MEDICAL POLICY

Medical Policy Title	**Urine Drug Testing**
Policy Number	**2.02.50**
Current Effective Date	**October 22, 2026**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

Presumptive Drug Testing for Pain Management

I. Presumptive (immunoassay) urine drug testing, in office or at point-of-care, for outpatient pain management, is considered **medically appropriate** for **EITHER** of the following indications:

   A. Baseline screening before or at the time treatment is initiated when **ALL** of the following conditions are met:

      1. An adequate clinical assessment of patient history and risk of substance use disorder (SUD) is performed;
      2. Clinicians have knowledge of test interpretation; **and**
      3. There is a plan in place regarding how to use test findings clinically; **or**

   B. Subsequent monitoring of treatment at a frequency appropriate for the risk level of the individual patient (please refer to Policy Guidelines).

Presumptive Drug Testing for Substance Use Treatment

II. Presumptive (immunoassay) urine drug testing, in office or at point-of-care, for outpatient substance use treatment, is considered **medically appropriate** for **EITHER** of the following indications:

   A. Baseline screening before or at the time treatment is initiated, when **ALL** of the following conditions are met:

      1. One (1) time per program entry;
      2. An adequate clinical assessment of patient history and risk of SUD is performed;
      3. Clinicians have knowledge of test interpretation; **and**
      4. There is a plan in place regarding how to use test findings clinically; **or**

   B. Subsequent monitoring of treatment, either during a stabilization or maintenance phase at a frequency appropriate for the risk level of the individual patient (please refer to Policy Guidelines).

Definitive Drug Testing for Pain or Substance Use

III. Definitive urine drug testing, in outpatient pain management or substance use treatment, is considered **medically appropriate** in **ANY** of the following circumstances:

A. When presumptive urine drug testing is unable to identify the following:

1. A specific substance or metabolite;
2. Specific drugs in a large family of drugs;
3. A specific substance or metabolite that is not detectable by qualitative urine drug testing (e.g., fentanyl, meperidine, synthetic cannabinoids);
4. A negative qualitative urine drug test result (or to confirm a positive result) that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan; **or**
5. A non-prescribed medication or illicit use, to ensure the safe ongoing prescription of controlled substances;

B. When a definitive concentration of a drug is needed to guide management (e.g., discontinuance of THC use according to a treatment plan);

C. To rule out an error as the cause of a qualitative urine drug testing result;

D. When used as part of a differential assessment of medication efficacy, side effects, or drug-drug- interactions.

RELATED POLICIES

Not Applicable

POLICY GUIDELINE(S)

I. Testing frequency is dependent on the stability of the patient, the type of treatment, the treatment setting and the half-life of drugs in the matrix being tested.

II. 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.

III. Testing should be performed randomly or selectively based on patient history.

IV. Testing should not be performed as part of standard protocols (e.g., routine standing orders).

V. Testing should be supported by both an order for the test and rationale for the testing.

VI. The medical record should include documentation that the results were reviewed and will impact patient care.

VII. Presumptive urine drug testing (UDT) for opioid pain management should be part of the pain management strategy and may be performed as follows:

A. Prior to initiating opioid therapy.

B. Every three (3) months to assess effectiveness of the prescribed dose and decisions regarding tapering or increasing the dose are planned.

C. At least annually.

VIII. For end-of-life pain management with opioids, testing is indicated if there is any reason to consider diversion of the drug (lost scripts, lost pills, enormous escalation of utilization without member appearing to have consumed the specific amount of opioids).

IX. Frequency of presumptive urine drug testing for substance use disorder is based on the consecutive days of abstinence as follows:

A. 0 to 30 days consecutive abstinence: One (1) to three (3) presumptive urine drug tests per week. Requests for coverage of more than three (3) presumptive urine drug tests per week must be accompanied by clinical documentation to support additional testing.

B. 31 to 90 consecutive days of abstinence: One (1) to three (3) presumptive urine drug tests per week. Requests for coverage of more than three (3) presumptive urine drug tests per week must be accompanied by clinical documentation to support additional testing.

C. Greater than 90 consecutive days of abstinence: One (1) to three (3) presumptive urine drug tests per month.

1. Requests for coverage of more than three (3) physician-directed presumptive urine drug tests in one (1) month must be accompanied by clinical documentation to support additional testing. (e.g., Contingency management in SUD is over a 10-week to 12-week period.)

X. Definitive urine drug testing for opioid pain management may be performed to detect specific opioids that cannot be identified on standard immunoassays or in the event of unexpected urine drug test results.

XI. Frequency of definitive urine drug testing and the rationale for testing must be documented in the patient's medical record. Frequency is based on the following consecutive days of abstinence, as follows:

A. Zero (0) to 30 days consecutive days of abstinence: One (1) physician-directed testing profile per week. Requests for coverage of more frequent definitive urine drug tests in one (1) week must be accompanied by clinical documentation to support additional testing.

B. 31 to 90 consecutive days of abstinence: One (1) to three (3) physician-directed testing profile(s) per month. Requests for coverage of more than three (3) definitive urine drug tests in one month must be accompanied by clinical documentation to support additional testing.

C. Greater than 90 consecutive days of abstinence: One (1) to three (3) physician-directed

testing profile(s) per three-month period. Requests for more than three (3) definitive urine drug tests in a three-month period must be accompanied by clinical documentation to support additional testing.

XII. Frequency of urine drug testing for individuals on chronic opioid therapy depends on the risk of opioid misuse and/or the existence of an opioid disorder. Frequency of testing ranges from:

A. Low risk: One (1) to two (2) times per twelve (12) month period

B. Moderate risk: One (1) to two (2) times per six (6) month period

C. High risk: One (1) to three (3) times per three-month period for prescribed medications, non-prescribed medications that may pose a safety risk if mixed with prescribed medications, and illicit substances based on patient history, clinical presentation and/or community usage.

DESCRIPTION

Drug testing is a vital part of addiction assessment and treatment planning, especially when combined with other clinical tools like substance use history, physical and mental evaluations, withdrawal severity scores, and standardized lab assessments (ASAM, 2013). Skilled clinicians use drug testing to verify self-reports, confirm diagnoses, identify denial or minimization, enhance treatment motivation, monitor progress, and validate abstinence or adherence to prescribed medications. Contingency management, which rewards abstinence, is one example of an effective intervention. Urine drug testing is especially important during the intensive “primary treatment” phase, which includes psychosocial support, psychoeducation, psychotherapy, and cognitive-behavioral strategies. Random and frequent testing should be maintained throughout this phase. In the post-treatment monitoring phase, continued random testing remains central, supporting long-term recovery and abstinence. Testing should be unpredictable and more frequent early in treatment, with reduced frequency as abstinence stabilizes. Varying the testing panels and methods further strengthens its effectiveness.

Categories of Urine Drug Testing

- Presumptive Drug Testing (Screening) detects the presence or absence of drugs in urine when immediate results are needed for patient care. Common methods include immunoassays (IA) and thin layer chromatography (TLC). IAs, which can be lab-based or point-of-care (e.g., a physician’s office), use antibodies to detect drugs through competitive binding. The amount of labeled drug that binds to the antibody is inversely related to the drug concentration in the sample.

  IA formats include cups, dipsticks, cassettes, or strips, read visually or with instruments. They vary in specificity—some detect individual drugs, others only drug classes—and may miss structurally similar substances. Cross-reactivity with other medications is possible but less common due to improved antibodies.

  The most common tests SAMHSA-5 panel tests for amphetamines, THC, cocaine, opiates (e.g., codeine, morphine), and PCP. Panels can be expanded to include benzodiazepines and synthetic/semi-synthetic opioids like oxycodone, buprenorphine, and methadone. Results are

qualitative—positive (above threshold) or negative (below threshold)—and do not confirm drug absence. IA tests offer rapid results: minutes for onsite, 1–4 hours for lab-based.

- Definitive (Confirmatory) Testing identifies specific drugs and metabolites by analyzing their molecular structures. It confirms results from screening, evaluates and detects substances not identifiable by immunoassays (IAs). These lab-based tests quantify drug levels in urine and report exact concentrations.

Common methods include:

- Gas Chromatography-Mass Spectrometry (GC-MS): The gold standard for confirmatory testing. It separates and identifies compounds but typically requires prior specification of target drugs. Turnaround is several days.
- Liquid Chromatography-Tandem Mass Spectrometry (LC-MS/MS): Faster and easier than GC-MS, it uses two mass spectrometers for enhanced detection without needing derivatization.
- Quantitative or confirmation testing can be performed as a reflex test which is performed after an initial test result to identify further diagnostic information.

Urine drug tests are vulnerable to tampering, including dilution (e.g., excessive water intake), commercial adulterants, and synthetic urine. Some tampering can be detected through visual inspection or onsite checks of temperature, creatinine, and specific gravity.

Accurate interpretation requires understanding drug metabolites and manufacturing byproducts. For example, trace hydrocodone in patients prescribed oxycodone may be acceptable due to manufacturing impurities.

Urine testing is commonly used at treatment initiation to assess current drug use. While routine universal screening may detect more misuse and reduce stigma, it can strain healthcare resources and affect trust. Selective testing based on risk assessment is an alternative. Protocols vary, some confirm all positive qualitative results with quantitative tests, while others confirm only unexpected results or those involving drugs with unreliable immunoassays.

SUPPORTIVE LITERATURE

Choucair et al (2024) studied the use of DART-MS/MS as a faster and more efficient alternative to traditional opioid detection methods in clinical laboratories. Current practices typically involve IA screening followed by LC-MS/MS confirmation, which, while accurate, are time-consuming and require extensive sample preparation. The researchers optimized DART-MS/MS by adjusting variables like temperature, extraction methods, and hydrolysis times, and evaluated its performance across 12 opioids. The method demonstrated high sensitivity and specificity for several opioids, including fentanyl, codeine, and hydrocodone, but was less effective for others like morphine and oxycodone. The study concludes that DART-MS/MS shows promise as a rapid, quantitative tool for opioid testing in urine, though further research is needed to broaden its clinical applications.

Magura et al (2023) investigated the comparative effectiveness of two drug testing methodologies—presumptive testing and direct-to-definitive testing—using two biological matrices: oral fluid and urine. A total of 1098 samples (urine and oral fluid) from individuals applying for methadone

treatment were collected. All samples were evaluated via IA and LC-MS/MS. Presumptive testing, typically performed with IA, offers rapid screening but is susceptible to false positives and negatives due to limited specificity and cross-reactivity. Direct-to-definitive testing, using advanced techniques like LC-MS/MS, provides highly accurate identification of drug compounds without the need for preliminary screening. The study analyzes a national sample of individuals misusing drugs to evaluate detection windows, analyte coverage, and diagnostic accuracy across both matrices. Urine testing is traditionally favored for its longer detection window and regulatory acceptance, while oral fluid testing is less invasive and better suited for detecting recent drug use. The findings aim to inform clinical and forensic toxicology practices by highlighting the trade-offs between speed, accuracy, and operational efficiency in drug testing protocols.

PROFESSIONAL GUIDELINE(S)

The American Society for Addiction Medicine (ASAM) updated its guidelines on Appropriate Use of Drug Testing in Clinical Addiction (2017). The guidelines include the following recommendations:

- Drug testing should be used widely in addiction treatment settings because evidence suggests that drug testing assists with monitoring adherence and abstinence in treatment and can improve patient outcomes and should be used in combination with a patient's self-reported information about substance use. Providers should understand that drug tests are designed to measure whether a substance has been used within a particular window of time and drug testing panels should be based on the patient's drug of choice, prescribed medications, and drugs commonly used in the patient's geographic location and peer group.
- Presumptive testing should be a routine part of initial and ongoing patient assessment, as it can provide more immediate (albeit less accurate) results. Definitive testing techniques should be used whenever a provider wants to detect specific substances not identified by presumptive methods, to quantify levels of the substance present, and to refine the accuracy of the results; and the results inform clinical decisions that have major clinical or non-clinical implications for the patient (e.g. treatment transition, changes in medication therapies, changes in legal status).
- For people in addiction treatment, frequency of testing should be dictated by patient acuity and level of care, and 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 least weekly) at the beginning of treatment, and the frequency should be decreased to monthly as recovery progresses and is stable.
- Testing should occur on a random schedule in outpatient services following weekends, holidays, and paydays, when feasible because the patient's opportunity for substance use is greater relative to residential treatment. Additional drug testing should be considered if a patient is experiencing stressful psychological events.

The ASAM published a National Practice Guideline for the Treatment of Opioid Use Disorder (2020)

which identifies the following:

- Urine drug testing can be used during assessment and diagnosis to validate patient self-reported information and to identify poly-substance use.
- Testing can be used to monitor patients for adherence to medication and for use of illicit and controlled substances during treatment.
- The frequency of drug testing is determined by a number of factors including the stability of the patient, type of treatment and treatment setting. The guideline also notes that no further clarification was found in the literature related to urine drug testing and this is considered a gap in literature.

The American Society of Interventional Pain Physicians (ASIPP) 2023 updated guidelines for opioids for chronic noncancer pain and made the following recommendations for urine drug testing:

- Urine drug monitoring (UDM) should be implemented at the initiation of opioid therapy and conducted periodically for monitoring therapeutic compliance as per available guidance referential to mode and frequency of testing. (Evidence Level: Moderate; Strength of Recommendation: Strong).
- Tapering or weaning processes must be initiated slowly after appropriate criteria have been met and should entail slow tapering of the dosage across a specified period of time. Reinstitution of opioid therapy can be considered when such treatment is deemed medically necessary if the patient's behavior and pattern of drug use are shown to be stable, and if results of at least two consistent urine drug tests are negative (for opioids and/or illicit drugs). (Evidence Level: Moderate; Strength of Recommendation: Moderate).
- Adherence monitoring to assess and sustain appropriate use must be instituted at proper intervals, as based on risk stratification and indication(s) of other issues that may be regarded as negatively influencing therapeutic compliance. Evidence Level: Moderate; Strength of recommendation: Moderate

In 2014, the American College of Occupational and Environmental Medicine (ACOEM) updated its guidelines for Opioids for Treatment of Acute Subacute, Chronic, and Postoperative Pain chronic use of opioids and recommends:

- Baseline and random urine drug screening, qualitative and quantitative, for patients prescribed opioids for the treatment of subacute or chronic pain to evaluate presence or absence of the drug, its metabolites and other substance(s) use. In certain situations, other screenings (e.g., hair particularly for information regarding remote use or blood) (for acute toxicity) may be appropriate. (C; High Confidence).

The Centers for Disease and Control Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (2022) recommends:

- 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 (recommendation

category: B, evidence type 4).

- If clinicians suspect their patient might be sharing or selling opioids and not taking them, clinicians should consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal. A negative drug test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result.
- Experts agreed that, prior to starting opioids for chronic pain, and periodically during opioid therapy, clinicians should use urine drug testing to assess for prescribed opioids, as well as other controlled substances and illicit drugs that increase the risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, and heroin.
- Most Experts agreed that urine drug testing at least annually for all patients was reasonable. Some experts noted that this interval might be too long in some cases and too short in others, and that the follow-up intervals should be left to the discretion of the clinician.
- In most situations, initial urine drug testing can be performed with a relatively inexpensive IA panel for commonly prescribed opioids and illicit drugs. Patients who are prescribed less-commonly-used opioids might require specific testing for those agents. The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard IAs or on the presence of unexpected urine drug test results.
- Clinicians should not test for substances for which results would not affect patient management or for which implications for patient management are unclear.
- Clinicians should be familiar with the drugs included in urine drug testing panels used in their practice and should understand how to interpret results for these drugs. Before ordering urine drug testing, clinicians should have a plan for responding to unexpected results.
- Clinicians should explain to patients that urine drug testing is intended to improve their safety, they should also explain expected results (e.g., presence of prescribed medication and absence of drugs, including illicit drugs, not reported by the patient).
- Clinicians should ask patients about use of prescribed and other drugs and ask whether there might be unexpected results. This will provide an opportunity for patients to provide information about changes in their use of prescribed opioids or other drugs.
- Clinicians should use unexpected results to improve patient safety (e.g., changing in pain management, tapering or discontinuing opioids, re-evaluating more frequently, offering naloxone, or referring for treatment for substance use disorder, all as appropriate). If tests for prescribed opioids are repeatedly negative, confirming that the patient is not taking the prescribed opioid, clinicians can discontinue the prescription without a taper.
- Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety.

REGULATORY STATUS

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service. Laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA).

Laboratories that offer laboratory-developed tests must be licensed by CLIA for high-complexity testing. More information is available at: Clinical Laboratory Improvement Amendments (CLIA) | FDA [accessed 2026 Sep 24]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
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 (e.g., utilizing immunoassay [e.g., 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 (e.g., utilizing immunoassay [e.g., 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 (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography (e.g., DART, DESI, GC-MS, GCMS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
80320-80373	Definitive drug testing (code range)
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3 analytes
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6 analytes
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more analytes
83992	Phencyclidine (PCP)

Code	Description
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service (ToxProtect, Genotox Laboratories, Ltd)
0051U	Prescription drug monitoring, evaluation of drugs present by liquid chromatography tandem mass spectrometry (LC-MS/MS), urine or blood, 31 drug panel, reported as quantitative results, detected or not detected, per date of service (UCompliDx, Elite Medical Laboratory Solutions, LLC)
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service (NextGen Precision™ Testing, Precision Diagnostics LBN Precision Toxicology, LLC)
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected (ComplyRX, Claro Labs)
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain (Foundation PI℠, Ethos Laboratories)
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation (Comprehensive Screen, Aspenti Health)
0328U	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service (CareView360, Newstar Medical Laboratories LLC)

Code	Description
0603U	Drug assay, presumptive, 77 drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS), results reported as positive or negative (SLL Comprehensive Drug Analysis, Soft Landing Labs)

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HCPCS Codes

Code	Description
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, 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 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

Code	Description
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 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 (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

ICD10 Codes

Code	Description
F11.10-F11.99	Opioid related disorders (code range)
F14.10-F14.99	Cocaine related disorders (code range)

Code	Description
F16.10-F16.99	Hallucinogen related disorders (code range)
F45.42	Pain disorder with related psychological factors
G89.21-G89.4	Chronic pain (code range)

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Urine Drug Testing (LCD L39611) [accessed 2026 Aug 21]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

08/18/16, 08/17/17, 01/17/19, 11/21/19, 11/19/20, 11/18/21, 11/17/22, 10/19/23, 10/17/24, 10/16/25, 10/22/26	
Date	**Summary of Changes**
10/22/26	• Annual review. Policy intent unchanged.
12/29/25	• Code edit. Added 0603U. Policy intent unchanged.
10/16/25	• Annual review; intent to the policy unchanged.
01/01/25	• Summary of changes tracking implemented.
08/18/16	• Original effective date