Clinical Policy: Drugs of Abuse: Definitive Testing

Reference Number: CP.MP.50 Coding Implications
Date of last Revision: 03/23 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 health plans affiliated with Centene Corporation® 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*:

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).

II. It is the policy of health plans affiliated with Centene Corporation that outpatient confirmatory/definitive (quantitative) drug testing of more than 14 drugs/drug classes is **not medically necessary.**

III. It is the policy of health plans affiliated with Centene Corporation that urine drug testing (UDT) is considered **not medically necessary** if provided for reasons that include, but are not limited to, the following:

A. 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;
B. Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations);
C. Screening in asymptomatic patients, except as listed in sections I or II;
D. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.);
E. 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.);
F. Same-day screening of drug metabolites in specimens sourced from any combination of blood, saliva and urine by either preliminary or confirmatory/definitive analyses;
G. Blanket orders;
H. Reflex definitive drug tests when presumptive testing is performed at point of care;
I. 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;
J. Billing of individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered;
K. Performing presumptive point of care testing and ordering presumptive immunoassay (IA) testing from a reference laboratory;
L. Performing presumptive IA testing and ordering presumptive IA testing from a reference laboratory with or without reflex testing;
M. Performing IA presumptive screening prior to definitive testing without a specific physician's order for the presumptive testing;
N. 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;
O. 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.
- Requests for prior authorization will be accepted up to 10 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.

Background

A drug of abuse (DOA) is defined as a drug, chemical, or plant product known to be misused for recreational 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 common drugs tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamines.[3,8,12] These tests can vary by region based on epidemiologic trends. There currently is no uniformity for what is included in extended DOA testing or cutoff values that should be used for detection of drugs that are not covered by workplace testing laws.[8]

According to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), a review examining the relevance and role of urine drug testing for treatment of opioid misuse found that providers are better equipped to evaluate opioid therapy with the aid of urine drug testing.[22] However, two literature searches, one from the timeframe 1995-2017 and one from 2000 to present, revealed a significant gap in research evidence regarding the clinical significance of urine drug screening for substance-related disorders.[22,23]

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.[27]

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.[27] 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).[27]

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 an increased 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.

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.[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.[8] 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]

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 2022, 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. 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.

CPT® Codes That Support Coverage Criteria

CPT®* Codes	Description
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
80184	Phenobarbital
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	Alcohol biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamine; 3 or 4
80326	Amphetamines; 5 or more

CPT®* Codes	Description
80327	Anabolic steroids; 1 or 2
80328	Anabolic steroids; 3 or more
80332	Antidepressants, serotonergic class; 1 or 2
80333	Antidepressants, serotonergic class; 3-5
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	Pregbalin
80367	Propoxyphene
80368	Sedative Hypnotics (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
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1 to 3

CPT®* Codes	Description
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)

CPT Codes That Do Not Support Coverage Criteria

CPT® Codes	Description
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
0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service

CPT® Codes	Description
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
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); definitive, qualitative or quantitative, all sources(s), 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
Policy developed	09/12	09/12
Modified criteria in I.A.1 that a presumptive test must be performed before a definitive test unless no reliable test is available. Added an indication for testing when the presumptive test is assumed to be positive based on patient history, but quantitative levels are required. Modified II.C. to state that screening in asymptomatic patients is medically unnecessary, unless otherwise stated in section I.	07/18	07/18
Revised background to clarify that immunoassays are able to detect low concentrations of a drug with a high degree of sensitivity but lack some specificity.	03/19	
Revised policy to state that HCPCS codes G0482 & G0483 are not medically necessary, and to reflect a 10 day post-collection authorization period. Updated coding tables to include 80367, 80368, 80369, 80370, 80372, 80373. Revised I.A.1 from "unless no reliable test is available" to "unless no reliable test is in existence" for clarification.	05/19	05/19
References reviewed and updated.	06/19	
Added criteria for presumptive testing. In II.B, added that "Tests are only for the specific drug(s) or number of drug classes for which the presumptive test is expected to be positive." Added the following not medically necessary indications: blanket orders; reflex definitive testing	05/20	06/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
when presumptive testing is performed at point of care; physician standing orders for all patients; billing codes for individual drugs which are included in a billed panel; presumptive immunoassay testing in a lab when presumptive POC testing has been performed; presumptive screening before definitive testing if presumptive testing not ordered; IA testing used to confirm a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Removed authorization protocol information about requests for ages <6 not being on PA, and for a 10 day window to submit PA requests after testing. Removed request requirements section. Added more CPT codes to support coverage criteria. Added the following CPT codes as not medically necessary: 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U. Added HCPCS codes 0011U and G0659 as medically necessary. Added ICD-10-CM codes. References reviewed and updated.		
Reinstated notes regarding PA not being required for children < 6 years of age, and a 10 day post-test window for PA.	07/20	
Corrected medical necessity statement in section I. to state that "one" of the following must be met, instead of "both."	08/20	
Added presumptive drug testing limits in chronic opioid therapy to I.B. Replaced all instances of "member" with "member/enrollee."	09/20	10/20
Changed name of policy from Outpatient Testing for Drugs of Abuse to Drugs of Abuse: Definitive Testing. Removed presumptive drug testing criteria from policy and created new policy, CP.MP.208 Drugs of Abuse: Presumptive Testing. Removed codes for presumptive drug testing: 80305, 80306, 80307. Added CPT-0054U to list of codes that do not support coverage criteria. Removed CPT-0006U, as code is deleted in 2021. Removed UM language regarding PA not being required for children < 6 years of age, and a 10 day post-test window for PA.	02/21	
Added 2021 CPT- 82077 to list of codes that support coverage criteria.	03/21	
Annual review. References updated and coding reviewed. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Updated ICD-10 codes to include code ranges.	06/21	06/21
Deleted note referring to CP.MP.208 Drugs of Abuse, Presumptive Testing	11/21	
Annual review. References reviewed and updated. Added "It is the policy of health plans affiliated with Centene Corporation" to criteria III. Updated background with no impact to criteria. Description updated for CPT code 80370. Reviewed by specialist.	03/22	03/22
Added CPT 0328U to the list of CPT codes that do not support coverage criteria. Removed (HCPCS codes G0482, G0483) from the policy statement in II.	10/22	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added protocols for prior authorization details: Testing for children < 6 years of age is exempt from prior authorization and requests for prior authorization will be accepted up to 10 business days after specimen collection and reviewed for medical necessity based on the above stated criteria.	12/22	12/22
Annual Review. Added an example of synthetic cannabinoids to I.A.1., drugs for which presumptive testing is not reliable. Coding reviewed. Replaced all instances of dashes (-) with the word "to" within the CPT and HCPCS codes. Added 0082U to the CPT codes that do not support coverage criteria list. Removed table of ICD-10 CM codes. Updated background information to include information regarding American Society of Addiction Medicine (ASAM). Other minor wording changes made to background with no clinical significance. References reviewed and updated. Policy reviewed by an internal specialist.	03/23	03/23

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):175-8. 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):97-117. 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.pdfUpdated 2021. Accessed February 22, 2023.
4. Becker W, Starrels JL. Prescription drug misuse: Epidemiology, prevention, identification, and management. UpToDate. www.uptodate.com. Updated November 7, 2022. Accessed February 22, 2023.
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 22, 2023.
6. Christo PJ, Manchikanti L, Ruan X, et al. Urine drug testing in chronic pain. *Pain Physician*. 2011;14(2):123-143.
7. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain - United States, 2016. *JAMA*. 2016 Apr 19; 315(15): 1624–1645. doi: 10.1001/jama.2016.1464
8. Hoffman RJ. Testing for drugs of abuse (DOA). UpToDate. www.uptodate.com. Updated September 21, 2022. Accessed February 22, 2023.
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 22, 2023.
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;14:175-187.
11. McKay JR. Continuing care for addiction: Implementation. UpToDate. www.uptodate.com. Updated August 3, 2021. Accessed February 22, 2023.
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):66-76. doi:10.4065/83.1.66
13. Wilfong A. Seizures and epilepsy in children: Initial treatment and monitoring. UpToDate. www.uptodate.com. Updated September 7, 2022. Accessed February, 17, 2023.
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 Adopted April 5, 2017. Accessed February 22, 2023.
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;78:163-186. 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-SE9.
17. Local coverage determination: controlled substance monitoring and drugs of abuse testing (L36029). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 5, 2015 (revised February 10, 2022). Accessed February 22, 2023.
18. Local coverage determination: controlled substance monitoring and drugs of abuse 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 8, 2021). Accessed February 22, 2023.
19. Local coverage determination: urine drug testing (L36037). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published December 1, 2015 (revised October 1, 2019). Accessed February 22, 2023.
20. Local coverage determination: controlled substance monitoring and drugs of abuse 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 8, 2021). Accessed February 22, 2023.
21. Local coverage determination: controlled substance monitoring and drugs of abuse testing (L35724). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. Published October 1, 2015 (revised April 8, 2021). Accessed February 22, 2023.
22. 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
23. 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;64:30-33. doi:10.1016/j.drugpo.2018.08.006

24. 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.asam.org/docs/default-source/public-policy-statements/1drug-testing---clinical-10-10.pdf. Published July 2002 (Revised October 2010). Accessed February 22, 2023.
25. 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 22, 2023.
26. Doyle K, Strathmann FG. Cost and Efficacy Assessment of an Alternative Medication Compliance Urine Drug Testing Strategy. *Pain Med*. 2017;18(2):307-315. doi:10.1093/pm/pnw165
27. 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 22, 2023.

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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. 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.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.