

Controlled Substance Monitoring and Drugs of Abuse Testing

Presumptive UDT CPTs: 80305, 80306, 80307
Definitive UDT CPTs: G0480, G0481, G0482, G0483, G0659

CMS Policy for Delaware, Maryland, New Jersey, Pennsylvania, Virginia (Suburbs), and Washington, D.C.

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

For purposes of clarification the term physician or clinician refers to a Physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

Urine drug testing (UDT) provides objective information to assist clinicians in identifying the presence or absence of drugs or drug classes in the body and making treatment decisions. A presumptive drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used. However, urine is the best specimen for presumptive screening, as blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants.

Common methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by presumptive testing. A presumptive test may be followed by definitive testing, when there is a positive inconsistent finding from the presumptive test in the setting of a symptomatic patient, as described below. Typically, the "spot" chemical tests (referred to above) are urine dipsticks or multiple drug cup devices.

Examples of drugs or classes of drugs that are commonly assayed by presumptive tests, followed by definitive testing, are: alcohols, amphetamines, barbituates/sedatives, benzodiazepines, cocaine and metabolites, methadone, antihistamines, stimulants, opioid analgesics, salicylates, cardiovascular drugs, antipsychotics, cyclic antidepressants, and others. Focused drug screens, most commonly for illicit drug use, may be more useful clinically.

There should be a direct correlation between those positive findings generated from presumptive testing and those requested definitive tests to specifically confirm such findings.

This policy provides:

- The appropriate indications and expected frequency of testing for safe medication management of prescribed substances in risk stratified pain management patients or in identifying and treating substance use disorders.
- Documentation requirements, by the clinician in the patient's medical record, to support the medical necessity for drug testing on an individual patient basis.

An overview of presumptive urine drug testing (UDT) and definitive UDT testing by various methodologies.

Visit QuestDiagnostics.com/MLCP to view current limited coverage tests, reference guides, and policy information.

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• Definitions

By way of definition and as used in this document, the following terminology relates to the basic forms of UDT:

1. Presumptive (Qualitative) Drug Testing (hereafter called "presumptive" UDT)
 - Used when medically necessary to determine the presence or absence of drugs or drug classes in a urine sample;
 - Results expressed as negative or positive or as a numerical result;
 - Includes competitive immunoassays (IA) and thin layer chromatography.
2. Definitive (Quantitative) Confirmation (hereafter called "definitive" UDT)
 - Used when medically necessary to identify specific medications, illicit substances and metabolites; Reports the results of drugs absent or present in concentrations of ng/ml;
 - Limited to GC-MS and LC-MS/MS testing methods only.
3. Specimen Validity Testing
 - Urine specimen testing to ensure that it is consistent with normal human urine and has not been adulterated or substituted;
 - May include pH, specific gravity, oxidants and creatinine.
4. Point of Care Testing (POCT)
 - Used when medically necessary by clinicians for immediate test results for the immediate management of the patient;
 - Available when the patient and physician are in the same location;
 - IA test method that primarily identifies drug classes and a few specific drugs;
 - Platform consists of cups, dipsticks, cassettes, or strips; Read by the human eye.
5. Immunoassay (IA)
 - Ordered by clinicians primarily to identify the presence or absence of drug classes and some specific drugs;
 - Biochemical tests that measure the presence above a cutoff level of a substance (drug) with the use of an antibody;
 - Read by photometric technology
6. Standing Orders
 - Test request for a specific patient representing repetitive testing to monitor a condition or disease for a limited number of sequential visits
 - Individualized orders for certain patients for pre-determined tests based on historical use, risk and community trend patient profiles;
 - Clinician can alter the standing order.

Note: A "profile" differs from a "panel" in that a profile responds to the clinical risks of a particular patient, whereas a panel encourages unnecessary or excessive testing when no clinical cause exists.
7. Blanket Orders
 - Test request that is not for a specific patient; rather, it is an identical order for all patient's in a clinician's practice without individualized decision making at every visit.
8. Reflex Testing
 - Laboratory testing that is performed reflexively after initial test results to identify further diagnostic information essential to patient care.
 - Testing Indications, performed as a step necessary to complete a physician's order is not considered reflex testing.

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• Drug Test Methods

- The Clinical Laboratory Improvement Amendments (CLIA) regulates laboratory testing and requires clinical labs to be certified by their State as well as the CMS before they can accept human samples for diagnostic testing. Multiple types of CLIA certificates may be obtained based on the complexity of testing a lab conducts. CLIA levels of complexity (CLIA-waived, moderate complexity and high complexity) are addressed only as they relate to the HCPCS code description.

A. Presumptive Testing Methods:

1. *CLIA-waived Presumptive UDT:*

CLIA-waived presumptive UDT consist of various platforms including cards, dipsticks, cassettes and cups based on qualitative competitive immunoassay methodology with one or more analytes in the test.

- Positive test results are presumptive or not definitive due to sensitivity and cross-reactivity limitations.
- Negative test results do not necessarily indicate the absence of a drug or substance in the urine specimen.
- Presumptive UDT may be ordered when it is necessary to rapidly obtain and integrate results into clinical assessment and treatment decisions.
- This type of test should only be used when results are needed immediately.

2. *Presumptive UDT by FDA Approved/Cleared IA Analysis:*

- Chemistry analyzers with IA UDT technology are used in an office or clinical laboratory setting. When FDA approved/cleared platforms and reagents are used, testing is classified as moderately complex.
- This test may be used when less immediate test results are required.
- At no time is IA technology by chemistry analyzer analysis considered confirmatory (definitive) testing.
- Presumptive positive tests are not definitive due to sensitivity, specificity, and cross-reactivity limitations.
- Negative test results do not necessarily indicate the absence of a drug or substance in the urine specimen

3. *Presumptive UDT by Laboratory Developed Test (LDT) IA Analysis:*

- Similar to #2 above except only performed in a clinical laboratory setting.

Limitations of Presumptive UDT:

Presumptive UDT testing is limited for the following reasons:

- Primarily screens for drug classes rather than specific drugs, and therefore, the practitioner may not be able to determine if a different drug within the same class is causing the positive result;
- Produces erroneous results due to cross-reactivity with other compounds or does not detect all drugs within a drug class;
- Given that not all prescription medications or synthetic/analog drugs are detectable or have assays available, it is unclear as to whether other drugs are present when some tests are reported as positive;
- Cut-off may be too high to detect presence of a drug. This information could cause a practitioner to make a wrong assumption or clinical decision.

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B. Definitive UDT:

Gas Chromatography coupled with Mass Spectrometry (GC-MS) and High Performance Liquid Chromatography coupled with Tandem Mass Spectrometry (LC-MS/MS) are complex technologies that use the separation capabilities of gaseous or liquid chromatography with the analytical capabilities of mass spectrometry.

Both methodologies require the competency of on-site highly trained experts in this technology and interpretation of results. While these tests require different sample preparation and analytical runs, they are quantitative tests that identify all specific drugs, metabolites, and most illicit substances and report the results as absent or present in concentrations of ng/mL.

Quantification should not be used to determine adherence with a specific dosage or time of dose of a pain medication or illicit drug for clinical purposes. Rather, the use of quantitative drug data may be important for many reasons such as in a differential patient assessment.

For example, when several opioids are present in the urine of a patient prescribed a single opioid, quantification may help the clinician decide whether the presence of the other opioids is consistent with metabolism of the prescribed opioid, opioid contamination during manufacturing, or if more than one drug within a class is being used.

Quantification may also provide information in the setting of illicit drug use. Serial creatinine-corrected quantitative values may assist in the differential assessment of ongoing drug use or cessation of drug use with continued drug excretion.

Definitive UDT is reasonable and necessary in order to:

- Identify a specific substance or metabolite that is inadequately detected by a presumptive UDT;
- Definitively identify specific drugs in a large family of drugs;
- Identify a specific substance or metabolite that is not detected by presumptive UDT such as fentanyl, meperidine, synthetic cannabinoids and other synthetic/analog drugs;
- Identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of THC use according to a treatment plan);
- Identify a negative, or confirm a positive, presumptive UDT result that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan;
- Rule out an error as the cause of a presumptive UDT result;
- Identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances; and
- Use in a differential assessment of medication efficacy, side effects, or drug-drug interactions.

Definitive UDT may be reasonable and necessary based on patient specific indications, including historical use, medication response, and clinical assessment, when accurate results are necessary to make clinical decisions. The clinician's rationale for the definitive UDT and the tests ordered must be documented in the patient's medical record.

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Covered Indications for UDT:

- **Group A – Symptomatic patients, multiple drug ingestion or patients with unreliable history.**

A patient who presents in a variety of medical settings with signs or symptoms of substance use toxicity will be treated presumptively to stabilize the patient while awaiting rapid, then definitive testing to determine the cause(s) of the presentation.

The need for definitive UDT is based upon rapid test findings, responses to medical interventions, and treatment plan.

A presumptive UDT should be performed as part of the evaluation and management of a patient who presents in an urgent care setting with any one of the following:

- Coma
- Altered mental status in the absence of a clinically defined toxic syndrome or toxidrome
- Severe or unexplained cardiovascular instability (cardiotoxicity)
- Unexplained metabolic or respiratory acidosis in the absence of a clinically defined toxic syndrome or toxidrome
- Seizures with an undetermined history
- To provide antagonist to specific drug

The presumptive findings, definitive drug tests ordered and reasons for the testing must be documented in the patient's medical record.

- **Group B - Diagnosis and treatment for substance abuse or dependence.**

A patient in active treatment for substance use disorder (SUD) or monitoring across different phases of recovery may undergo medical management for a variety of medical conditions.

A physician who is writing prescriptions for medications to treat either the SUD or other conditions may need to know if the patient is taking substances which can interact with prescribed medications or taking prescribed medications as expected.

The risk of drug-drug interactions is inherent to the patient, and may be compounded by prescribed medications.

UDT is a medically necessary and useful component of chemical dependency diagnosis and treatment. The UDT result influences treatment and level of care decisions.

Ordered tests and testing methods (presumptive or definitive) must match the stage of screening, treatment, or recovery; the documented history; and Diagnostic and Statistical Manual of Mental Disorders (DSM V) diagnosis.

For patients with no known indicators of risk for SUDs, the clinician may screen for a broad range of commonly abused drugs using presumptive UDT.

For patients with known indicators of risk for SUDs, the clinician may screen for a broad range of commonly abused drugs using definitive UDT.

For patients with a diagnosed SUD, the clinician should perform random UDT, at random intervals in order to properly monitor the patient. Testing profiles must be determined by the clinician based on the following medical necessity guidance criteria:

- Patient history, physical examination, and previous laboratory findings
- Stage of treatment or recovery;
- Suspected abused substance;
- Substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The patient's medical record must include an appropriate testing frequency based on the stage of screening, treatment, or recovery; the rationale for the drugs/drug classes ordered; and the results must be documented in the medical record and used to direct care.

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• **Group C - Treatment for patients on chronic opioid therapy (COT).**

A physician who is writing prescriptions for medications to treat chronic pain can manage a patient better if the physician knows whether the patient is consuming another medication or substance, which could suggest the possibility of SUD or lead to drug-drug interactions. Additionally, UDT may help the physician monitor for medication adherence, efficacy, side effects, and patient safety in general.

A broad cross section of the general population will develop either cancer pain syndrome or non-cancer pain which will require prolonged or chronic opioid therapy for management. The risk of addiction in this population is considered equivalent to the risk in the general population. In contrast to the population of individuals who have a history of SUD, in the cancer and non-cancer pain population the risk of SUD is inherent to the substance(s) to which the patient is exposed.

1. *COT UDT Testing Objectives:*

- a. Identifies absence of prescribed medication and potential for abuse, misuse, and diversion;
- b. Identifies undisclosed substances, such as alcohol, unsanctioned prescription medication, or illicit substances;
- c. Identifies substances that contribute to adverse events or drug-drug interactions;
- d. Provides objectivity to the treatment plan;
- e. Reinforces therapeutic compliance with the patient;
- f. Provides additional documentation demonstrating compliance with patient evaluation and monitoring;
- g. Provides diagnostic information to help assess individual patient response to medications (e.g., metabolism, side effects, drug-drug interaction, etc.) over time for ongoing management of prescribed medications.

2. *Medical Necessity Guidance:*

Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment, and documented by the clinician in the patient's medical record and minimally include the following elements:

- Patient history, physical examination and previous laboratory findings;
- Current treatment plan;
- Prescribed medication(s); and
- Risk assessment plan.

National pain organizations, physician societies, and the Federation of State Medical Boards recommend a practical approach to definitive UDT for COT.

Frequency of testing beyond the baseline presumptive UDT must be based on individual patient needs substantiated by documentation in the patient's medical record. Recommendations for the ordering of presumptive and definitive UDT for patients on COT are as follows:

a. *COT Baseline Testing:*

Initial presumptive or definitive COT patient testing may include amphetamine/methamphetamine, barbiturates, benzodiazepines, cocaine, methadone, oxycodone, tricyclic antidepressants, tetrahydrocannabinoid, opioids, opiates, heroin, and synthetic/analog or "designer" drugs.

b. *COT Monitoring Testing:*

Ongoing testing may be medically reasonable and necessary based on the patient history, clinical assessment, including medication side effects or inefficacy, suspicious behaviors, self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other clinician documented change in affect or behavioral pattern.

The frequency of testing must be based on a complete clinical assessment of the individual's risk potential for abuse and diversion using a validated risk assessment interview or questionnaire and should include the patient's response to prescribed medications and the side effects of medications.

The clinician should perform random UDT at random intervals, in order to properly monitor a patient. UDT testing does not have to be associated with an office visit.

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• Drug Testing Panels

A. Presumptive UDT Panels

Presumptive UDT testing may be ordered as a panel because the Medicare billing codes are defined on a “per patient encounter” basis regardless of the number of analytes tested.

Presumptive UDT orders should be individualized based on clinical history and risk assessment, and must be documented in the medical record.

B. Definitive UDT Panels

At the current time, physician-directed definitive profile testing is reasonable and necessary when ordered for a particular patient based upon historical use and community trends. However, the same physician-defined profile is not reasonable and necessary for every patient in a physician’s practice.

Definitive UDT orders should be individualized based on clinical history and risk assessment, and must be documented in the medical record.

• Specimen Type

Urine or oral fluid is the preferred biologic specimen for testing because of the ease of collection, storage, and cost-effectiveness. UDT cannot detect the dosage of drug ingested/used, the time of use, or the means of delivery (intravenous vs. oral vs. inhaled). Detection time of a substance in urine is typically 1-3 days depending on the drug, rate of metabolism, and rate of excretion. Lipid-soluble drugs, such as marijuana, may remain in body fat and be detected upwards of a week or more.

• Other Covered Services

1. Reflex Testing by Reference Laboratories – since reference laboratories do not have access to patient-specific data, reflex testing under the following circumstances is reasonable and necessary:
 - To verify a presumptive positive UDT using definitive UDT (GC-MS or LCMS/MS) before reporting the presumptive finding to the ordering clinician and without an additional order from the clinician;
 - Or
 - To confirm the absence of prescribed medications when a negative result is obtained by presumptive UDT in the laboratory for a prescribed medication listed by the ordering clinician.
2. Direct to definitive UDT without a presumptive UDT is reasonable and necessary, when individualized for a particular patient, in the following circumstances:
 - To identify a specific substance or its metabolite that is in a large class of drugs, or that is inadequately detected or not detected by presumptive UDT, such as fentanyl, meperidine, synthetic cannabinoids, and other synthetic/analog drugs;
 - For use in a differential assessment of medication efficacy, side effects, or drug-drug interactions;
 - To identify non-prescribed medication or illicit substance use for ongoing safe prescribing of controlled substances, where clinician has documented concerns related to safety risks attendant to failure to identify specific substances suspected based upon clinical review and judgment; or
 - To identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of THC use according to a treatment plan).
3. Definitive testing to confirm a negative presumptive UDT result, upon the order of the clinician, is reasonable and necessary in the following circumstances:
 - a. The result is inconsistent with a patient’s self-report, presentation, medical history, or current prescribed medication plan (should be present in the sample);
 - b. Following a review of clinical findings, the clinician suspects use of a substance that is inadequately detected or not detected by a presumptive UDT; or
 - c. To rule out an error as the cause of a negative presumptive UDT result.
4. Definitive testing to confirm a presumptive UDT positive result, upon the order of the clinician, is reasonable and necessary when the result is inconsistent with the expected result, a patient’s self-report, presentation, medical history, or current prescribed medication plan.

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Limitations

Non-Covered Services

1. Blanket Orders.
2. Reflex definitive UDT is not reasonable and necessary when presumptive testing is performed at point of care because the clinician may have sufficient information to manage the patient. If the clinician is not satisfied, he/she must determine the clinical appropriateness of and order specific subsequent definitive testing (e.g., the patient admits to using a particular drug, or the IA cut-off is set at such a point that is sufficiently low that the physician is satisfied with the presumptive test result).
3. Routine standing orders for all patients in a physician's practice are not reasonable and necessary.
4. It is not reasonable and necessary for a physician to perform presumptive POCT and order presumptive IA testing from a reference laboratory. In other words, Medicare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.
5. It is not reasonable and necessary for a physician to perform presumptive IA testing and order presumptive IA testing from a reference laboratory with or without reflex testing. Medicare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.
6. It is not reasonable and necessary for a reference laboratory to perform and bill IA presumptive UDT prior to definitive testing without a specific physician's order for the presumptive testing.
7. IA testing, regardless of whether it is qualitative or semi-quantitative (numerical), may not be used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other IA testing methods. Definitive UDT provides specific identification or quantification by GC-MS or LCMS/MS.
8. Drug testing of two different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.
9. UDT for medico-legal or employment purposes or to protect a physician from drug diversion charges.
10. Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.

As published in CMS IOM Pub. 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
 - Furnished in a setting appropriate to the patient's medical needs and condition.
 - Ordered and furnished by qualified personnel.
 - One that meets, but does not exceed, the patient's medical needs.
 - At least as beneficial as an existing and available medically appropriate alternative.

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Notice: This LCD imposes frequency limitations as well as diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

For frequency limitations please refer to the Utilization Guidelines section below.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

1. The contractor will consider presumptive UDT testing in excess of 12 per Calendar year not reasonable and necessary.
NOTE: An exception to the above limitation will be made when patients have documented diagnoses consistent with a substance abuse disorder (SUD), for which patients presumptive UDT shall not occur more than 3 times within a seven-day period, based upon the following guidelines for monitoring abstinence.
 - a. For patients with 0 to 30 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 presumptive UDT per week. More than 3 presumptive panels in one week is not reasonable and necessary and is not covered by Medicare.
 - b. For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT per week. More than 3 presumptive UDT in one week is not reasonable and necessary and is not be covered by Medicare.
 - c. For patients with > 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT in one month. More than 3 physician-directed UDT in one month is not reasonable and necessary and is not covered by Medicare.
2. The contractor will only pay for one presumptive UDT test per patient per date of service regardless of the number of billing providers.
3. For chronic opioid therapy (COT), the contractor will consider up to 12 definitive tests (i.e., definitive UDT) per Calendar year reasonable and necessary. This would correspond to random testing performed 1-3 times every 3 months for prescribed medications, non-prescribed medications that may pose a safety risk if mixed with prescribed and illicit substances based on patient history, clinical presentation or community usage.

CPT/HCPCS Codes

Presumptive UDT

- 80305 Drug test prsmv dir opt obs
- 80306 Drug test prsmv instrmnt
- 80307 Drug test prsmv chem analyzr

Definitive UDT

- G0480 Drug test def 1-7 classes
- G0481 Drug test def 8-14 classes
- G0482 Drug test def 15-21 classes
- G0483 Drug test def 22+ classes
- G0659 Drug test def simple all cl

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There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**

**Note—Bolded diagnoses below have the highest utilization*

Code	Description
F10.20	Alcohol dependence, uncomplicated
F11.20	Opioid dependence, uncomplicated
F11.90	Opioid use, unspecified, uncomplicated
F12.20	Cannabis dependence, uncomplicated
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F14.20	Cocaine dependence, uncomplicated
F15.10	Other stimulant abuse, uncomplicated
F15.20	Other stimulant dependence, uncomplicated
F16.20	Hallucinogen dependence, uncomplicated
F18.20	Inhalant dependence, uncomplicated
F19.20	Other psychoactive substance dependence, uncomplicated
M51.16	Intervertebral disc disorders w radiculopathy, lumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M54.16	Radiculopathy, lumbar region
M54.50	Low back pain, unspecified
M54.59	Other low back pain
M79.18	Myalgia, other site
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z79.891	Long term (current) use of opiate analgesic
Z79.899	Other long term (current) drug therapy

*** Report monitoring of patient compliance in a drug treatment program using Z71.51 as the primary diagnosis and the specific drug dependence diagnosis as the secondary diagnosis.**

***Use ICD-10-CM code Z79.891 for COT monitoring.**

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Disclaimer:

This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Quest Diagnostics does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

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CMS Policy for Delaware, Maryland, New Jersey, Pennsylvania, Virginia (Suburbs), and Washington, D.C.

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**

**Note—Bolded diagnoses below have the highest utilization*

Code	Description
F10.120	Alcohol abuse with intoxication, uncomplicated
F11.20	Opioid dependence, uncomplicated
F19.20	Other psychoactive substance dependence, uncomplicated
M47.812	Spondylosis w/o myelopathy or radiculopathy, cervical region
M47.816	Spondylosis w/o myelopathy or radiculopathy, lumbar region
M47.817	Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M51.16	Intervertebral disc disorders w radiculopathy, lumbar region
M51.17	Intvrt disc disorders w radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.2	Cervicalgia
M54.50	Low back pain, unspecified
M54.59	Other low back pain
M79.18	Myalgia, other site
M79.7	Fibromyalgia
Z71.51 *	Drug abuse counseling and surveillance of drug abuser
Z79.891	Long term (current) use of opiate analgesic
Z79.899	Other long term (current) drug therapy

*** Report monitoring of patient compliance in a drug treatment program using Z71.51 as the primary diagnosis and the specific drug dependence diagnosis as the secondary diagnosis.**

Visit QuestDiagnostics.com/MLCP to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov

Disclaimer:

This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Quest Diagnostics does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

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