid addiction and opioid dosage, as listed below:

- Low risk: Once per year
- Moderate risk: Twice per year
- High risk or opioid dose over 120 mg MED/d: 3-4 times per year
- Aberrant behavior: Each visit

In 2020, Washington State Agency Medical Directors' Group released a guideline on prescribing long-term opioid therapy. Use of UDT was mentioned as an element of assessment of patients on long-term opioid therapy.¹⁶ No pain management guidelines were identified that had recommendations on oral fluid or hair testing.

Substance Abuse Treatment

American Society of Addiction Medicine (ASAM)

The American Society of Addiction Medicine (ASAM) has published several documents on drug testing: a public policy statement (2010),¹⁷ a white paper (2013), which provided background on the science and current practices of drug testing,¹⁸ and guidelines (2017) on the effective use of drug testing.⁹

ASAM's public policy statement asserts that: "Urine drug testing is a key diagnostic and therapeutic tool that is useful for individual 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."¹⁷ ASAM recommended drug testing where medically appropriate in clinical diagnostic settings and clinical treatment settings. The term "drug testing" in this document was a broad term that included urine or other body fluids or tissues.

The ASAM White Paper concluded that "The most important challenge in drug testing today is not the identification of every drug that we are technologically capable of detecting, but to do medically necessary and accurate testing for those drugs that are most likely to impact clinical



outcomes.¹⁸ The paper acknowledged that more specific guidance on drug testing was needed, which led to the development of the 2017 guidelines, described below.

The 2017 ASAM guidance on appropriate drug testing in clinical addiction medicine advises health care providers that before choosing the type of drug test, they should first identify the questions they are seeking to answer and be aware of benefits and limitations of the various drug tests. **Table 4** summarizes characteristics of urine, oral fluid, and hair drug tests that may inform the decision of what type of drug test to use.⁹

The ASAM also published a focused update in 2020 focusing on the treatment of opioid use disorder. The guideline states that "urine drug testing is a reasonably practical and reliable method to test for adherence to medication and illicit drug use. However, other reliable biological tests for the presence of drugs may be used. The frequency of drug testing should be determined by a number of factors, including the stability of the patient, the type of treatment, and the treatment setting. Drug testing is required a minimum of eight times per year for patients in OTP [opioid treatment programs]".¹⁹

Table 4. Summary of Drug Testing Characteristics

| Characteristics | Urine | Oral Fluid | Hair |
|-------------------------------|--|---|---------------------------------------|
| General detection period | Hours to days | Minutes to hours | Weeks to months |
| Point-of-care testing | Yes | Yes | No |
| Primarily detects | Drug metabolite | Parent drug compound | Parent drug compound |
| Best use in treatment setting | Intermediate-term detection in ongoing treatment | Short-term detection in ongoing treatment | Long-term monitoring, 3-month history |
| Ease of collection | Requires restroom | Easily collected | Easily collected |
| Resistance to tampering | Low | High, with some uncertainty | High when chemically untreated |
| Retesting same sample | Possible | Difficult | Easy |

Adapted from Jarvis et al (2017).⁸

Medicare National Coverage

There is no national coverage determination.



Regulatory Status

The US Food and Drug Administration (FDA) regulates drugs of abuse tests that are sold to consumers or health care professionals in the US. The FDA reviews many of these tests before they are sold for use. In its review, the FDA evaluates the design and performance of tests and sample collection systems to help ensure that they produce accurate results. The FDA does not review drugs of abuse tests intended for employment and insurance testing provided they include a statement in their labeling that the device is intended solely for use in employment and insurance testing. The FDA review does not include test systems intended for federal drug testing programs (e.g., programs run by the Substance Abuse and Mental Health Services Administration, the Department of Transportation, and the US military.)

The FDA has cleared assays for urine testing of drugs of abuse as well as oral fluid specimen collection devices and assays for analysis of oral fluid for drugs of abuse through the 510(k) regulatory pathways. Several collection devices are commercially available in the US, 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. Immunoassays of urine specimens have previously been cleared by the FDA and are used as the predicates for the oral fluid immunoassays.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). Testing with GC/MS and some immunoassays are performed in laboratory settings. Laboratories that offer laboratory-developed tests must be licensed by the CLIA for high-complexity testing.

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History

| Date | Comments |
|----------|---|
| 08/11/14 | New Policy. Policy developed with review of the literature through January 21, 2014. Medically necessary under specific conditions. Clinical input added. Policy approved with a hold for provider notification and will be effective December 30, 2014. |
| 04/24/15 | Annual Review. Revised last bullet point under quantitative UDT from "Testing is for no more than for 6 substances" to "Testing is for no more than 6 different drugs". Policy updated with literature review through January 2015. Reference 15 added; others renumbered. Policy statement clarified as noted. Related policy 2.01.30 removed. Coding update. The following codes were deleted effective 12/31/14, notation made: 80100-80104, 80154, 82055, 82101, 82145, 82205, 82520, 82646, 82654, 82742, 83805, 80840, 83925 and 84022. The following codes were added and are effective as of 1/1/15: 80300-80304, 80320-80326, 80339-80347, 80353, 80358, 80361-80364, 80369-80370. |
| 03/09/16 | Annual Review. Policy updated with literature review through November 30, 2015; references added. 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. |
| 05/04/16 | Update Related Policies. Policy 3.01.02 was deleted and replaced with policy 3.01.520. |
| 03/01/17 | Annual Review, approved February 14, 2017. Policy updated with literature review through October 25, 2016; references 7, 14, 16, and 22 added. In policy statements and policy guidelines, "qualitative" changed to "presumptive" and "quantitative" changed |



| Date | Comments |
|-------------|--|
| | to "definitive". Coding update; removed terminated CPT and HCPCS codes. Added HCPCS codes G0480-G0483. |
| 10/01/17 | Coding update. Added new CPT codes 0006U, 0007U, and 0011U (effective 8/1/17). |
| 11/07/17 | Policy moved to new format, no changes to policy statement. |
| 01/01/18 | Coding update, removed CPT codes 80300, 80301, 80302, 80303, and 80304 as the codes were terminated 1/1/17. |
| 06/26/18 | Coding update, added CPT code 0020U and HCPCS code G0659. |
| 08/01/18 | Annual Review, approved July 10, 2018. Significant revision of the policy. Criteria for testing for pain management programs more clearly differentiated from testing for substance use disorder treatment programs. The specific criteria for testing for pain management programs expanded and modified to be consistent with the Washington State Agency Medical Directors' Group (AMDG) guidelines. The specific criteria for testing for substance use disorder treatment programs expanded and modified to be consistent with American Society of Addiction Medicine (ASAM) guidelines. All limits on the number and frequency of tests for pain management programs modified to be consistent with the Washington State Agency Medical Directors' Group (AMDG) guidelines. All limits on the number and frequency of tests for substance use disorder treatment programs modified to be consistent with American Society of Addiction Medicine (ASAM) guidelines. Added emphasis on necessary medical record documentation. Updated Coding section. Revised explanations of Stabilization Phase and Maintenance Phase. Added references. Title changed from "Drug Testing in Pain Management and Substance Abuse Treatment Settings" to "Drug Testing in Pain Management and Substance Use Disorder Treatment Settings". Added CPT codes 0020U and 0051U. CPT codes 0006U, 0011U, 80184, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80353, 80358, 80361, 80362, 80363, 80364, 80369, 80370, 82542, and 83992 were removed from the policy. |
| 10/01/18 | Coding update, removed CPT code 0020U. |
| 01/11/19 | Coding update, added new CPT code 0082U (new code effective 1/1/19). |
| 11/01/19 | Annual Review, approved October 4, 2019. Literature review through September 2019. No changes to policy statements. |
| 01/01/20 | Coding update, added CPT codes 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, and 0150U (new codes effective 1/1/20). |
| 10/01/20 | Add related policy 5.01.35 Prescription Digital Therapeutics for Substance Use Disorder. No other changes. |
| 11/01/20 | Annual Review, approved October 22, 2020. No changes to policy statements. |
| 02/01/21 | Annual Review, approved January 6, 2021. No changes to policy statement. Coding update: added new CPT code 0227U new effective 1/1/2021. |



| Date | Comments |
|----------|---|
| 09/01/21 | Update Related Policies. Removed Policy 3.01.520 as it has been archived. |
| 02/01/22 | Annual Review, approved January 24, 2022. No changes to policy statements. |
| 02/01/23 | Annual Review, approved January 23, 2023. Policy updated with literature review through September 28, 2022; references added. Minor editorial refinements to policy statements; intent unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization. |
| 11/01/23 | Minor update. Removed 5.01.35 Prescription Digital Therapeutics for Substance Use Disorder, from Related policies, due to archival. |
| 02/01/24 | Annual Review, approved January 8, 2024. No changes to policy statements. Literature reviewed. 0143U-0150U termed 7/01/2023. Term date added to codes. Added 5.01.643 Prescription Digital Therapeutics for Substance Use Disorders to Related Policy section. |
| 02/01/25 | Annual Review, approved January 13, 2025. Policy updated with literature review through September 20, 2024; reference added. Policy statements unchanged. |
| 01/01/26 | Coding update. Added new CPT code 0603U effective January 1, 2026. |

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

