Clinical Policy: Outpatient Testing for Drugs of Abuse

Reference Number: LA.CP.MP.50c
Date of Last Revision: 04/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and monitoring of adherence to a controlled substance treatment regimen (e.g., for chronic non-cancer pain) and to identify drug misuse or addiction prior to starting or during treatment with controlled substances.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections *outpatient* testing for drugs of abuse is medically necessary for presumptive drug testing when a member/enrollee meets *the criteria in A,B, or C* and is limited to 24 total tests per member/enrollee per calendar year:

A. Verification of compliance with treatment, identification of undisclosed drug use or abuse, or evaluation of aberrant* behavior beginning at the start of treatment, as part of a routine monitoring program for individuals who meet one of the following (*Note: aberrant behavior includes, but is not limited to, lost prescriptions, repeated requests for early refills, and prescriptions from multiple providers, unauthorized dose escalation, and apparent intoxication):

1. Receiving treatment for chronic pain with prescription opioid or other potentially abused medications;
2. Undergoing treatment for, or monitoring for relapse of, opioid addiction or substance use disorder;

B. Clinical evaluation suggests use of non-prescribed medications or illegal substances;

C. On initial entrance into a pain management program.

II. It is the policy of Louisiana Healthcare Connections that *outpatient* testing for drugs of abuse (DOA) is **medically necessary** for confirmatory/definitive (quantitative) testing for a specific drug(s) when meeting *the criteria in A, B, or C* and limited to 12 total tests per calendar year:

A. Documented history or suspicion of illicit or prescription drug use or noncompliance or a high probability of non-adherence to a prescribed drug regimen documented in the medical record; *and all of the following:*

1. A preliminary/presumptive drug test has been previously performed, unless no reliable test exists (e.g., synthetic cannabinoids);
2. The findings from that preliminary/presumptive (qualitative) test (either positive or negative) are either:
   a. Inconsistent with the expected results as suggested by medical history, clinical presentation, and/or member's/enrollee's own statement after a detailed discussion about their recent medication and drug use;
   b. Consistent with the clinical scenario but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result;
3. Resolving the inconsistency is essential to the ongoing care of the member/enrollee;
4. The requested confirmatory/definitive test(s) is for ≤ 14 drugs/drug classes;

5. Tests are only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results;

B. The provider expects the presumptive test to be positive (e.g., the member/enrollee reports recent use), *and all of the following:*
   1. Information regarding specific substance and/or quantity is desired;
   2. There are established benchmarks for clinical decision making based on specific substance and/or quantitative levels;
   3. ≤ 14 drugs/drug classes are requested;
   4. Tests are only for the specific drug(s) or number of drug classes for which the presumptive test is expected to be positive;

C. The request is for a serum therapeutic drug level in relation to the medical treatment of a disease or condition (e.g., phenobarbital level in the treatment of seizures).

III. It is the policy of Louisiana Healthcare Connections that no more than one presumptive and one definitive drug test will be reimbursed per day per beneficiary, from the same or different provider**.**

IV. It is the policy of Louisiana Healthcare Connections that outpatient confirmatory/definitive (quantitative) drug testing of more than 14 drugs/drug classes is **not medically necessary.**

V. It is the policy of Louisiana Healthcare Connections that urine drug testing (UDT) is considered **not medically necessary** if provided for reasons that include, but are not limited to, the following:

A. Universal drug testing (screening) in a primary care setting is not covered.
B. Drug testing without signs or symptoms of substance use, or without current controlled substance treatment is not covered.
C. As a condition of:
   1. Employment or pre-employment purposes (pre-requisite for employment or as a requirement for continuation of employment);
   2. Participation in school or community athletic or extracurricular activities or programs;
D. Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations);
E. Screening in asymptomatic patients, except as listed in sections I or II;
F. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.);
G. As a component of a medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.);
H. Same-day screening of drug metabolites in specimens sourced from any combination of blood, saliva and urine by either preliminary or confirmatory/definitive analyses;
I. Blanket orders;
J. Reflex definitive drug tests when presumptive testing is performed at point of care;
K. Routine standing orders for all patients in a physician's practice. Physician-defined standing orders for pre-determined drug panels according to specific patient profiles for a limited sequential period may be reasonable and necessary and must be documented in the patient's medical record;

L. Billing of individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered;
M. Performing presumptive point of care testing and ordering presumptive immunoassay (IA) testing from a reference laboratory;
N. Performing presumptive IA testing and ordering presumptive IA testing from a reference laboratory with or without reflex testing;
O. Performing IA presumptive screening prior to definitive testing without a specific physician's order for the presumptive testing;
P. IA testing, regardless of whether it is qualitative or semi-quantitative used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Semi-quantitative IA testing provides a presumptive test (numerical) result. Definitive UDT provides specific identification and/or quantification by GC-MS or LC-MS/MS;
Q. Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.

Protocols for testing requiring prior authorization
• Testing for children < 6 years of age is exempt from prior authorization.

Background
A drug of abuse (DOA) is defined as a medication, substance, chemical, or plant product known to be misused for recreational or non-prescribed purposes.[8] In the United States, the basic screening test for DOA includes five drugs: amphetamine, cocaine, marijuana, opioids, and phencyclidine.[3,8,12] Other drugs that may be tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamines.[3,8,12] Tests can vary by region based on epidemiologic trends. Currently, there is no uniformity for what is included in extended DOA testing or cutoff values that should be used for detection of drugs not covered by workplace testing laws.[8]

The three methods of drug assays include immunoassay, chromatography, and mass spectrometry. Immunoassay is the most widely used method for initial testing for DOA and offers results within minutes.[8] These tests provide a relatively inexpensive method to detect low concentrations of a substance with a high degree of specificity.[8] This can be most easily performed using point-of-care test kits such as a urine drug cup. However, in the clinical setting, point-of-care testing does not perform to manufacturers' claims, and untrained staff can improperly interpret test results.[8]

Gas chromatography/mass spectrometry (GC/MS) or liquid chromatography (LC/MS) are typically used as confirmatory tests.[1] Chromatography is used to separate a specimen into its component parts, and mass spectrometry is used to identify those parts. Chromatography, LC/MS and GC/MS require specialized training for lab staff and instruments to provide a highly sensitive and specific technique for detecting drugs or metabolites.[8] It often takes many hours to obtain results; therefore, these tests are generally not used for preliminary screening in the clinical setting.[8] The mass spectrometer is capable of detecting even minute amounts of a given

substance and is considered to have the highest specificity of all lab detection methods.[8] It is most commonly used for confirmatory test results that are primarily of forensic importance.[1,8] GC/MS rarely provides results that are clinically necessary or useful beyond those obtained by standard immunoassays or chromatography.[8]

The ordering clinician must be knowledgeable regarding the type of testing being requested, level of suspicion for drug use or exposure, the reason for obtaining the test, and the likelihood of false-positive or false-negative results.[8] Knowledge of potential drug exposure allows a clinician working in an addiction or chronic pain management program to include testing for a metabolite of a parent drug, instead of simply testing for the parent drug, for a patient with a tendency for opioid abuse.[8] If initial screening does not correlate with expected findings and there is concern for false-positive or false-negative results, then confirmatory testing improves the accuracy of initial results.[9]

Immunoassays can yield false-positive results when cross-reacting medications or drugs are present in the sample.[8] Cross-reacting substances can be found in common prescription medications, over-the- counter cold medications, and even in some food substances.[8] The highest false-positive results occur with amphetamine testing due to the chemical structure of amphetamine being present in many over-the counter medications and herbal supplements.[8] False-negative results can occur from inappropriate specimen collection, transport, testing procedures or from patient attempts to undermine the testing. The most common cause of false-negative results is failure to detect a specific drug within a given class of drugs because the chemical combination makes it unreactive with the test.[8]

American Society of Addiction Medicine (ASAM)
In 2019, the American Society of Addiction Medicine (ASAM) developed a consensus document on the ethical use of drug testing in clinical addiction medicine, which provides a broad discussion of drug testing methods, procedures, and practices. Drug testing can provide a treating clinician with objective information regarding a patient's recent substance use. It can assist with the identification, diagnosis and treatment of addiction and support patients in recovery.[30]

Drug testing should be used only when clinically necessary. Presumptive testing should be a routine part of initial and ongoing assessments. Definitive testing may be used to detect specific substances not identified in presumptive methods and to refine the accuracy of the test results. Definitive testing may be used to detect specific substances not identified by presumptive methods, quantify levels of the substance present, and to refine the accuracy of the test results.[30] In addition, definitive testing may be used when the results are needed to inform clinical decisions with major clinical or non-clinical implications for the patient (e.g., treatment transitions, changes in medication therapies, changes in legal status).[30]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

CPT® Codes That Support Coverage Criteria

CPT®* Codes	Description
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
0011U*	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
80143	Acetaminophen
80150	Amikacin
80151	Amiodarone
80156	Carbamazepine; total
80157	Carbamazepine; free
80158	Cyclosporine
80159	Clozapine
80161	Carbamazepine; -10,11-epoxide
80162	Digoxin; total
80163	Digoxin; free
80167	Felbamate
80168	Ethosuximide
80169	Everolimus
80170	Gentamicin
80171	Gabapentin, whole blood, serum, or plasma
80173	Haloperidol
80175	Lamotrigine
80177	Levetiracetam
80180	Mycophenolate (mycophenolic acid)
80181	Flecainide
80183	Oxcarbazepine
80184	Phenobarbital
80189	Itraconazole
80193	Leflunomide
80204	Methotrexate
80220	Hydroxychloroquine
80320*	Alcohols
80321*	Alcohol biomarkers; 1 or 2
80322*	Alcohol biomarkers; 3 or more
80323*	Alkaloids, not otherwise specified
80324*	Amphetamines; 1 or 2

CPT®* Codes	Description
80325*	Amphetamines; 3 or 4
80326*	Amphetamines; 5 or more
80327*	Anabolic steroids; 1 or 2
80328*	Anabolic steroids; 3 or more
80332*	Antidepressants, serotonergic class; 1 or 2
80333*	Antidepressants, serotonergic class; 3 to5
80334*	Antidepressants, serotonergic class; 6 or more
80335*	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336*	Antidepressants, tricyclic and other cyclicals; 3 to 5
80337*	Antidepressants, tricyclic and other cyclicals; 6 or more
80338*	Antidepressants, not otherwise specified
80339*	Antiepileptics, not otherwise specified; 1 to 3
80340*	Antiepileptics, not otherwise specified; 4 to 6
80341*	Antiepileptics, not otherwise specified; 7 or more
80342*	Antipsychotics, not otherwise specified; 1 to 3
80343*	Antipsychotics, not otherwise specified; 4 to 6
80344*	Antipsychotics, not otherwise specified; 7 or more
80345*	Barbiturates
80346*	Benzodiazepines; 1 to 12
80347*	Benzodiazepines; 13 or more
80348*	Buprenorphine
80349*	Cannabinoids, natural
80350*	Cannabinoids, synthetic; 1 to 3
80351*	Cannabinoids, synthetic; 4 to 6
80352*	Cannabinoids; synthetic; 7 or more
80353*	Cocaine
80354*	Fentanyl
80356*	Heroin metabolite
80357*	Ketamine and norketamine
80358*	Methadone
80359*	Methylenedioxyamphetamines (MDA, MDEA, MDMA)
80360*	Methylphenidate
80361*	Opiates, 1 or more
80362*	Opioids and opiate analogs; 1 or 2
80363*	Opioids and opiate analogs; 3 or 4
80364*	Opioids and opiate analogs; 5 or more
80365*	Oxycodone
80366*	Pregabalin
80367*	Propoxyphene
80368*	Sedative hypnotic (non-benzodiazepines)
80369*	Skeletal muscle relaxants; 1 or 2
80370*	Skeletal muscle relaxants; 3 or more
80371*	Stimulants, synthetic
80372*	Tapentadol
80373*	Tramadol
80374*	Stereoisomer (enantiomer) analysis, single drug class

CPT®* Codes	Description
80375*	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1 to 3
80376*	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4 to 6
80377*	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
82077	Alcohol (ethanol); any specimen except urine and breath, immunoassay (eg, IA, EIA, ELISA, RIA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)
83992	Phencyclidine (PCP)
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or 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; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or 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 (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
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

CPT Codes That Do Not Support Coverage Criteria

CPT® Codes	Description
0051U*	Prescription drug monitoring, evaluation of drugs present by liquid chromatography tandem mass spectrometry (LC-MS/MS), urine or blood, 31 drug panel, reported as quantitative results, detected or not detected, per date of service
0054U*	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service
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
0093U*	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected
0110U*	Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected

CPT® Codes	Description
0116U*	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications
0328U*	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service

HCPCS Codes That Support Coverage Criteria

HCPCS Codes	Description
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(s), includes specimen validity testing, per day, 1 to 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 to 14 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

HCPCS Codes That Do Not Support Coverage Criteria

HCPCS Codes	Description
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 to 21 drug class(es), including metabolite(s) if performed
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	8/15/20		
Reworded Criteria I to limit to 24 total tests per member/enrollee per calendar year. Criteria II to limit to 12 test per calendar year. Removed (HCPCS codes G0482, G0483) from the policy statement in III. Added **"**In a primary care setting without signs or symptoms of substance use or without current controlled substance treatment" to section IV. Removed Protocols for testing requiring prior authorization. Added "and may not support medical necessity" to coding implications. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Removed CPT codes. Removed G0659 from HCPCS codes. Updated ICD-10-CM Codes That Support Coverage Criteria. Updated references. Changed all instances of member to member/enrollee. Added "c" to the end of the policy number.	11/22	1/14/23	
Added ICD-10 codes that support coverage. Added relevant codes for presumptive and definitive testing. CPT codes and table inserted. Annual Review. Added an example of synthetic cannabinoids to I.A.1., drugs for which presumptive testing is not reliable. Coding reviewed and updated. Updated background information to include information regarding American Society of Addiction Medicine	7/2023	9/25/23	10/26/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
(ASAM). Other minor wording changes made to background with no clinical significance. References reviewed and updated. Policy reviewed by an internal specialist.			
Annual review. Updated section III. Added Protocols for testing requiring prior authorization. Updated section V. (A) and (B). Updated ICD-10-CM Codes That Support Coverage Criteria. Updated background with no clinical significance. References reviewed and updated. Internal specialist review.	9/2024	11/20/24	12/21/24
Annual review. Description and background updated with no clinical significance. Removed "Requests for prior authorization…" from Protocols for testing requiring prior authorization section. Removed ICD-10-CM Codes That Support Coverage Criteria table. Removed deleted codes 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U from CPT Codes That Do Not Support Coverage Criteria table. Updated codes and descriptions. References reviewed and updated.	4/2025	6/24/25	7/24/25

References

1. Rabelo Alves MN, Piccinotti A, Tameni S, Polettini A. Evaluation of buprenorphine LUCIO immunoassay versus GCMS using urines from a workplace drug testing program. *J Anal Toxicol*. 2013;37(3):175 to 8. doi: 10.1093/jat/bkt006.
2. Argoff CE, Alford DP, Fudin J, et al. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. *Pain Med*. 2018;19(1):97 to 117. doi:10.1093/pm/pnx285
3. Treatment Improvement Protocol 63: Medications for Opioid Use Disorder. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf. Updated 2021. Accessed February 6, 2025.
4. Becker W, Starrels JL. Prescription drug misuse: Epidemiology, prevention, identification, and management. UpToDate. www.uptodate.com. Published July 26, 2023. Accessed February 6, 2025.
5. Treatment Improvement Protocol 47: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/sma13-4182.pdf. Published 2013. Accessed February 6, 2025.
6. Christo PJ, Manchikanti L, Ruan X, et al. Urine drug testing in chronic pain. *Pain Physician*. 2011;14(2):123 to 143.
7. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1 to 95. Published 2022 Nov 4. doi:10.15585/mmwr.rr7103a1
8. Hoffman RJ. Urine drug testing. UpToDate. www.uptodate.com. Published October 7, 2024. Accessed February 12, 2025.

9. Interagency guideline on prescribing opioids for pain. Agency Medical Directors' Group. http://www.agencymeddirectors.wa.gov/files/2015amdgopioidguideline.pdf. Published June 2015. Accessed February 6, 2025.
10. Manchikanti L, Malla Y, Wargo BW, Fellows B. Comparative evaluation of the accuracy of immunoassay with liquid chromatography tandem mass spectrometry (LC/MS/MS) of urine drug testing (UDT) opioids and illicit drugs in chronic pain patients. *Pain Physician*. 2011;14:175 to 187.
11. McKay JR. Continuing care for addiction: Implementation. UpToDate. www.uptodate.com. Published September 7, 2023. Updated April 16, 2024. Accessed February 6, 2025.
12. Moeller KE, Lee KC, Kissack JC. Urine drug screening: practical guide for clinicians [published correction appears in Mayo Clin Proc. 2008 Jul;83(7):851]. *Mayo Clin Proc*. 2008;83(1):66 to 76. doi:10.4065/83.1.66
13. Wilfong A. Seizures and epilepsy in children: Initial treatment and monitoring. UpToDate. www.uptodate.com. Updated December 2, 2024. Accessed February 6, 2025.
14. Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine. American Society of Addiction Medicine. https://www.asam.org/quality-care/clinical-guidelines/drug-testing. Published April 5, 2017. Accessed February 6, 2025.
15. Dasgupta A. Challenges in Laboratory Detection of Unusual Substance Abuse: Issues with Magic Mushroom, Peyote Cactus, Khat, and Solvent Abuse. *Adv Clin Chem*. 2017;78:163 to 186. doi: 10.1016/bs.acc.2016.07.004
16. Snyder ML, Fantz CR, Melanson S. Immunoassay-Based Drug Tests Are Inadequately Sensitive for Medication Compliance Monitoring in Patients Treated for Chronic Pain. *Pain Physician.* 2017 Feb;20(2S):SE1 to SE9.
17. Local coverage determination: urine drug testing (L36029). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 5, 2015 (revised October 15, 2023). Accessed February 12, 2025.
18. Local coverage determination: urine drug testing (L36668). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published June 28, 2016 (revised April 17, 2024). Accessed February 6, 2025.
19. Local coverage determination: urine drug testing (L39611). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published November 3, 2023. Accessed February 12, 2025.
20. Local coverage determination: urine drug testing (L36707). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published June 28, 2016. (revised April 17, 2024). Accessed February 12, 2025.
21. Local coverage determination: urine drug testing (L35724). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 1, 2015 (revised October 17, 2024). Accessed February 12, 2025.
22. Local coverage determination: controlled substance monitoring and drugs of abuse testing (L36393). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/search.aspx. Published October 11, 2015 (revised October 1, 2019). Accessed February 12, 2025.

23. Local coverage determination: urine drug testing (L34645). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 1, 2015 (revised November 12, 2023). Accessed February 12, 2025.
24. Local coverage determination: controlled substance monitoring and drugs of abuse testing (L35006). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 1, 2015 (revised October 17, 2019). Accessed February 12, 2025.
25. Chakravarthy K, Goel A, Jeha GM, Kaye AD, Christo PJ. Review of the Current State of Urine Drug Testing in Chronic Pain: Still Effective as a Clinical Tool and Curbing Abuse, or an Arcane Test?. *Curr Pain Headache Rep*. 2021;25(2):12. Published 2021 Feb 17. doi:10.1007/s11916-020-00918-z
26. McEachern J, Adye-White L, Priest KC, et al. Lacking evidence for the association between frequent urine drug screening and health outcomes of persons on opioid agonist therapy. *Int J Drug Policy*. 2019;64:30 to 33. doi:10.1016/j.drugpo.2018.08.006
27. American Society of Addiction Medicine. Public Policy Statement on Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in other Clinical Settings. https://www.maineaap.org/assets/docs/Public-Policy-Statement-on-Drug-Testing-as-a-Component-of-Addiction-Treatment.pdf. Published July 2002 (revised October 2010). Accessed February 12, 2025.
28. Technical Assistance Publication Series 32: Clinical drug testing in primary care. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4668.pdf. Published May 2012. Accessed February 6, 2025.
29. Doyle K, Strathmann FG. Cost and Efficacy Assessment of an Alternative Medication Compliance Urine Drug Testing Strategy. *Pain Med*. 2017;18(2):307 to 315. doi:10.1093/pm/pnw165
30. American Society of Addiction Medicine. Public Policy Statement on Ethical Use of Drug Testing in the Practice of Addiction Medicine. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/public-policy-statements/2019-ethical-use-of-drug-testing-in-the-practice-of-addiction-medicine.pdf?sfvrsn=75bb4bc2_0. Published August 3, 2019. Accessed February 12, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.