

## Clinical UM Guideline

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**Subject:** Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain  
**Guideline #:** CG-LAB-09  
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### Description

This document addresses the drug testing involving urine, blood, saliva, sweat, or hair samples in the outpatient setting for adherence monitoring of controlled substance use as part of the management of chronic pain and for individuals undergoing treatment for opioid addiction and substance use disorder.

**Note:** This document **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.

**Note:** Drug testing or screening for employment issues may be addressed in the member certificate. Please refer to the member's benefits for further information.

**Note:** Sample validation is a method that is sometimes needed to assure source integrity. Quality assurance to assure sample integrity is part of expected clinical laboratory test management.

**Note:** For more information about drug testing sample validation, please see:

- [GENE.00041 Genetic Testing to Confirm the Identity of Laboratory Specimens](#)

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### Clinical Indications

#### Medically Necessary:

*Presumptive* urine drug testing (UDT) to verify compliance with treatment, identify undisclosed drug use or abuse, or evaluate aberrant\* behavior is considered **medically necessary** up to 24 times per year, beginning at the start of treatment, as part of a routine monitoring program for individuals who are:

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

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

*Presumptive* urine drug testing is also considered **medically necessary** for the following:

- A. To assess an individual when clinical evaluation suggests use of non-prescribed medications or illegal substances; **or**
- B. On initial entrance into a pain management program or substance use disorder recovery program.

*Definitive* urine drug testing is considered **medically necessary** when all of the following criteria are met:

- A. The *presumptive* urine drug testing was done for a medically necessary reason; **and**
- B. The *presumptive* test was negative for prescribed medications, positive for a prescription drug with abuse potential which was not prescribed, or positive for an illegal drug (for example, but not limited to methamphetamine or cocaine), **and**
  - 1. The specific definitive test(s) ordered are supported by documentation specifying the rationale for each quantitative test ordered; **and**
  - 2. Clinical documentation reflects how the results of the test(s) will be used to guide clinical care.

The use of blood samples as an alternative to urine for drug testing is considered **medically necessary** when the use of urine is not feasible (for example, when an individual has advanced kidney failure).

#### **Not Medically Necessary:**

The use of *presumptive* urine drug testing is considered **not medically necessary** when the criteria above are not met.

The use of *definitive* urine drug testing is considered **not medically necessary** when the criteria above are not met.

The use of presumptive or definitive testing panels is considered **not medically necessary** unless all components of the panel have been determined to be medically necessary based on the criteria above. However, individual components of a panel may be considered medically necessary when criteria above are met.

The use of blood samples for drug testing is considered **not medically necessary** in all other circumstances, including when the criteria above have not been met.

The use of saliva, sweat, or hair samples for drug testing is considered **not medically necessary** in all circumstances.

The use of any of the following for *definitive* drug testing of urine or blood samples is considered **not medically necessary** in all circumstances

- A. Reflex testing; **and**
- B. Standing orders; **and**
- C. Blanket orders.

<b>Coding</b>
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*The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

#### **CPT**

	<i>Presumptive Drug Class Screening codes:</i>
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

*Definitive Drug Testing codes:*

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	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; 3-5
80334	Antidepressants, serotonergic class; 6 or more
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 6 or more
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1-3
80340	Antiepileptics, not otherwise specified; 4-6
80341	Antiepileptics, not otherwise specified; 7 or more
80342	Antipsychotics, not otherwise specified; 1-3
80343	Antipsychotics, not otherwise specified; 4-6
80344	Antipsychotics, not otherwise specified; 7 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids, synthetic; 7 or more
80353	Cocaine
80354	Fentanyl
80355	Gabapentin, non-blood
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines
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
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; 1-3
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
83992	Phencyclidine (PCP)
0006U	Detection of interacting medications, substances, supplements and foods, 120 or more analytes, definitive chromatography with mass spectrometry, urine, description and severity

of each interaction identified, per date of service  
 Drug-drug, Drug-substance Identification and Interaction; Aegis Sciences Corporation  
 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  
 Cordant CORE™; Cordant Health Solutions

**HPCPS**

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 [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

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 [eg, 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 [eg, 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, 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 [eg, alcohol dehydrogenase]), 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 [eg, IA, EIA, ELISA, EMIT, FPIA] and enzymatic methods [eg, alcohol dehydrogenase]), 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

P2031 Hair analysis (excluding arsenic)

**ICD-10 Diagnosis**

All diagnoses

<b>Discussion/General Information</b>
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### Urine Drug Testing (UDT)

The use of UDT in individuals with a substance use disorder or undergoing opioid treatment for chronic pain conditions is common and serves several purposes. According to the American College of Physicians (ACP, 2008), the reasons for UDT include:

- Enhancing patient care.
- Providing objective documentation of an individual's compliance with the treatment plan and opioid agreement.
- Reducing the risk of an unrecognized drug misuse/abuse problem.
- Serving as an adjunct to self-reports of drug/substance use.
- Proving or disproving abuse/addiction of illicit or non-prescribed licit drugs.
- Justifying continuation of chronic opioid analgesic therapy in individuals who adhere to the treatment plan and have acceptable urine drug tests.
- Providing a rationale to change the treatment plan in individuals with unacceptable urine drug tests and justifying referral to addiction specialists.

The American Pain Society (APS) and American Academy of Pain Medicine (AAPM) joint guidelines panel released their opioid treatment guidelines titled *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-cancer Pain* in 2009 (Chou, 2009). In this document they addressed the monitoring of controlled substances use via UDT as part of a chronic opioid treatment (COT) program. The guideline section on monitoring (Section 5) states:

5.1 Clinicians should reassess patients on COT periodically and as warranted by changing circumstances. Monitoring should include documentation of pain intensity and level of functioning, assessments of progress toward achieving therapeutic goals, presence of adverse events, and adherence to prescribed therapies (strong recommendation, low-quality evidence).

5.2 In patients on COT who are at high risk or who have engaged in aberrant drug-related behaviors, clinicians should periodically obtain urine drug screens or other information to confirm adherence to the COT plan of care (strong recommendation, low-quality evidence).

5.3 In patients on COT not at high risk and not known to have engaged in aberrant drug-related behaviors, clinicians should consider periodically obtaining urine drug screens or other information to confirm adherence to the COT plan of care (weak recommendation, low-quality evidence). Clinicians should periodically reassess all patients on COT. Regular monitoring of patients once COT is initiated is critical because therapeutic risks and benefits do not remain static.

The American Society of Addiction Medicine (ASAM) published a document titled, *Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM) (2013)*. This document details the critical issues that surround the topic of drug testing, including the various technologies available, testing of various body fluids and substances, when and why to test specific individuals, interpretation of test results, and the principles of testing in various settings. They address many of the complicated issues surrounding quantitative testing, about which they state, "Definitive (also: "confirmatory" or "identification" testing) testing, which involves chromatography and mass spectrometry, incurs additional expense and thus should be done for specific indications." As well as:

In general, positive IA [immunoassay] results need only be subjected to definitive testing when the results conflict with patients' account of their drug use or when drug specificity is needed in class-specific assays (i.e. amphetamines, benzodiazepines, opiates). In a pain practice it is sometimes, but not always, important to identify the specific drug, not just the class of the drug.

Overall, they do not provide a supporting rationale for across the board definitive testing in any setting.

In 2017 ASAM published a document titled *Appropriate Use of Drug Testing in Clinical Addiction Medicine* (Jarvis 2017). In this publication they provided an array of recommendations related to UDT and other drug testing procedures. Regarding presumptive and definitive testing they included the following recommendations:

- Presumptive testing should be a routine part of initial and ongoing patient assessment.
- Presumptive testing should be used when it is a priority to have more immediate (although less accurate) results.

- Definitive testing techniques should be used whenever a provider wants to detect specific substances not identified by presumptive methods, quantify levels of the substance present, and refine the accuracy of the results.
- Definitive testing should be used when the results inform clinical decisions with major clinical or non-clinical implications for the patient (e.g. treatment transition, changes in medication therapies, changes in legal status).
- If a patient disputes the findings of a presumptive test, a definitive test should be done.
- When ordering a definitive test, providers should advise the testing laboratory if the presence of any particular substance or group of substances is suspected or expected.

Regarding testing frequency they recommended that:

- For people in addiction treatment, frequency of testing should be dictated by patient acuity and level of care.
- Providers should look to tests' detection capabilities and windows of detection to determine the frequency of testing.
- Providers should understand that increasing the frequency of testing increases the likelihood of detection of substance use, but there is insufficient evidence that increasing the frequency of drug testing has an effect on substance use itself.
- Drug testing should be scheduled more frequently at the beginning of treatment; test frequency should be decreased as recovery progresses.
- During the initial phase of treatment, drug testing should be done at least weekly. When possible, testing should occur on a random schedule.
- When a patient is stable in treatment, drug testing should be done at least monthly. Individual consideration may be given for less frequent testing if a patient is in stable recovery. When possible, testing should occur on a random schedule.

Finally, they recommended the following related to UDT:

- Urine should be considered the most well-established and well-supported biological matrix for presumptive detection of substance use in a clinical setting.
- Urine should be considered the best established matrix for POCTs.\*

\* Point of care tests.

The exact frequency and pattern of urine drug screening is individualized based on the risk for abuse. The Washington State Agency Medical Directors' Group (AMGD) published an Interagency Guideline on opioid dosing for chronic non-cancer pain. This guideline and related expert commentary support low-risk individuals having UDT up to once per year, moderate-risk up to 2 per year, high-risk individuals up to 3-4 tests per year, and individuals exhibiting aberrant behaviors should be tested at the time of the office visit. The American Pain Society guidelines (Chou, 2009) state that for individuals at low-risk for adverse outcomes, quarterly or semi-annual monitoring is sufficient. For very high-risk individuals, weekly monitoring may be reasonable. However, they state that there is insufficient evidence to support this recommendation. This observation is reiterated in a recent review article by McMillin and colleagues (2013), where they comment that there is a lack of detailed guidelines addressing the appropriate use of DUT to support chronic pain management. The ASAM white paper does not recommend an upper limit for testing. However, in the context of abuse, they do recommend no less than testing once weekly at first then down to once monthly when abstinence is established.

The risk for abuse may be measured using standard tools, such as the Screener and Opioid Assessment for Patients with Pain (SOAPP<sup>®</sup>; PainEdu.org, 2013) and the Opioid Risk Tool (Webster, 2005). These types of tools may help clinicians assess the suitability of long-term opioid therapy for chronic pain patients, and may help differentiate those patients who require more or less clinician monitoring while on long-term opioid therapy. The SOAPP tool is available for free and can be accessed at <https://www.painedu.org/soapp.asp>. There are four different versions available (5, 14, 24 questions and the Revised SOAPP [SOAPP-R]) allowing for varying levels of evaluation. All versions of the SOAPP tool may be self-administered at or prior to an office visit, or completed as part of an interview with a nurse, physician or psychologist. The ORT was developed by Webster et al. and has become widely used. Like the SOAPP, it may be self-administered or used as part of a clinical evaluation. A version of the ORT is available below. Other tools similar to the SOAPP and ORT are available elsewhere.

**OPIOID RISK TOOL (ORT) (Webster, 2005)**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

		<u>Circle the score that applies:</u>		
		Mark each item	Item Score	Item Score if
		that applies	if Female	Male
Family History of Substance Abuse:	Alcohol	_____	1	3
	Illegal prescription drugs	_____	2	3
	Prescription drugs	_____	4	4
	Alcohol	_____	3	3
Personal History of Substance Abuse:	Illegal prescription drugs	_____	4	4
	Prescription drugs	_____	5	5
Age (Mark box if 16-45):		_____	1	1
History of preadolescent Sexual Abuse:		_____	3	0
Psychological disease:	Attention deficit disorder	_____	Mark "2" if any, some, or all four Psychological diseases are present	
	Obsessive compulsive disorder	_____		
	Bipolar	_____		
	Schizophrenia	_____		
	Depression	_____		
<b>Total</b>		_____	_____	_____

Risk categories: Low = 0-3; Moderate = 4-7; High ≥8

Another issue within the topic of UDT is the use of presumptive vs. definitive testing. Presumptive testing is intended to identify the use or non-use of a drug or class of drugs. Definitive tests are more specific, and allow for the detection of specific drugs or metabolites of interest. In most cases presumptive testing is used because it is quick, fairly accurate, and easily accessible in a wide variety of settings. Definitive testing may be needed when presumptive results alone are not sufficient to guide clinical care. However, in most situations, the identification or quantification of a specific drug of interest may not result in a different treatment plan. Definitive testing, particularly when performed repeatedly, must be clinically meaningful and documentation must support the specific necessity of each definitive assay performed as well as how that test result will affect clinical management.

*Drug Testing of Blood, Saliva, Sweat, or Hair Samples*

At this time, the use of samples other than urine, including blood, hair, saliva, and sweat, is not recommended by most authoritative organizations that provide guidance on drug testing, including the American Society of Addiction Medicine (ASAM, 2013, 2015), the ACP (Kirschner, 2014), the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM, Chou, 2010) and the Washington State Agency Medical Directors' Group (AMGD, 2010).

The ASAM (2013) does mention the use of blood, hair, saliva (oral fluid), and sweat, but they do not make specific recommendations on how, when, and why they should be used. They do provide comments on the benefits and drawback of these substrates. They state that urine is preferred as a sample substrate relative to blood because blood collection is invasive, poses significant difficulties in collecting, and the samples require extensive lab preparation. Furthermore, they noted that there is significantly shorter duration of active drug and metabolites in blood vs. urine. For hair samples, the ASAM guideline noted benefits including difficulty in falsifying sampling and a longer period of detection. However, they noted that hair samples do not allow for the determination of when drugs were taken, and recent exposures cannot be detected. The ASAM guideline states that sweat patch testing techniques are fairly tamper resistant but vulnerable to unintentional or accidental damage. For saliva they comment that while this method shares similar attractive attributes with urine, such as noninvasive collection and easy laboratory analysis, they state that there is a much shorter duration of active drug and metabolites and lower detection rates vs. UDT. Their 2015 guideline titled "National Practice Guideline for the Use of Medications in the Treatment of Addiction

Involving Opioid Use” does not mention the use of blood, hair, saliva, or sweat samples for testing and recommend only urine drug testing at the standard methodology.

In the 2017 ASAM recommendations (Jarvis, 2017) they address the use of alternate sample matrices in the following statements:

- The relevance of blood testing in addiction treatment is limited mostly to emergency situations where there is a need to assess intoxication or impairment.
- No statements about the appropriateness of breath testing were endorsed by the Expert Panel.
- Oral fluid testing is appropriate for presumptive detection of substance use in addiction treatment settings.
- There is insufficient evidence to support the use of sweat testing in addiction treatment. More research is needed before sweat testing can be recommended over urine testing in clinical settings.
- Hair testing in addiction treatment can detect long-term patterns of use. Routine use of hair testing is not appropriate for addiction treatment.

While these recommendations support the use of oral fluid testing, the evidentiary basis for this is weak.

The U.S. Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) has published two documents that address drug testing for individuals in primary care and substance abuse disorder treatment programs (SAMHSA, 2012, 2014). In these documents they discuss the benefits and drawbacks of drug testing using alternative sample sources. However, in their primary care document (2012) they clarify that urine is the most widely used and studied source. This was reiterated in their 2014 Treatment Improvement Protocol for opioid addiction programs.

However, in some circumstances the use of UDT is not possible. In the SAMHSA 2014 protocol they state, “Urine testing is not feasible for patients with renal failure (e.g., those on dialysis) or other bladder control impairments.” In such circumstances the use of blood drug testing may be reasonable.

In summary, the use of blood, hair, saliva, and sweat is not widely recommended and they each have significant drawbacks to their use when compared to UDT.

### *Testing Panels*

Many commercial laboratories market multi-test panels for the presence of various prescription and illicit drugs and their metabolites. While the use of some individual tests included in these test panels may be reasonable under specific circumstances, the use of all the tests within a panel is rarely justified unless there is clinical evidence that an individual has used or been exposed to multiple substances, and knowledge of such exposure provides information that leads to meaningful impact on treatment.

### *Reflex testing, Standing orders, and Blanket orders*

The use of reflex testing, standing orders, and blanket orders for definitive testing of urine or blood samples is contrary to good clinical practice, which is based on clinical decision-making as to the necessity of specific laboratory tests. In the case of these types of tests, they are done in the absence of the requisite clinical decision making process, and based solely on automated processes devoid of clinical judgment. They do not meet the requirement for there to be documentation of a specific rationale for each ordered test and documentation of how the test will be used to modify treatment for the tested individual.

## Definitions

**Blanket order:** A test request that is not for a specific individual, but it is an identical order for all individuals in a clinician’s practice. Such orders do not take the clinical situation of each individual into consideration at the time of request, or during each every visit.

**Definitive testing:** A type of testing that is more specific than presumptive testing, and allows for the detection of specific drugs or metabolites.

Drug diversion: Prescription drugs provided to an individual other than the one to whom the drugs were prescribed.

Planned testing: Testing being conducted at a time previously scheduled and known to the individual being tested.

Presumptive testing: A type of testing that is intended to identify the use or non-use of a drug or general class of drugs.

Random testing: Testing being conducted at a time not previously scheduled and not known to the individual being tested.

Reflex Testing: A laboratory test that is performed "reflexively" after an initial or presumptive test result suggests the need for further diagnostic information. This type of testing is not based on a specific clinical situation and provider's order, but is built into the testing process. Testing performed as a step necessary to complete the request of physician responsible for a members care and provided by an order is not considered reflex testing.

Standing order: A test request for a specific individual representing: 1) repetitive testing to monitor a condition or disease, or 2) individualized orders for repetitive automatic testing for certain individuals for pre-determined tests based on historical use, risk, and community trend patient profiles. Definitive drug testing standing orders are not consistent with ordering laboratory testing based upon clinical findings, nor are they sensitive to the individual's history of drug use and community patterns of drug use.

Testing panel: A type of laboratory procedure where multiple tests are automatically run on a single sample to detect the presence of a variety of substances or class of substances.

## References

### Peer Reviewed Publications:

1. Christo PJ, Manchikanti L, Ruan X, et al. Urine drug testing in chronic pain. *Pain Physician*. 2011; 14(2):123-143.
2. Owen GT, Burton AW, Schade CM, Passik S. Urine drug testing: current recommendations and best practices. *Pain Physician*. 2012; 15(3 Suppl):ES119-ES133.
3. Melanson SE. The utility of immunoassays for urine drug testing. *Clin Lab Med*. 2012; 32(3):429-447.
4. Melanson SE, Ptolemy AS, Wasan AD. Optimizing urine drug testing for monitoring medication compliance in pain management. *Pain Med*. 2013; 14(12):1813-1820.
5. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. *Pain Med*. 2005; 6(6):432-442.

### Government Agency, Medical Society, and Other Authoritative Publications:

1. American Society of Addiction Medicine. Drug testing: a White Paper of the American Society of Addiction Medicine (ASAM). October 26, 2013. Available at: <http://www.asam.org/docs/default-source/publicity-policy-statements/-pdf-.pdf?sfvrsn=0>. Accessed on January 30, 2018.
2. American Society of Addiction Medicine. National practice guideline for the use of medications in the treatment of addiction involving opioid use. 2015. Available at: <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npq>. Accessed on January 30, 2018.
3. Chou R, Fanciullo GJ, Fine PG, et al.; American Pain Society–American Academy of Pain Medicine Opioids Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009. 10(2):113-130.
4. Centers of Medicare and Medicaid, Complying with documentation requirements for laboratory services. August 2016. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf>. Accessed on January 30, 2018.
5. Jarvis M, Williams J, Hurford M, et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. *J Addict Med*. 2017; 11(3):163-173.
6. Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, safe, and effective prescription of opioids for chronic non-cancer pain: American Society of Interventional Pain Physicians (ASIPP) guidelines. *Pain Physician*. 2017; 20(2S):S3-S92.

7. McMillin GA, Slawson MH, Marin SJ, Johnson-Davis KL. Demystifying analytical approaches for urine drug testing to evaluate medication adherence in chronic pain management. *J Pain Palliat Care Pharmacother.* 2013; 27(4):322-339.
8. PainEDU.org. Opioid risk management. About the SOAPP. Available at: <https://www.painedu.org/opioid-risk-management/>. Accessed on January 30, 2018.
9. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Medication-assisted treatment for opioid addiction in opioid treatment programs. A treatment improvement protocol TIP 43. 2014 Available at: <http://store.samhsa.gov/shin/content/SMA12-4214/SMA12-4214.pdf>. Accessed on January 30, 2018.
10. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. National practice guideline for the use of medications in the treatment of addiction involving opioid use. 2015. Available at: <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>. Accessed on January 30, 2018.
11. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Technical Assistance Publication Series 32: Clinical drug testing on primary care. 2012. Available at: <https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf>. Accessed on January 30, 2018.
12. Washington State Agency Medical Directors' Group. Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy. 2010 Update. Available at: <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>. Accessed on January 30, 2018.

<b>Index</b>
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Buprenorphine  
Naloxone  
Suboxone®

**The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.**

<b>History</b>
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Status	Date	Action
	06/28/2018	Updated Coding section with 07/01/2018 CPT changes; revised descriptor for code 0006U.
Reviewed	03/22/2018	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	02/23/2018	Behavioral Health Subcommittee review. Updated References section.
	12/27/2017	The document header wording updated from "Current Effective Date" to "Publish Date." Updated Coding section with 01/01/2018 CPT descriptor changes for codes 80305-80307.
Revised	08/03/2017	MPTAC review.
Revised	07/21/2017	Behavioral Health Subcommittee review. Updated formatting in Clinical Indications section. Added new NMN statement regarding reflex testing, standing orders, and blanket orders. Updated Description, Discussion, and References sections.
	01/01/2017	Updated Coding section with 08/01/2017 CPT changes; added 0006U and 0011U. Updated Coding section with 01/01/2017 CPT and HCPCS changes; removed codes 80300, 80301, 80302, 80303, 80304, G0477, G0478, G0479 deleted 12/31/2016.
Reviewed	08/04/2016	MPTAC review.
Reviewed	07/29/2016	Behavioral Health Subcommittee review. Updated Discussion and References sections.
Revised	02/05/2015	MPTAC review.
Revised	01/29/2016	Behavioral Health Subcommittee review. Revised title to change "Substance Abuse" to "Substance Use Disorder". Added the use of blood, saliva, sweat, or hair to position statement. Revised Background, Coding and References sections.
	01/01/2016	Updated Coding section with 01/01/2016 HCPCS changes, removed codes G0431, G0434, G6031, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6048, G6051, G6052, G6053, G6056, G6057, G6058 deleted 12/31/2015; also removed ICD-9 codes.
Revised	02/05/2015	MPTAC review.

Revised	01/30/2015	Behavioral Health Subcommittee review. Revised clinical indications section to address “presumptive” and “definitive” testing. Clarified the limit of 24 tests per calendar year to be a rolling 24 year. Updated Discussion, Definitions, and References sections.
	01/01/2015	Updated Coding section with 01/01/2015 CPT and HCPCS changes; removed deleted codes and codes 80184, 82491, 82492, 82541, 82542, 82543, 82544 (no longer applicable).
Revised	02/13/2014	MPTAC review.
Revised	02/07/2014	Behavioral Health Subcommittee review. Added not medically necessary statement addressing the use of testing panels. Updated Discussion, Definitions, and References sections.
New	11/14/2013	MPTAC review. Initial document development.

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Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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