

Reimbursement Policy

Policy Number: RPLAB070

Policy Title: Prescription Medication and
Illicit Drug Testing

Approval Date: May 15, 2026

Effective Date: Sept. 4, 2026

Policy Disclaimer

If a conflict arises between a Reimbursement Policy and any Plan document under which a member is entitled to covered services, the Plan document will govern. If a conflict arises between a reimbursement policy and any provider contract pursuant to which a provider participates in and/or provides covered services to eligible member(s) and/or plans, the provider's contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, Benefit Booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Illinois may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submitting accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology (CPT®) Assistant, Healthcare Common Procedure Coding System, ICD-10-CM and ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies, and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Description

The Plan has implemented certain lab management reimbursement criteria. Not all requirements apply to each product. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information

This policy does not describe or define the legal responsibility of providers. Providers should refer to state and federal laws for such guidance.

This policy does not address the use of drug testing in the following circumstances:

- A. State, federally regulated and legally mandated drug testing (e.g., court-ordered drug screening, forensic examinations).
- B. Non-forensic testing for commercial driver's licensing or any other job-related testing (e.g., as a prerequisite for employment or as a means for continuation of employment).
- C. As a component of care rendered in an urgent/emergency situation.

Presumptive drug screening using urine samples:

1. Presumptive drug screening using urine samples (no more than 24 times per year) (qualitative, semi-quantitative or quantitative) **may be reimbursable** in ANY of the following situations:
 - a. To assess an individual being treated for chronic, non-cancer pain when clinical evaluation of the individual (history/signs/symptoms) suggests the use of non-prescribed medications or illegal substances:
 - i. Prior to initiating chronic opioid pain therapy in chronic non-cancer pain to determine if the individual has been exposed to controlled substances or potentially confounding illicit drugs.
 - ii. To verify an individual's compliance with treatment or identify undisclosed drug abuse as part of routine monitoring for individuals who are receiving treatment for non-cancer chronic pain with prescription opioid pain medication. The random testing interval and drugs selected for testing should be based on the individual's history, condition and treatment, as documented in the medical record.
 1. Monitoring of low risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to one time per year after initiation of therapy.
 2. Monitoring of moderate risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to two times per year after initiation of therapy.

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3. Monitoring of high risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to four times per year after initiation of therapy.
 4. For individuals with aberrant behavior (lost prescriptions, multiple requests for early refills, and opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.) testing at the time of visit meets coverage criteria.
- b. In pregnant individuals at high-risk for substance abuse in whom the suspicion of drug use exists based on the answers to substance abuse screening questions or indicated by information from the prescription drug monitoring program (PDMP), as documented in the medical record.
 - c. In newborns when there is a history of maternal substance abuse or agitated/altered mental status in the birthing parent
 - d. In candidates for organ transplant who have a history of substance abuse (to demonstrate abstinence prior to transplant)
 - e. In individuals with a suspicion of or a diagnosis of mental illness, (e.g., anxiety disorders, schizophrenia, major depressive disorder, mood disorders, suicidal ideations, substance abuse disorders)
 - f. In individuals with attention-deficit hyperactivity and disruptive behavior disorders
 - g. In cancer patients on opioid pain medication
 - h. In individuals with epilepsy
 - i. For the management and compliance monitoring of an individual under treatment for substance abuse or dependence at the following frequency (after baseline at initial evaluation) and must be documented in the individual's medical record:
 - i. For individuals with 0 to 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 2 per week.
 - ii. For individuals with > 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 3 in one month.
 - j. In individuals where substance abuse is in the differential diagnosis of the presenting conditions

Definitive Drug Testing

2. Confirmatory/definitive qualitative or quantitative drug testing up to seven (7) drug classes (no more than 24 times per year) **may be reimbursable** when laboratory-based definitive drug testing is specifically requested, the rationale is documented by the individual's treating physician and **ANY** of the following conditions are met:
 - a. The result of the presumptive drug screen is different than that suggested by the individual's medical history, clinical presentation or individual's own statement; (e.g., test was negative for prescribed medications, test was positive for prescription drug with abuse potential, which was not prescribed, test was positive for an illegal drug):

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- b. For diagnosing and monitoring individuals with substance use disorder or dependence, when accurate and reliable results are necessary for treatment decisions.
 - i. Individuals with 0 to 30 consecutive days of abstinence, random definitive drug testing at a frequency not to exceed 1 per week.
 - ii. Individuals with 31 to 90 consecutive days of abstinence, random definitive drug testing at a frequency of 1 to 3 per month. No more than 3 definitive drug tests in one month will be allowed.
 - iii. Individuals with > 90 consecutive days of abstinence, definitive drug testing at a frequency of 1 to 3 test(s) every three months. No more than 3 definitive drug tests in a 3-month period will be allowed.
 - c. For monitoring of individuals on opioid therapy (to ensure adherence to the therapeutic plan, for treatment planning, and for detection of other, non-prescribed opioids).
 - d. A presumptive test does not exist or does not adequately detect the specific drug or metabolite to be tested (e.g., specific drugs within the amphetamine, barbiturate, benzodiazepine, tricyclic antidepressants, and opiate/opioid drug classes as well as synthetic/analog or “designer” drugs)
 - e. To definitively identify specific drugs in a large family of drugs
 - f. To identify drugs when a definitive concentration of a drug is needed to guide management.
- 3. When laboratory-based definitive drug testing is requested for larger than seven drug class panels, confirmatory/definitive qualitative or quantitative drug testing **is not reimbursable**.
 - 4. Confirmatory/definitive qualitative or quantitative or presumptive (qualitative, semi-quantitative or quantitative) drug testing using proprietary tests (e.g., CareView360) **is not reimbursable**.

Specimen Validity Testing

- 5. Specimen validity testing, (e.g., urine specific gravity, urine creatinine, pH, urine oxidant level, genetic identity testing, [NextGen Precision™ Testing]), **is included in the base code and therefore will not be separately reimbursed**.

General

- 6. In all other situations not addressed above, presumptive drug screening and definitive drug testing **are not reimbursable**.

Documentation Requirements

The individual's medical record must contain documentation that fully supports the medical necessity for drug testing. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The clinician's documentation must be patient specific and accurately reflect the need for each test ordered. Each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient's medical record.

Laboratories that submit urine drug testing claims should possess, at a minimum, the following:

- A signed, valid requisition form from the ordering provider that specifies the tests being ordered, and
- Complete results of the tests performed.

The requisition form should include the following:

- A list of the specific drugs or drug classes being tested. Reference to a standard order or a "custom panel" is not acceptable; "Reflex" (or automatic) testing is not acceptable.
- The identity of the patient to include the patient name and date of birth;
- The identity of the ordering provider, including full name, credentials, and NPI number (preferred);
- A legible or appropriate electronic signature with the date signed from the ordering physician (not a stamp or photocopy, and it is not acceptable to state that the physician's signature is on file);
- The facility and location where the sample was collected (e.g., office, home, hospital, residential treatment center);
- The type of sample (e.g., urine, saliva, blood, or hair);
- The date and time the sample was collected;
- The identity of the individual who collected the sample; and
- The date and time the sample was received in the laboratory.

Lab results should contain the following:

- The complete identification of the entity performing the testing (including name, address, and CLIA number);
- The patient's name and date of birth;
- The ordering provider's name and NPI number;
- Facility name, if applicable;
- The date the sample was collected;
- The date the sample was received in the laboratory;
- The date the test results were reported; and
- Complete test results, including validity testing if performed.

Orders

Orders must be patient-specific and include the rationale/need for the test requested. Panel testing is restricted to panels published in the current CPT manual. Orders must be signed and dated by the ordering health care professional.

Note: Retro orders are not acceptable.

Reimbursement

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1. The following **IS reimbursed** (see complete Reimbursement Information above) for:
 - a. Presumptive drug screening based upon appropriate clinical criteria (qualitative, semi-quantitative or quantitative);
 - b. Definitive drug testing (qualitative or quantitative) for up to seven drug classes when the presumptive drug screening meets one of the following criteria:
 - i. The test was negative for prescribed medications, or
 - ii. Positive for a prescription drug with abuse potential which was not prescribed, or
 - iii. Positive for an illegal drug with patient denial of using the drug, or
 - iv. A presumptive test does not exist or does not adequately detect the specific drug or metabolite to be tested.
 - c. Blood specimens in patients with anuric Chronic Renal Failure.
 2. The following **will not be reimbursed**:
 - a. Any AMA definitive drug class codes;
 - b. Same-day testing of the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen) by either presumptive or definitive analyses;
 - c. Blanket orders or routine standing orders for all patients in the physician's practice;
 - d. Samples with abnormal validity tests;
 - e. Drug testing for patients in a facility setting (inpatient or outpatient) is not separately billable from the facility fee.
 3. Only urine or oral fluid specimens will be covered - except blood specimens will be covered for patients with anuric Chronic Renal Failure.
 4. Confirmatory/definitive testing should be supported by documentation of rationale in the individual's medical record.
 5. More than one presumptive test result per individual per date of service regardless of the number of billing providers **will not be reimbursed**:
 - a. It is not reasonable or necessary for a provider to perform qualitative point-of-care testing and also order presumptive testing from a reference laboratory on the same specimen.
 - b. It is not reasonable or necessary for a provider to perform presumptive immunoassay testing and also order presumptive immunoassay testing from a reference laboratory with or without reflex testing on the same specimen.

Procedure Codes

The following is not an all-encompassing code list. The inclusion of a code does not guarantee it is a covered service or eligible for reimbursement.

Code	Description
80305	DRUG TEST PRSMV DIR OPT OBS
80306	DRUG TEST PRSMV INSTRMNT
80307	DRUG TEST PRSMV CHEM ANALYZR
80320-80377	DEFINITIVE DRUG CLASSES
0007U	RX TEST PRSMV UR W/DEF CONF
0011U	U RX MNTR LC-MS/MS ORAL FLUID
0051U	RX MNTR LC-MS/MS UR/BLD 31
0054U	RX MNTR 14+ DRUGS & SBSTS
0079U	CMPRTV DNA ALYS MLT SNPS
0082U	RX TEST DEF 90+ RX/SBSTS UR
0093U	RX MNTR 65 COM DRUGS URINE
0227U	RX ASY PRSMV 30+RX/METABLT
0328U	DRUG ASSAY 120+ RX and METABLT
0517U	THER RX MNTR 80+ PSYACTIV RX
0518U	THER RX MNTR 90+ PN&MTL HLTH
0519U	THER RX MNTR MEDS P/D/A 110+
0520U	THER RX MNTR 200+ RX/SBSTS
0587U	THER RX MNTR 60-150RX&METABL
0603U	RX ASY PRSMV 77RX/METABLT UR
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0482	Drug test def 15-21 classes
G0483	Drug test def 22+ classes
G0659	Drug test def simple all classes

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Additional Resources

Reimbursement Policy (formerly known as Clinical Payment and Coding Policy)

CPCP020 Drug Testing (may apply for certain health benefit plans)

References

1. Hoffman R. Urine drug testing. Updated October 7, 2024. <https://www.uptodate.com/contents/urine-drug-testing>
2. Jones J. Clinical vs. Forensic: The Differences Cost More Than Just Money. United States Drug Testing Laboratories. <http://www.usdtl.com/media/mediaarticles/clinical-vs-forensic-the-differences-cost-more-than-just-money>
3. Eaton K, Lyman G. Dosing of anticancer agents in adults. Updated October 22, 2025. <https://www.uptodate.com/contents/dosing-of-anticancer-agents-in-adults>
4. National Center for Drug Abuse Statistics. Drug Abuse Statistics <https://drugabusestatistics.org/>
5. Phan HM, Yoshizuka K, Murry DJ, Perry PJ. Drug testing in the workplace. *Pharmacotherapy*. 2012;32(7):649-56. doi:10.1002/j.1875-9114.2011.01089.x
6. ASAM. Appropriate Use of Drug Testing in Clinical Addiction Medicine. 2017. <https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf>
7. Jannetto PJ, Langman LJ. Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. *The Journal of Applied Laboratory Medicine: An AACC Publication*. 2018;2(4):471-472. doi:10.1373/jalm.2017.025304
8. Becker W, Starrels J. Prescription drug misuse: Epidemiology, prevention, identification, and management. Updated January 8, 2026. <https://www.uptodate.com/contents/prescription-drug-misuse-epidemiology-prevention-identification-and-management>
9. Pesce A, West C, Egan City K, Strickland J. Interpretation of urine drug testing in pain patients. *Pain medicine (Malden, Mass)*. 2012;13(7):868-85. doi:10.1111/j.1526-4637.2012.01350.x
10. Chua I, Petrides AK, Schiff GD, et al. Provider Misinterpretation, Documentation, and Follow-Up of Definitive Urine Drug Testing Results. *J Gen Intern Med*. 2020;35(1):283-290. doi:10.1007/s11606-019-05514-5
11. Owusu Obeng A, Hamadeh I, Smith M. Review of Opioid Pharmacogenetics and Considerations for Pain Management. *Pharmacotherapy*. 2017;37(9):1105-1121. doi:10.1002/phar.1986
12. Trescot AM, Datta S, Lee M, Hansen H. Opioid pharmacology. *Pain physician*. 2008;11(2 Suppl):S133-53. <https://www.painphysicianjournal.com/current/pdf?article=OTg3&journal=42>
13. CDC. U.S. Opioid Dispensing Rate Maps. Updated February 11, 2026. <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/us-dispensing-rate-maps.html>
14. CDC. Drug Overdose Deaths. <https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm>
15. CDC. Data Resources. <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/index.html>
16. Pesce A, Krock K, Ritz D, Cua A, Thomas R, Nickley J. Observations on 6-MAM (6-Monoacetylmorphine) in Urine. *J Clin Toxicol*. 2018;8(393):2161-0495.1000393.

-
17. Weaver MF. Prescription Sedative Misuse and Abuse. *The Yale journal of biology and medicine*. 2015;88(3):247-56.
 18. Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. *Jama*. 2013;309(7):657-9. doi:10.1001/jama.2013.272
 19. Greller H, Gupta A. Benzodiazepine poisoning. Updated August 25, 2025. <https://www.uptodate.com/contents/benzodiazepine-poisoning>
 20. Blank A, Hellstern V, Schuster D, et al. Efavirenz treatment and false-positive results in benzodiazepine screening tests. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2009;48(12):1787-9. doi:10.1086/599109
 21. Kandel DB, Hu MC, Griesler P, Wall M. Increases from 2002 to 2015 in prescription opioid overdose deaths in combination with other substances. *Drug and alcohol dependence*. 2017;178:501-511. doi:10.1016/j.drugalcdep.2017.05.047
 22. Eskridge KD, Guthrie SK. Clinical issues associated with urine testing of substances of abuse. *Pharmacotherapy*. 1997;17(3):497-510.
 23. Algren DA, Christian MR. Buyer Beware: Pitfalls in Toxicology Laboratory Testing. *Missouri medicine*. 2015;112(3):206-10.
 24. ALFA. CLIAwaived, Inc. https://www.cliawaived.com/web/items/pdf/ALF_03_3152_1_Panel_Drug_Test_Insert~493file1.pdf
 25. Wondfo. Drug Tests Strip. <https://en.wondfo.com/vancheerfile/files/2023/3/20230313023235769.pdf>
 26. Moeller KE, Kissack JC, Atayee RS, Lee KC. Clinical Interpretation of Urine Drug Tests: What Clinicians Need to Know About Urine Drug Screens. *Mayo Clinic proceedings*. 2017;92(5):774-796. doi:10.1016/j.mayocp.2016.12.007
 27. Kampman K. Stimulant use disorder: Treatment overview. Updated February 12, 2026. <https://www.uptodate.com/contents/stimulant-use-disorder-treatment-overview>
 28. Microgenics. DRI(r) Amphetamines Assay. Microgenics Corporation. <http://tools.thermofisher.com/content/sfs/manuals/0138-DRI-Amphetamines-Assay-EN.pdf>
 29. Fucci N. False positive results for amphetamine in urine of a patient with diabetes mellitus. *Forensic science international*. 2012;223(1-3):e60. doi:10.1016/j.forsciint.2012.08.010
 30. Bertron JL, Seto M, Lindsley CW. DARK Classics in Chemical Neuroscience: Phencyclidine (PCP). *ACS Chem Neurosci*. 2018;9(10):2459-2474. doi:10.1021/acscchemneuro.8b00266
 31. Microgenics. CEDIA(r) Phencyclidine (PCP) Assay. Microgenics Corporation. <http://tools.thermofisher.com/content/sfs/manuals/10007400-CEDIA-Phencyclidine-PCP-Assay-EN.pdf>
 32. Ly BT, Thornton SL, Buono C, Stone JA, Wu AH. False-positive urine phencyclidine immunoassay screen result caused by interference by tramadol and its metabolites. *Annals of emergency medicine*. 2012;59(6):545-7. doi:10.1016/j.annemergmed.2011.08.013
 33. Rengarajan A, Mullins ME. How often do false-positive phencyclidine urine screens occur with use of common medications? *Clinical toxicology (Philadelphia, Pa)*. 2013;51(6):493-6. doi:10.3109/15563650.2013.801982

-
34. Levine BS, Smith ML. Effects of diphenhydramine on immunoassays of phencyclidine in urine. *Clinical chemistry*. 1990;36(6):1258.
 35. Brahm NC, Yeager LL, Fox MD, Farmer KC, Palmer TA. Commonly prescribed medications and potential false-positive urine drug screens. *American journal of health-system pharmacy : AJHP : official journal of the American Society of Health-System Pharmacists*. 2010;67(16):1344-50. doi:10.2146/ajhp090477
 36. FDA. 510(k) Substantial Equivalence Determination Decision Summary Assay Only Template https://www.accessdata.fda.gov/cdrh_docs/reviews/K112395.pdf
 37. CDC. Nationwide Trends. <https://www.drugabuse.gov/publications/drugfacts/nationwide-trends>
 38. Miech RA, Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. Monitoring the Future: National Survey Results on Drug Use, 1975-2014. 2015. https://monitoringthefuture.org/wp-content/uploads/2022/08/mtf-vol1_2014.pdf
 39. Altunkaya D, Smith RN. Aberrant radioimmunoassay results for cannabinoids in urine. *Forensic science international*. 1990;47(3):195-205.
 40. Rollins DE, Jennison TA, Jones G. Investigation of interference by nonsteroidal anti-inflammatory drugs in urine tests for abused drugs. *Clinical chemistry*. 1990;36(4):602-6.
 41. Herrmann ES, Cone EJ, Mitchell JM, et al. Non-smoker exposure to secondhand cannabis smoke II: Effect of room ventilation on the physiological, subjective, and behavioral/cognitive effects. *Drug and alcohol dependence*. 2015;151:194-202. doi:10.1016/j.drugalcdep.2015.03.019
 42. Cone EJ, Bigelow GE, Herrmann ES, et al. Non-smoker exposure to secondhand cannabis smoke. I. Urine screening and confirmation results. *Journal of analytical toxicology*. 2015;39(1):1-12. doi:10.1093/jat/bku116
 43. Vohra V, Marraffa JM, Wojcik SM, Eggleston W. An assessment of urine THC immunoassay in healthy volunteers receiving an oral proton-pump inhibitor. *Clinical toxicology (Philadelphia, Pa)*. 2019;1-3. doi:10.1080/15563650.2019.1662917
 44. Drake LR, Scott PJH. DARK Classics in Chemical Neuroscience: Cocaine. *ACS Chem Neurosci*. 2018;9(10):2358-2372. doi:10.1021/acschemneuro.8b00117
 45. Nelson L. Cocaine: Acute intoxication. Updated July 21, 2025. <https://www.uptodate.com/contents/cocaine-acute-intoxication>
 46. CDC. Stimulant Overdose. Updated July 17, 2025. <https://www.cdc.gov/overdose-prevention/about/stimulant-overdose.html>
 47. FDA. DRI Cocaine Metabolite Assay. https://www.accessdata.fda.gov/cdrh_docs/pdf18/K181499.pdf
 48. Michna E, Jamison RN, Pham LD, et al. Urine toxicology screening among chronic pain patients on opioid therapy: frequency and predictability of abnormal findings. *The Clinical journal of pain*. 2007;23(2):173-9. doi:10.1097/AJP.0b013e31802b4f95
 49. Knezevic NN, Khan OM, Beiranvand A, Candido KD. Repeated Quantitative Urine Toxicology Analysis May Improve Chronic Pain Patient Compliance with Opioid Therapy. *Pain physician*. 2017;20(2s):S135-s145.
 50. Jamison RN, Ross EL, Michna E, Chen LQ, Holcomb C, Wasan AD. Substance misuse treatment for high-risk chronic pain patients on opioid therapy: a randomized trial. *Pain*. 2010;150(3):390-400. doi:10.1016/j.pain.2010.02.033

-
51. Katz NP, Sherburne S, Beach M, et al. Behavioral monitoring and urine toxicology testing in patients receiving long-term opioid therapy. *Anesthesia and analgesia*. 2003;97(4):1097-102, table of contents.
 52. Starrels JL, Becker WC, Alford DP, Kapoor A, Williams AR, Turner BJ. Systematic review: treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. *Annals of internal medicine*. 2010;152(11):712-20. doi:10.7326/0003-4819-152-11-201006010-00004
 53. Christo PJ, Manchikanti L, Ruan X, et al. Urine drug testing in chronic pain. *Pain physician*. 2011;14(2):123-43.
 54. Owen GT, Burton AW, Schade CM, Passik S. Urine drug testing: current recommendations and best practices. *Pain physician*. 2012;15(3 Suppl):Es119-33. <https://www.texaspain.org/assets/udt-article.pdf>
 55. Smith PE, McBride A. Illicit drugs and seizures. *Seizure*. 1999;8(8):441-3. doi:10.1053/seiz.1999.0346
 56. Wilfong A. Management of convulsive status epilepticus in children. Updated April 28, 2025. <https://www.uptodate.com/contents/management-of-convulsive-status-epilepticus-in-children>
 57. McClellan J, Stock S. Practice Parameter for the Assessment and Treatment of Children and Adolescents With Schizophrenia. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2013;52(9):976-990. doi:10.1016/j.jaac.2013.02.008
 58. Farkas A, Lipanot K, Sherman K. Routine Laboratory Screening for Acetaminophen and Salicylate Ingestion in Preadmission Psychiatric Patients Is Unnecessary. *Annals of emergency medicine*. 2021;77(6):604-612. doi:10.1016/j.annemergmed.2021.01.027
 59. Kell MJ. Utilization of plasma and urine methadone concentrations to optimize treatment in maintenance clinics: I. Measurement techniques for a clinical setting. *Journal of addictive diseases*. 1994;13(1):5-26. doi:10.1300/J069v13n01_02
 60. Couto JE, Webster L, Romney MC, Leider HL, Linden A. Use of an algorithm applied to urine drug screening to assess adherence to a hydrocodone regimen. *Journal of clinical pharmacy and therapeutics*. 2011;36(2):200-7. doi:10.1111/j.1365-2710.2010.01236.x
 61. Couto JE, Webster L, Romney MC, Leider HL, Linden A. Use of an algorithm applied to urine drug screening to assess adherence to an oxycontin regimen. *Journal of opioid management*. 2009;5(6):359-64.
 62. Nafziger AN, Bertino JS, Jr. Utility and application of urine drug testing in chronic pain management with opioids. *The Clinical journal of pain*. 2009;25(1):73-9. doi:10.1097/AJP.0b013e31817e13cc
 63. McEvoy J, Millet RA, Dretchen K, Morris AA, Corwin MJ, Buckley P. Quantitative levels of aripiprazole parent drug and metabolites in urine. *Psychopharmacology*. 2014;231(23):4421-8. doi:10.1007/s00213-014-3781-1
 64. 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;20(2s):Se1-se9.
 65. Vopat ML, Messamore WG, Trent JJ, et al. Urine Screening for Opioid and Illicit Drugs in the Total Joint Arthroplasty Population. *Kans J Med*. 2020;13:71-76.

-
66. Palamar JJ, Le A, Guarino H, Mateu-Gelabert P. A comparison of the utility of urine- and hair testing in detecting self-reported drug use among young adult opioid users. *Drug and alcohol dependence*. 2019;200:161-167. doi:10.1016/j.drugalcdep.2019.04.008
 67. Böttcher M, Lierheimer S, Peschel A, Beck O. Detection of heroin intake in patients in substitution treatment using oral fluid as specimen for drug testing. *Drug and alcohol dependence*. 2019;198:136-139. doi:10.1016/j.drugalcdep.2019.02.011
 68. Krasowski MD, McMillin GA, Melanson SEF, Dizon A, Magnani B, Snozek CLH. Interpretation and Utility of Drug of Abuse Screening Immunoassays: Insights From Laboratory Drug Testing Proficiency Surveys. *Arch Pathol Lab Med*. 2020;144(2):177-184. doi:10.5858/arpa.2018-0562-CP
 69. Argoff CE, Alford DP, Fudin J, et al. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. *Pain medicine (Malden, Mass)*. 2018;19(1):97-117. doi:10.1093/pm/pnx285
 70. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1-95. doi:10.15585/mmwr.rr7103a1
 71. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. *MMWR Recomm Rep*. 2016;65(1):1-49. doi:10.15585/mmwr.rr6501e1
 72. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain <https://www.cdc.gov/mmwr/volumes/71/rr/pdfs/rr7103a1-h.pdf>
 73. Kale N. Urine Drug Tests: Ordering and Interpreting Results. *American family physician*. 2019;99(1):33-39.
 74. AAFP. Clinical Preventive Service Recommendation Opioid Use Disorder (OUD): Screening. <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/oud.html>
 75. FSMB. Guidelines for the Chronic Use of Opioid Analgesics. Federation of State Medical Boards. https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/opiod_guidelines_as_adopted_april-2017_final.pdf
 76. FSMB. Strategies for Prescribing Opioids for the Management of Pain. <https://www.fsmb.org/siteassets/advocacy/policies/strategies-for-prescribing-opioids-for-the-management-of-pain.pdf>
 77. AAPM. Use of Opioids for the Treatment of Chronic Pain. <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/pain-management-toolkit/docs/use-of-opioids-for-the-treatment-of-chronic-pain.ashx>
 78. Chou R, Fanciullo GJ, Fine PG, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *The Journal of Pain*. 2009;10(2):113-130.e22. doi:10.1016/j.jpain.2008.10.008
 79. Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. *Pain physician*. 2012;15(3 Suppl):S67-116.
 80. 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.

-
81. AMDG. Interagency Guideline on Prescribing Opioids for Pain.
<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>
 82. AMDG. Supplemental Guidance on Prescribing Opioids for Postoperative Pain.
<http://agencymeddirectors.wa.gov/Files/FinalSupBreeAMDGPostopPain091318wcover.pdf>
 83. DWD. Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. Department of Workforce Development, State of Wisconsin.
 84. ASAM. Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM).
 85. Jarvis M, Williams J, Hurford M, et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. *Journal of addiction medicine*. 2017;11(3):163-173.
doi:10.1097/adm.0000000000000323
 86. Brunner E, Chen CA, Klein T, et al. Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits. *J Gen Intern Med*. Sep 2025;40(12):2814-2859. doi:10.1007/s11606-025-09499-2
 87. OASAS. The Role of Toxicology Testing in Person-Centered Substance Use Disorder Treatment. <https://oasas.ny.gov/toxicology-testing-guidance-oasas-certified-programs>
 88. Nuckols TK, Anderson L, Popescu I, et al. Opioid prescribing: a systematic review and critical appraisal of guidelines for chronic pain. *Annals of internal medicine*. 2014;160(1):38-47. doi:10.7326/0003-4819-160-1-201401070-00732
 89. SAMHSA. Federal Guidelines for Opioid Treatment Programs.
<https://www.med.unc.edu/fammed/nctac/wp-content/uploads/sites/1256/2025/01/federal-guidelines-opioid-treatment-pep24-02-011-1.pdf>
 90. SAMHSA. Mandatory Guidelines for Federal Workplace Drug Testing Programs—Oral/Fluid
https://www.samhsa.gov/sites/default/files/programs_campaigns/division_workplace_programs/final-mg-oral-fluid.pdf
 91. AATOD. Guidelines for Addressing Benzodiazepine Use in Opioid Treatment Programs (OTPs). <https://www.aatod.org/advocacy/policy-statements/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps-april-6-2017/>
 92. HHS. Mandatory Guidelines for Federal Workplace Drug Testing Programs. Federal Register. <https://www.federalregister.gov/documents/2023/10/12/2023-21735/mandatory-guidelines-for-federal-workplace-drug-testing-programs>
 93. PMFT. Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations- Final Report.
<https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf>
 94. WFSBP. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia Part 3: Update 2015 Management of special circumstances: Depression, Suicidality, substance use disorders and pregnancy and lactation
 95. NICE. Epilepsies: diagnosis and management. <https://www.nice.org.uk/guidance/ng217>
 96. AAN. Diagnostic Assessment of The Child With Status Epilepticus.
<https://www.aan.com/Guidelines/home/GuidelineDetail/234>

97. DVA, DOD. VA/DoD Clinical Practice Guideline for The Management Of Substance Use Disorders.
98. DVA, DOD. VA/DoD Clinical Practice Guideline for Opioid Therapy For Chronic Pain. <https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf>
99. DVA, DOD. VA/DOD Clinical Practice Guideline for The Management Of Pregnancy. https://www.healthquality.va.gov/guidelines/WH/up/VA-DoD-CPG-Pregnancy-Full-CPG_508.pdf
100. Katzman MA, Bleau P, Blier P, et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC psychiatry*. 2014;14 Suppl 1(Suppl 1):S1-S1. doi:10.1186/1471-244X-14-S1-S1
101. APA. The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults. <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>
102. WHO. mhGAP Intervention Guide. <https://iris.who.int/bitstream/handle/10665/250239/9789241549790-eng.pdf>
103. ACOG. Opioid Use and Opioid Use Disorder in Pregnancy.
104. Wong S, Ordean A, Kahan M. Substance use in pregnancy. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC*. 2011;33(4):367-384. doi:10.1016/s1701-2163(16)34855-1
105. Ordean A, Wong S, Graves L. No. 349-Substance Use in Pregnancy. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC*. 2017;39(10):922-937.e2. doi:10.1016/j.jogc.2017.04.028
106. Grant CN, Bélanger RE. Position Statement: Cannabis and Canada's children and youth. *Pediatric Child Health*. 2023;22(2):98-102.
107. Bélanger SA, Andrews D, Gray C, Korczak D. ADHD in children and youth: Part 1- Etiology, diagnosis, and comorbidity. *Paediatr Child Health*. 2018;23(7):447-453. doi:10.1093/pch/pxy109

Policy History

Approval Date	Description
05/15/2026	09/04/2026; Document updated with literature review. The following changes were made to Reimbursement Information: Added "(no more than 24 times per year)" to #1 and #2 to provide clarity and transparency on the number of tests allowed in a year to align with the remainder of the Reimbursement Information. References revised.
01/07/2026	04/24/2026; Added code 0603U. No other changes.
09/05/2025	01/01/2026: New policy.