

# CODING & BILLING FOR PAIN MANAGEMENT



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# Outline

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- What's New in Chronic Pain for 2015
- Epidural Injections (Medicare)
- Facet Injections & Denervation (Medicare & BCBS)
- Urine Drug Screens (Medicare & BCBS)



# Revised Codes for 2015

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- **Vertebroplasty**
  - 2014 codes 22520-22522 deleted
  - New codes for 2015
    - 22510 – cervical/thoracic
    - 22511 – lumbar/sacral
    - 22512 – each additional level, whether cervical/thoracic or lumbar/sacral
  - All codes include bone biopsy & imaging
  - Moderate sedation is bundled



# Revised Codes for 2015

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- Kyphoplasty
  - 2014 codes 22523-22525 deleted
  - New codes for 2015
    - 22513 – thoracic
    - 22514 – lumbar
    - 22515 – each additional level, whether thoracic or lumbar
  - All codes include bone biopsy & imaging
  - Moderate sedation is bundled



# Joint Injections – New & Revised Codes

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## ■ NEW CODES

- 20604 – inj, small joint or bursa with U/S
- 20606 – inj, intermediate joint or bursa with U/S
- 20611 – inj, major joint or bursa with U/S

## ■ REVISED CODES

- 20600, 20605 AND 20610
- Added “without ultrasound guidance” to definition



# 2015 Medicare Bundled Codes

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- Fluoro bundled for all epidurals for Medicare
  - 62310, 62311, 62318, 62319
  - Plus transforaminal epidurals
- Not bundled in CPT Code
  - Bill other payers
- Imaging guidance bundled for sacroplasty (0200T, 0210T)



# New Modifiers

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- “X” modifiers to take place of 59 modifier
  - XE – separate encounter
  - XS – separate structure
  - XP – separate practitioner
  - XU – unusual non-overlapping service
- Voluntary implementation so far



# Ultrasound Guidance

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- The AMA's 2015 Changes, An Insider's View gives an example of the verbiage contemplated to be in the report, as follows:
  - "I performed a focused ultrasound evaluation, including reviewing the specific area to be injected, and the best approach for the injection. The joint was noted to be of [normal] [abnormal] anatomic structure. The pathological findings included \_\_\_\_\_. Using ultrasound guidance, I inserted the needle into the joint. Permanent images were recorded and placed in the chart."





# PALMETTO MEDICARE LCD

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## **EPIDURAL INJECTIONS**

(62310, 62311, 62318, 62319)

(64479-64484)



# Epidurals - Indications

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- Radicular Pain
- Neurogenic claudication
- Post Laminectomy Syndrome
- Low back pain substantial imaging abnormalities (disc herniation, severe degenerative disc disease, etc.), or any other imaging abnormalities that result in foraminal central spinal canal stenosis.
- VAS Pain score  $\geq 3/10$  (moderate to severe) with functional impairment of ADL's.
- Failure of at least 4 weeks non-surgical, non-injection care



# Epidurals – Exceptions to Conservative Treatment

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- Exceptions to waiting 4 weeks since the onset of pain before receiving an LESI exist, but should be clearly documented in the medical record. These include, but are not limited to:
  - At least moderate pain with significant functional loss at work and/or home.
  - Severe pain unresponsive to outpatient medical management
  - Unable to tolerate non-surgical, non-injection care due to co-existing medical condition(s).
  - Prior successful LESI for same specific condition

# Epidurals –

## Imaging Requirements

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- Minimum Criteria: Plain films to rule out fracture, potential malignancies, etc.
- Advanced imaging (MRI, CT) may be appropriate prior to performing an LESI.

# Epidurals – Procedural Requirements



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- All elective LESIs done under image-guidance. Fluoroscopy and CT are the only two validated imaging methods.
- Contrast medium should be injected during epidural injection procedures.
- Films that adequately document final needle position and injectate flow must be retained and made available upon request.
- For each session, either only local anesthetic or no more than 80mg of triamcinolone, 80 mg of methylprednisolone, 12 mg of betamethasone, 15 mg of dexamethasone or equivalent corticosteroid dosing may be used.



# Epidurals – Utilization

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- There is no role for “series of three” ESIs.
- Levels per session
  - No more than 2 transforaminal injections may be performed at a single setting (e.g. single level bilaterally or two levels unilaterally)
  - One caudal or lumbar interlaminar injection per session and not in conjunction with a transforaminal injection.
- Frequency with criteria
  - No more than 3 LESIs may be performed in a 6-month period of time.
  - No more than 6 epidural injection sessions (therapeutic ESIs and/or diagnostic transforaminal injections), inclusive of all regions and all levels, may be performed in a 12-month period of time.
  - If a prior LESI provided no relief, a second LESI is allowed following reassessment of the patient and injection technique.



# Epidurals – ICD-10 Codes

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B02.23 Postherpetic polyneuropathy

B02.7 Disseminated zoster

B02.8 Zoster with other complications

G54.4 Lumbosacral root disorders, not elsewhere classified

G96.12\* Meningeal adhesions (cerebral) (spinal)

M48.06 Spinal stenosis, lumbar region

M48.07 Spinal stenosis, lumbosacral region

M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region

M51.16 Intervertebral disc disorders with radiculopathy, lumbar region

M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region

M51.26 Other intervertebral disc displacement, lumbar region

M51.27 Other intervertebral disc displacement, lumbosacral region

M51.36 Other intervertebral disc degeneration, lumbar region



# Epidurals – ICD-10 Codes

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M51.37 Other intervertebral disc degeneration, lumbosacral region

M54.15 Radiculopathy, thoracolumbar region

M54.16 Radiculopathy, lumbar region

M54.17 Radiculopathy, lumbosacral region

M54.18 Radiculopathy, sacral and sacrococcygeal region

M54.31 Sciatica, right side

M54.32 Sciatica, left side

M54.41 Lumbago with sciatica, right side

M54.42 Lumbago with sciatica, left side

M54.5 Low back pain

M79.2 Neuralgia and neuritis, unspecified

M96.1 Postlaminectomy syndrome, not elsewhere classified





# Epidurals – ICD-10 Codes

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M99.23 Subluxation stenosis of neural canal of lumbar region

M99.33 Osseous stenosis of neural canal of lumbar region

M99.43 Connective tissue stenosis of neural canal of lumbar region

M99.53 Intervertebral disc stenosis of neural canal of lumbar region

M99.63 Osseous and subluxation stenosis of intervertebral foramina of lumbar region

M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region



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**FACET BLOCKS**

(64490-64495)



# Facet Blocks- Indications

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- Chronic pain which is defined as continuous or intermittent pain persisting 6 months or more.
- Pain is unresponsive to conservative measures
- Does not have a strong radicular component
- No associated neurologic defect
- Pain is aggravated by hyperextension or rotation of spine.



# Facet Blocks- Limitations

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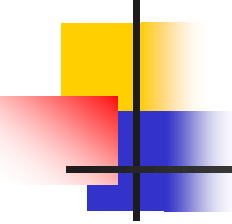
- Radiculopathy secondary to nerve root involvement must be ruled out by physical/electrophysiologic examination.
- Documentation in the patient's medical record must indicate how the provider arrived at the suspected diagnosis. As an example, the patient had back pain aggravated by hyperextension or rotation of the spine without a strong radicular component and no associated neurologic deficit.
- Providing multiple modalities such as epidural block, bilateral sacroiliac joint injections, lumbar sympathetic blocks on the same day as facet joint blocks or providing more than three levels of facet joint blocks on the same day is not considered medically necessary.
- We would not expect to see other pain management modalities performed on the same date of service as facet joint blocks.



# Facet Blocks- Utilization

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- The frequency for **therapeutic blocks** should be **2 months** or longer between each injection(s), provided that at least **> 50% relief** is obtained for **six weeks**. In the therapeutic phase, the interventional procedures should be repeated only as necessary according to the medical necessity criteria, and these are limited to a maximum of six times (not injections) per region for a period of 1 year
- A series of **2-3 injections** may be medically necessary for **diagnostic blocks** to establish consistency of results, particularly if diagnostic blocks are to be followed by neurolysis.
- **No more than three levels**, unilaterally or bilaterally, will be allowed for this procedure unless acceptable justification is presented.



# Facet Block - Diagnostic

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- A long acting local anesthetic agent is injected to temporarily denervate the facet joint.
- After a satisfactory block has been obtained, the patient is asked to indulge in the activities that usually aggravated his/her pain and to record his/her impressions of the effect of the procedure 4-8 hours after the injection.
- Temporary or prolonged **abolition** of the low back pain suggests that the facet joints were the source of symptoms.



# Facet Blocks – ICD-10 Codes

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## Group 1 Codes:

### ICD-10 Codes

### Description

M47.011	Anterior spinal artery compression syndromes, occipito-atlanto-axial region
M47.012	Anterior spinal artery compression syndromes, cervical region
M47.013	Anterior spinal artery compression syndromes, cervicothoracic region
M47.014	Anterior spinal artery compression syndromes, thoracic region
M47.015	Anterior spinal artery compression syndromes, thoracolumbar region
M47.016	Anterior spinal artery compression syndromes, lumbar region
M47.021	Vertebral artery compression syndromes, occipito-atlanto-axial region
M47.022	Vertebral artery compression syndromes, cervical region
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region



# Facet Blocks – ICD-10 Codes

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M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M53.81	Other specified dorsopathies, occipito-atlanto-axial region
M53.82	Other specified dorsopathies, cervical region
M53.83	Other specified dorsopathies, cervicothoracic region





# Facet Blocks – ICD-10 Codes

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M54.03	Panniculitis affecting regions of neck and back, cervicothoracic region
M54.04	Panniculitis affecting regions of neck and back, thoracic region
M54.05	Panniculitis affecting regions of neck and back, thoracolumbar region
M54.06	Panniculitis affecting regions of neck and back, lumbar region
M54.07	Panniculitis affecting regions of neck and back, lumbosacral region
M54.08	Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region
M54.09	Panniculitis affecting regions, neck and back, multiple sites in spine
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.2	Cervicalgia
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.81	Occipital neuralgia
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M62.830	Muscle spasm of back
M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.24	Subluxation stenosis of neural canal of sacral region
M99.25	Subluxation stenosis of neural canal of pelvic region
M99.26	Subluxation stenosis of neural canal of lower extremity
M99.27	Subluxation stenosis of neural canal of upper extremity
M99.28	Subluxation stenosis of neural canal of rib cage
M99.29	Subluxation stenosis of neural canal of abdomen and other regions



# Facet Blocks – ICD-10 Codes

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M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.34	Osseous stenosis of neural canal of sacral region
M99.35	Osseous stenosis of neural canal of pelvic region
M99.36	Osseous stenosis of neural canal of lower extremity
M99.37	Osseous stenosis of neural canal of upper extremity
M99.38	Osseous stenosis of neural canal of rib cage
M99.39	Osseous stenosis of neural canal of abdomen and other regions
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.44	Connective tissue stenosis of neural canal of sacral region
M99.45	Connective tissue stenosis of neural canal of pelvic region
M99.46	Connective tissue stenosis of neural canal of lower extremity
M99.47	Connective tissue stenosis of neural canal of upper extremity
M99.48	Connective tissue stenosis of neural canal of rib cage
M99.49	Connective tissue stenosis of neural canal of abdomen and other regions
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.54	Intervertebral disc stenosis of neural canal of sacral region
M99.55	Intervertebral disc stenosis of neural canal of pelvic region
M99.56	Intervertebral disc stenosis of neural canal of lower extremity



# Facet Blocks – ICD-10 Codes

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M99.57	Intervertebral disc stenosis of neural canal of upper extremity
M99.58	Intervertebral disc stenosis of neural canal of rib cage
M99.59	Intervertebral disc stenosis of neural canal of abdomen and other regions
M99.62	Osseous and spondylosis stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and spondylosis stenosis of intervertebral foramina of lumbar region
M99.64	Osseous and spondylosis stenosis of intervertebral foramina of sacral region
M99.65	Osseous and spondylosis stenosis of intervertebral foramina of pelvic region
M99.66	Osseous and spondylosis stenosis of intervertebral foramina of lower extremity
M99.67	Osseous and spondylosis stenosis of intervertebral foramina of upper extremity
M99.68	Osseous and spondylosis stenosis of intervertebral foramina of rib cage
M99.69	Osseous and spondylosis stenosis of intervertebral foramina of abdomen and other regions
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
M99.74	Connective tissue and disc stenosis of intervertebral foramina of sacral region
M99.75	Connective tissue and disc stenosis of intervertebral foramina of pelvic region
M99.76	Connective tissue and disc stenosis of intervertebral foramina of lower extremity
M99.77	Connective tissue and disc stenosis of intervertebral foramina of upper extremity
M99.78	Connective tissue and disc stenosis of intervertebral foramina of rib cage
M99.79	Connective tissue and disc stenosis of intervertebral foramina of abdomen and other regions



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**FACET BLOCKS & DENERVATION**

**(64490-64495)**

**(64633-64636)**



# Facet Joint Blocks

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- A successful trial of controlled diagnostic MBB's consists of 2 separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoro, that has resulted in at least a 50% reduction in pain for the duration of the local anesthetic used (e.g., 3 hours longer with bupivacaine than lidocaine).
- No therapeutic intra-articular injections (ie, steroids, saline, or other substances) should be administered for a period of at least 4 weeks prior to the diagnostic medial branch block.
- The diagnostic blocks should involve the levels being considered for RF treatment and should not be conducted under IV sedation unless specifically indicated (eg, patient is unable to cooperate with the procedure).
- Therapeutic medical branch blocks are not covered.



# Facet Joint Denervation

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- All of the following criteria must be met:
  - No prior spinal fusion surgery in the vertebral level being treated
  - Disabling low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical, and radiographic evaluations; and the pain is not radicular
  - Pain has failed to respond to three (3) months of conservative management, consisting of oral analgesics (nonsteroidal anti-inflammatory & acetaminophen), manipulation or PT, and a home exercise program.
  - There has been a successful trial of controlled medial branch blocks
  - If there has been a prior successful radiofrequency (RF) denervation, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine)



# Facet Blocks/Denervation Limitations

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- Radiofrequency denervation is considered INVESTIGATIONAL for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above, including but not limited to treatment of thoracic facet joint and sacroiliac joint pain.
- All other methods of denervation are considered INVESTIGATIONAL for the treatment of chronic spinal/back pain, including, but not limited to pulsed radiofrequency denervation, laser denervation, chemodenervation, and cryodenervation.
- Therapeutic medial branch blocks are considered INVESTIGATIONAL.
- If there has been a prior successful radiofrequency (RF) denervation, additional diagnostic medial branch blocks for the same level of the spine are NOT MEDICALLY NECESSARY.



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## URINE DRUG TESTINGS





# Presumptive UDT

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- Medical Necessity Documentation must include:
  - Patient history, physical examination and previous laboratory findings;
  - Current treatment plan;
  - Prescribed medication(s)
  - Risk assessment plan



# Presumptive UDT

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## ■ Baseline Testing

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

## ■ 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.
- Frequency of testing is based on a risk assessment and should include the patient’s response to prescribed medications and side effects of medications.
- UDT should be performed at random intervals.



# UDT Frequency of Testing

<b>Risk Group</b>	<b>Baseline</b>	<b>Frequency of Testing</b>
<b>Low Risk</b>	Prior to Initiation of COT	Random testing 1-2 times every 12 months for prescribed medications, non-prescribed medications that may pose a safety risk if taken with prescribed medications, and illicit substances based on patient history, clinical presentation, and/or community usage.
<b>Moderate Risk</b>	Prior to Initiation of COT	Random testing 1-2 times every 6 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications, and illicit substances, based on patient history, clinical presentation, and/or community usage.
<b>High Risk</b>	Prior to Initiation of COT	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 and/or community usage.



# Definitive UDT

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- Definitive testing to confirm a negative presumptive UDT result, upon the order of the clinician, is reasonable and necessary in the following circumstances:
  - The result is inconsistent with a patient's self-report, presentation, medical history, or current prescribed medication plan (should be present in the sample);
  - 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
  - To rule out an error as the cause of a negative presumptive UDT result.
- 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.



# Definitive UDT w/out Presumptive UDT

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- 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, etc.;
  - 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).



# Non-Covered UDT Services

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- Blanket Orders
- 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).
- Routine standing orders for all patients in a physician's practice are not reasonable and necessary.
- Medicare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.
- 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.
- Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.



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URINE DRUG TESTING



# Presumptive (Qualitative) UDT

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- In outpatient pain management, qualitative (i.e., immunoassay, MS LC) urine drug testing may be considered medically necessary for:
  - Baseline screening before initiating treatment or at the time treatment is initiated, when the following conditions are met:
    - An adequate clinical assessment of patient history and risk of substance abuse is performed;
    - Clinicians have knowledge of test interpretation;
    - There is a plan in place regarding how to use test findings clinically
  - Subsequent monitoring of treatment at a frequency appropriate for the risk-level of the individual patient.





# Definitive (Quantitative) UDT

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- Quantitative UDT, in OP pain management or substance abuse treatment, may be considered medically necessary under the following circumstances:
  - When immunoassays for the relevant drug(s) are not commercially available.
  - In specific situations for which quantitative drug levels are required for clinical decision making
- Specific situations for quantitative drug testing may include:
  - Unexpected positive test inadequately explained by the patient
  - Unexpected negative test (suspected medication diversion)
  - Need for quantitative levels to compare with established benchmarks for clinical decision making



# Frequency

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- Frequency of screening using a risk-based approach, as recommended by the Washington State Inter-Agency Guideline, is as follows:
  - Low risk by Opioid Risk Tool (ORT): Up to 1 per year
  - Moderate risk by ORT: Up to 2 per year
  - High risk or opioid dose >120 MED/d: Up to 3 to 4 per year
  - Recent history of aberrant behavior: Each visit



# Non-Covered UDT Services

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- Routine qualitative or quantitative urine drug testing (e.g., testing at every visit, without consideration for specific patient risk factors or without consideration for whether quantitative testing is required for clinical decision making).
- Routine confirmation of qualitative tests with quantitative testing is considered not medically necessary.



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URINE DRUG TESTING



# Presumptive (Qualitative) UDT

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- On the patient's initial entrance into a non-cancer chronic pain management program, when starting treatment with a controlled substance.
- To assess a patient when clinical evaluation of the patient suggests the patient's use of non-prescribed medications or illegal substances.
- To verify a patient's compliance with treatment, identify undisclosed drug use or abuse, or evaluate aberrant\* behavior as part of a routine monitoring program for individuals who are receiving treatment for non-cancer chronic pain with prescription opioid or other potentially abused medications.

\*Aberrant behavior includes, but is not limited to, lost prescriptions, repeated requests for early refills, prescriptions from multiple providers, unauthorized dose escalation, and apparent intoxication.



# Documentation Requirements

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- The patient's medical records (e.g., history and physical, progress notes) must be maintained by the ordering/treating physician and clearly state the medical necessity for performing a Qualitative UDT.
- A Qualitative UDT must be ordered in writing by the treating physician, including all drugs/drug classes to be tested, and the names of drugs prescribed, dosages and frequency and dates prescribed must be clearly documented.
- The treating physician must document in the patient's medical records the specific medical reasons for ordering a UDT and how the UDT results will drive the patient's treatment options.
- The ordering/treating physician must document in the patient's medical records that the drugs or drug classes for which UDT is to be performed are only those likely to be present in the patient, based on the patient's medical history or current clinical presentation.
- Specific drugs for which specimens are being tested must be stated by the ordering physician in a written order.



# UDT Frequency

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- UDT for management of a patient's non-cancer chronic pain should include baseline drug testing prior to initiation of opioid therapy, compliance monitoring within 1 to 3 months after baseline testing, and random monitoring every 6-12 months.
- More frequent testing may be appropriate if there are unexpected results, complaints, or behavior patterns are documented.
- The rationale for more frequent testing must be documented in the medical record.
- Since random testing is acknowledged as the best strategy, testing at every visit would be considered not medically necessary



# Quantitative UDT

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- BCBS of SC considers quantitative UDT as investigational and/or experimental and **NOT medically necessary.**





The End

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**QUESTIONS?**