

## ***Urine Drug Testing for Substance Use and Pain Management***

**Effective:** October 1, 2018

**Next Review:** December 2018

**Last Review:** September 2018

### **IMPORTANT REMINDER**

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

### **DESCRIPTION**

Presumptive and definitive urine drug testing are often used in coordination with a multifaceted intervention approach to monitor patients in pain management and substance use treatment programs. This policy is not intended to interfere with appropriate monitoring of opioid use.

### **MEDICAL POLICY CRITERIA**

**Notes:**

- This policy does not address the use of urine drug testing in the following circumstances:
  - Emergency department testing, including for the detection of potential overdose or poisoning.
  - Screening for commercial drivers licensing, or any other job-related testing.
  - State/legally mandated drug testing.
- Presumptive immunoassay (qualitative) and/or definitive confirmatory (quantitative) urine drug testing will not be covered as required for, or in conjunction with, participation in care at a facility. Urine drug testing is considered included in the facility reimbursement.

- I. Presumptive immunoassay (qualitative) urine drug testing with codes 0007U, 80305, 80306, or 80307 may be considered **medically necessary** when all of the following are met:
  - A. Only 1 of the 4 presumptive codes may be billed per date of service with one unit per code for pain management or substance use treatment; and
  - B. Testing does not exceed 15 presumptive codes per year
- II. Presumptive immunoassay (qualitative) urine drug testing for pain management or substance use treatment, is considered **not medically necessary** when the above criteria (I) are not met **or** when such testing exceeds 15 presumptive codes per year.
- III. Definitive confirmatory (quantitative) urine drug testing with codes G0480, G0481, or G0659 may be considered **medically necessary** when all of the following are met:
  - A. Only 1 of the 3 definitive codes may be billed per date of service with one unit per code for pain management or substance use treatment; and
  - B. Testing does not exceed 15 definitive codes per year.
- IV. Definitive confirmatory (quantitative) urine drug testing for pain management or substance use treatment is considered **not medically necessary** when the above criteria (criteria III) are not met, including the use of codes G0482 and G0483, **or** when such testing exceeds 15 definitive codes per year.

*NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.*

## CROSS REFERENCES

None

## BACKGROUND

According to an evidence assessment by the American Society of Interventional Pain Physicians (ASIPP), approximately one-third of chronic pain patients do not use opioids as prescribed or may abuse them.<sup>[1]</sup> Moreover, studies report that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and use of illicit drugs.<sup>[2]</sup>

According to the National Pharmaceutical Council (NPC) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guideline regarding current understanding of assessment, management, and treatment of pain, the primary drugs used to treat pain may be categorized into three classes:<sup>[3]</sup>

- **Nonopioid analgesics (nonopioids):** acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), including aspirin and other salicylic acid derivatives.
- **Opioid analgesics (opioids):** mu opioid agonists (i.e., morphine-like agonists) and agonist-antagonist opioids.
- **Adjuvant analgesics or co-analgesics:** a diverse group of drugs, with primary indications for conditions other than pain, with analgesic properties relevant to some

conditions. Commonly used adjuvant analgesics include antiepileptic drugs (AEDs), tricyclic antidepressants (TCAs), and local anesthetics (LAs).

The NPC notes that, “variations of this classification system exist, and terminology in the field is also evolving.”

## **Monitoring Drug Use**

Various strategies are available to monitor patients in pain management and substance abuse treatment. Multicomponent interventions are often used which may include patient contracts, risk assessment screening instruments and tracking of aberrant behaviors. One strategy for monitoring patients is testing of biological specimens for the presence or absence of drugs. Currently, urine is the most commonly used biological substance. Advantages of urine sampling are that it is readily available, and there are standardized techniques for detecting drugs in urine. Other biological specimens (e.g., blood, oral fluids, hair and sweat) can also be tested and may gain popularity over time as techniques for collecting and analyzing these specimens become more standardized.

## **Urine Drug Testing**

There are various approaches to incorporating urine drug screening into pain management and substance abuse treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use. Some clinicians believe that urine drug screening should be routinely used to establish baseline information about substance use, but the optimal frequency and interval of testing remains uncertain. A universal approach to screening may uncover more inappropriate use, and may reduce patients’ sense that testing is being performed due to a lack of trust. However, routine universal screening may place an unnecessary burden on the healthcare system and on the doctor-patient relationship. An alternative approach is selective testing of patients who are judged to be at increased risk for drug misuse.

Full informed consent is a requirement before urine drug testing. Patients should be informed of the specific drug testing protocol before treatment and should provide written agreement with the plan for monitoring. As stated in a joint U.S. Veterans Affairs/Department of Defense guideline, patients’ refusal to consent to urine testing should be considered as one factor in the overall assessment of patients’ ability to adhere to treatment.<sup>[4]</sup>

There are two primary categories of urine drug testing:

### **I. Presumptive Immunoassay (Qualitative) Testing**

These tests can be performed either in a laboratory or at point-of-service with Certification of Waiver or a Medical Test Site Accredited License. Presumptive immunoassay tests are based on the principle of competitive binding and use antibodies to detect a particular drug or drug metabolite in a urine sample. With competitive binding, a fixed amount of a labeled drug is added to the urine sample, and the drug or metabolite in the sample competes with the labeled drug for binding sites on the antibody. The amount of labeled antigen that binds with the antibody is inversely proportional to the amount of the drug or metabolite in the sample.

Presumptive immunoassay tests vary in the type of compounds they can detect. Some detect specific drugs and may fail to recognize similarly structured drugs within the same

class. Other immunoassays identify only classes of drugs and thus results cannot be used to determine which drug a patient is taking. For example, a positive result to an opiate immunoassay can be due to morphine or hydromorphone. The degree of crossreactivity, i.e., an antibody's reactivity with a compound other than the target of the test, varies widely among immunoassays.

Presumptive immunoassay findings are generally reported qualitatively as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). Raising or lowering the threshold thus changes the proportion of positive tests. A negative test is interpreted as a level below the threshold and does not necessarily mean that the drug or metabolite is absent.

Immunoassays generally have a rapid turnaround time, within minutes for onsite tests and 1 to 4 hours for laboratory-based tests.<sup>[5]</sup>

## II. Definitive Confirmatory (Quantitative) Testing to Identify a Specific Drug

Confirmatory tests are performed in a laboratory or by a provider with Certificate of Registration, Compliance of Accreditation or Medical Test Site Categorized License or Accredited License. Gas chromatography/mass spectrometry (GC/MS) is considered to be the criterion standard for confirmatory testing. This technique involves using GC to separate the analytes in a specimen and MS to identify the specific molecular structures of the drug and its metabolites. The tests are able to quantify the amount of drug or metabolite present in the urine sample. Quantitative tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS generally requires specification of the drug or drugs to be identified. Alternatively, "broad spectrum screens" can be conducted. There is a several day turnaround time for GC/MS testing.<sup>[6]</sup>

### Urine Drug Test Accuracy

An issue with both types of urine drug testing is the possibility of sample tampering to mask the presence of illegal drugs. A variety of products and techniques are available to patients, and can be as simple as drinking a large amount of water to dilute the sample. There are also commercial dilution and cleaning products, additives and urine substitutes. Some of these techniques can be detected by visual inspection of the sample (e.g., color, or by onsite testing of sample characteristics including urine temperature, creatinine concentration, and specific gravity).

In addition, correct interpretation of urine drug testing results is very important. Knowledge of drug metabolites is essential for accurate interpretation. Accurate interpretation of test results also requires knowledge of the drug manufacturing process. For example, due to manufacturing impurities, a small amount of hydrocodone may be present in urine samples from patients prescribed oxycodone. Thus, it would be acceptable to have this degree of hydrocodone if high amounts of oxycodone were also present.

### Urine Drug Testing Strategy

Existing protocols vary for use of qualitative versus quantitative tests. Some of these involve conducting routine confirmation of positive qualitative tests with quantitative testing. Others use selective confirmation of positive qualitative tests, such as when an unexpected immunoassay

result is not adequately explained by the patient. There is also a mixed approach, with routine conformation of qualitative tests only for drugs with poor-performing presumptive immunoassays.

## **REGULATORY STATUS**

GC/MS tests and some immunoassays are performed in laboratory settings. Clinical laboratories may develop and validate in house (i.e., laboratory-developed) tests and market them as a service. Laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Act (CLIA).

A CLIA waiver is available for use of certain point-of-care immunoassays. Tests eligible for a CLIA waiver are those considered to be simple, with low risk of error and low potential for harm. The U.S. Food and Drug Administration (FDA) is tasked with approving manufacturers' applications for test system waivers. There are commercially available CLIA-waived tests for drugs such as cocaine, methadone, morphine/opiates and oxycodone.

## **EVIDENCE SUMMARY**

Assessment of diagnostic testing typically focuses on 3 main principles:

1. The analytic validity of the test, which refers to the technical accuracy of the test in detecting a mutation that is present or in excluding a mutation that is absent;
2. The clinical validity of the test, which refers to the diagnostic performance of the test (sensitivity, specificity, positive and negative predictive values) in detecting clinical disease; and
3. The clinical utility of the test, i.e., how the results of the diagnostic test will be used to change management of the patient and whether these changes in management lead to clinically important improvements in health outcomes.

The focus of the following literature appraisal is on evidence related to the clinical utility of urine drug testing to:

- Provide clinically relevant information beyond other strategies for monitoring drug use in pain management and substance abuse treatment patients, and
- Alter treatment decisions and improve health outcomes as a result of confirmatory testing and/or presumptive immunoassay testing compared to clinical evaluation techniques.

## **MANAGING PATIENTS WITH ROUTINE URINE DRUG TESTING VERSUS CONFIRMATORY URINE DRUG TESTING**

Confirmatory tests provide quantitative measurements of a wider range of medications and their metabolites compared to immunoassay testing and are considered effective for confirming an unexpected immunoassay result. Numerous studies were identified which evaluated the use of confirmatory urine drug testing to distinguish patients who are abusing prescription drugs from those who are complying with a prescribed dosing regimen.<sup>[7-13]</sup> However, no studies were identified that assessed how results from confirmatory testing improved patient management decisions or health outcomes compared to patients managed using routine immunoassay urine drug tests.

## **PRACTICE GUIDELINE SUMMARY**

## **CENTERS FOR DISEASE CONTROL AND PREVENTION**

In 2016, Centers for Disease Control and Prevention (CDC) guidelines on opioids for chronic pain was published.<sup>[14]</sup> The guidelines included the following recommendation on UDT: “When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.”

## **WASHINGTON STATE AGENCY MEDICAL DIRECTORS’ GROUP**

The Agency Medical Directors’ Group (AMDG) of Washington State updated guidelines on opioid dosing for chronic non-cancer pain were first published in 2010, and revised with the broadened scope of opioids for pain in 2015.<sup>[15,16]</sup> Regarding the use of urine drug testing (UDT), the WA AMDG made the following statements:

“The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse and verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline UDT and screen all patients for risk level to develop an appropriate monitoring plan as well as a basis for consultation or referral. Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. The Prescriber should repeat random UDT based on the patient’s risk category. There are several validated screening tools available to assess risk of aberrant behavior. The Opioid Risk Tool (ORT) provides a brief questionnaire that can easily be used in the primary care setting”

In addition, the WA AMDG noted that immunoassays are the most commonly used method of testing, although no standard UDT is suitable for all purposes and settings. The WA AMDG made the following recommendations regarding when confirmatory testing may be beneficial:

### **Natural Opioids (e.g., codeine, morphine)**

“Immunoassays for “opiates” are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.”

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

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

Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.”

## Synthetic Opioids (e.g., fentanyl, meperidine, methadone, propoxyphene)

“Current “opiates” immunoassays do not detect synthetic opioids. Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.”

Opinions vary on the optimal frequency of urine drug screening to monitor patients on opioid therapy for chronic pain. The WA AMDG UDT algorithm for monitoring opioid treatment in chronic non-cancer pain includes test frequency recommendations, summarized as follows:

- Low risk by Opioid Risk Tool (ORT): 1 per year
- Moderate risk by ORT: 2 per year
- High risk or opioid dose >120 MED/d: 3 to 4 per year
- Aberrant: At time of visit

Note that the ORT is a copyrighted instrument.<sup>[17]</sup>

## AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS

In 2017, the American Society of Interventional Pain Physicians (ASIPP) issued guidelines on responsible, safe, and effective opioid prescribing for chronic noncancer pain.<sup>[18]</sup> The guidelines included the following recommendations on urine drug testing:

**Table 1. 2017 ASIPP UDT Recommendations**

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

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

## AMERICAN PAIN SOCIETY AND AMERICAN ACADEMY OF PAIN MEDICINE

In 2009, the American Pain Society (APS) and American Academy of Pain and Medicine (AAPM) issued joint clinical practice guidelines on the use of opioid therapy in chronic noncancer pain.<sup>[19]</sup> The clinical guidelines were based upon a high quality systematic review of the current evidence which included a comprehensive literature search and transparent appraisal of the quality of evidence. The APS/AAPM guideline indicated the following:

“Patients with chronic pain may underreport or conceal illicit drug use. Regular or periodic urine drug screening has been proposed as a method for identifying patients using illicit drugs. Most urine drug screening tests utilize immunoassays, but cross-

reactivity between various drugs and chemicals can cause false positive results. Urine tests based on gas chromatography-mass spectrometry assays are considered the most specific test for identifying individual drugs and metabolites and are often used to confirm positive results on immunoassays.”

The APS/AAPM found the evidence regarding the diagnostic accuracy of urine drug screening to be limited to a single study with methodological shortcomings.

## **AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE**

The latest guidelines from the American College of Occupational and Environmental Medicine (ACOEM) on the use of opioids for the treatment of acute, subacute, chronic, and postoperative pain, were published in 2014.<sup>[20]</sup> An expert panel was convened to evaluate the current evidence, and develop recommendations. For urine drug testing, the panel recommended both presumptive and definitive testing at baseline and at random, “for patients prescribed opioids for the treatment of subacute [1-3 months] or chronic pain [> 3 months] to evaluate presence or absence of the drug, its metabolites and other substance(s) use. In certain situations, other screenings (eg, hair particularly for information regarding remote use or blood) (for acute toxicity) may be appropriate.” The recommendation strength was graded: C (on a scale of A-C, where A is strongly recommended, B is moderately recommended, and C is recommended); and the confidence in the recommendation was labeled: High.

Urine drug screening was not recommended for acute pain (up to 4 weeks) or for postoperative pain (up to 4 weeks).

As a companion to the guidelines, ACOEM developed a combined Opioid Consent Form and Opioid Treatment Agreement.<sup>[21]</sup> The form provides explanations of the potential benefits and harms to be expected from opioid treatment, and asks the patient to agree to numerous terms of opioid use, which include submitting to unscheduled urine, blood, saliva, or hair drug testing at the prescriber’s request and seeing an addiction specialist if requested.

Screening was recommended for all patients at baseline, and then randomly at least twice and up to four times a year, and at termination. Screening should also be performed if the provider suspects abuse of prescribed medication.

## **VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE**

In 2010, the Veterans Affairs (VA) and Department of Defense (DoD) issued clinical practice guidelines for managing opioid therapy for chronic pain treatment.<sup>[4]</sup> The recommendations on assessing adherence to prescribed opioids includes obtaining a urine drug test before initiating opioid therapy and randomly at follow-up to confirm appropriate use. Other strategies recommended include clinical assessment and screening aids such as random pill counts, adherence checklists and standardized instruments such as the Screener and Opioid Assessment for Patients with Pain (SOAPP).

The guideline included the following specific recommendations regarding urine drug testing:

1. “Inform patients that drug testing is a routine procedure for all patients starting or on opioid therapy (OT), and is an important tool for monitoring the safety of their treatment.
2. With patient consent, obtain a urinary drug test (UDT) in all patients prior to initiation of OT.



3. With patient consent monitor all patients on OT with periodic random UDTs to confirm adherence to the treatment plan. Increase the frequency of UDTs based on risk level for aberrant drug-related behaviors and following each dose increase.
4. Take into consideration a patient's refusal to take a UDT as part of the ongoing assessment of the patient's ability to adhere to the treatment plan and the level of risk for adverse outcomes.
5. When interpreting UDT results take into account other clinical information (e.g., past substance use disorder [SUD], other risk factors, aberrant drug-related behaviors, and other conditions indicating risk.)
6. Understanding of lab methods for drug testing and reporting are necessary to interpret UDT results (i.e., screen versus confirmatory test, substances tested, cut-off levels for tests). Maintain a close working relationship with the clinical laboratory to answer any questions about the UDT or for confirming the results."

Specific recommendations regarding confirmatory urine drug testing were not included in the VA/DoD guidelines.

## **AMERICAN SOCIETY OF ADDICTION MEDICINE**

The American Society of Addiction Medicine (ASAM) has published several documents on drug testing: a public policy statement (2010),<sup>[22]</sup> a white paper (2013), which provided background on the science and current practices of drug testing,<sup>[23]</sup> and guidelines (2017) on the effective use of drug testing.<sup>[24]</sup>

ASAM's public policy statement asserts that: "Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care, and should not face undue restrictions."<sup>[22]</sup> ASAM recommended drug testing where medically appropriate in clinical diagnostic settings and clinical treatment settings. The term "drug testing" in this document was a broad term that included urine or other body fluids or tissues.

The ASAM White Paper concluded that "The most important challenge in drug testing today is not the identification of every drug that we are technologically capable of detecting, but to do medically necessary and accurate testing for those drugs that are most likely to impact clinical outcomes."<sup>[23]</sup> The paper acknowledged that more specific guidance on drug testing was needed, which led to the development of the 2017 guidelines, described below.

The 2017 ASAM guidance on appropriate drug testing in clinical addiction medicine advises health care providers that before choosing the type of drug test, they should first identify the questions they are seeking to answer and be aware of benefits and limitations of the various drug tests.

## **SUMMARY**

In general, medical necessity means health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating illness, injury, disease or its symptoms meeting certain standards, appropriateness, and not primarily for convenience. Generally accepted standards of medical practice are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community,

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physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

The research regarding the clinical utility of presumptive immunoassay (qualitative) or definitive (quantitative) confirmatory urine drug testing in pain management and substance abuse treatment is limited. However, there is consensus among clinical practice guidelines that presumptive and definitive urine drug testing may be warranted in specific cases. Therefore, presumptive immunoassay and definitive confirmatory urine drug testing may be considered medically necessary when specific policy criteria are met.

This policy is not intended to interfere with appropriate monitoring of opioid use. Current research does not show an improvement in health outcomes for additional testing beyond what is covered in the policy criteria. Further, there are no established standards recognized by the medical community or professional societies that additional definitive confirmatory urine drug testing beyond 15 codes per year will add clinical utility. Clinical guidelines based on research recognize the limitations of the current literature, specifically a lack of rigorous prospective studies investigating the impact of screening on overall health outcomes. Practice recommendations based on provider consensus also state testing should be specific to the patient's situation. Therefore, all other presumptive or definitive confirmatory urine drug testing is considered not medically necessary when the policy criteria are not met.

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## CODES

Codes	Number	Description
CPT	0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
	<del>0020U</del>	<del>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, with specimen verification including DNA authentication in comparison to buccal DNA, per date of service (Deleted 10/1/2018)</del>
	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
HCPCS	G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.
	G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and

Codes	Number	Description
		variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
	G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
	G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)) , (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed.
	G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, 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

**Date of Origin:** December 2015