

If a conflict arises between a Clinical Payment and Coding Policy (“CPCP”) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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 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. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of 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 (“HIPAA”) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (“UB”) Editor, American Medical Association (“AMA”), Current Procedural Terminology (“CPT®”), CPT® Assistant, Healthcare Common Procedure Coding System (“HCPCS”), ICD-10 CM and PCS, National Drug Codes (“NDC”), Diagnosis Related Group (“DRG”) guidelines, Centers for Medicare and Medicaid Services (“CMS”) National Correct Coding Initiative (“NCCI”) Policy Manual, CCI table edits and other CMS guidelines.

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

Prescription Medication and Illicit Drug Testing in the Outpatient Setting

Policy Number: CPCPLAB070

Version 1.0

Plan CMO Approval Date: July 27, 2022

Plan Effective Date: January 1, 2023

Description

BCBSNM 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 (i.e., court-ordered drug screening, forensic examinations).

- B. Non-forensic testing for commercial driver's licensing or any other job-related testing (i.e., as a prerequisite for employment or as a means for continuation of employment).
- C. As a component of routine physical/medical examination.
- D. As a component of care rendered in an urgent/emergency situation.
- E. As a routine component of a behavioral health assessment.

Presumptive drug screening using urine samples

1. Presumptive drug screening using urine samples (qualitative, semi-quantitative or quantitative) **may be reimbursable** in ANY of the following situations:
 - a. To assess a patient under treatment for chronic, non-cancer pain or substance abuse or dependence when clinical evaluation of the patient (history/signs/symptoms) suggests the use of non-prescribed medications or illegal substances at the following frequency:
 - i. Prior to initiating chronic opioid pain therapy in chronic non-cancer pain to determine if the patient has been exposed to controlled substances or potentially confounding illicit drugs.
 - ii. To verify a patient'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 (1) 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 (2) times per year after initiation of therapy.
 3. Monitoring of high risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to four (4) 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 suspicion of drug use exists as a result of the answers to substance abuse screening questions or indicated by information from the 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 mother
 - 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, including but not limited to the following:
 - i. Anxiety disorders
 - ii. Schizophrenia
 - iii. Major depressive disorder
 - iv. Mood disorders
 - v. Suicidal ideations
 - vi. Substance abuse disorder
 - f. In individuals with attention-deficit hyperactivity and disruptive behavior disorders

- g. Testing of cancer patients on opioid pain medication
- h. Drug testing in individuals with epilepsy
- i. Random urine presumptive drug testing for management and compliance monitoring of a member under treatment for substance abuse or dependence at the following frequency after baseline at initial evaluation and must be documented in the patient's medical record:
 - i. For patients with 0 to 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 2 per week meets coverage criteria.
 - ii. For patients with > 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 3 in one month meets coverage criteria.
- j. In individuals where substance abuse is in the differential diagnosis of the presenting conditions EXCEPT as part of a general encounter without abnormal findings

Definitive Drug Testing

2. Confirmatory/definitive qualitative or quantitative drug testing **may be reimbursable** up to seven (7) drug classes when laboratory-based definitive drug testing is specifically requested, and the rationale documented by the patient's treating physician and **ANY** of the following conditions is met:
 - a. The result of the presumptive drug screen is different than that suggested by the patient's medical history, clinical presentation or patient's own statement. For example:
 - 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
 - b. For diagnosing and monitoring individuals with substance use disorder or dependence, when accurate and reliable results are necessary for treatment decisions.
 - i. For patients with 0 to 30 consecutive days of abstinence, random definitive drug testing at a frequency of not to exceed 1 per week meets coverage criteria
 - ii. For patients with 31 to 90 consecutive days of abstinence, random definitive drug testing at a frequency of 1 to 3 per month meets coverage criteria. More than 3 definitive drug tests in one month does not meet coverage criteria.
 - iii. For patients with > 90 consecutive days of abstinence, definitive drug testing at a frequency of 1 to 3 every three months meets coverage criteria. More than 3 definitive drug tests in a 3-month period does not meet coverage criteria.
 - 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 (for example, specific drugs within the amphetamine, barbiturate, benzodiazepine, tricyclic antidepressants, and opiate/opioid drug classes as well as synthetic/analog or "designer" drugs)
 - e. Definitively identify specific drugs in a large family of drugs
3. Confirmatory/definitive qualitative or quantitative drug testing **is not reimbursable** when laboratory-based definitive drug testing is requested without any prior presumptive screening test results indicating the clinical utility to confirm those results, unless there is not a presumptive screening test available. See the Reimbursement section below.

4. Confirmatory/definitive qualitative or quantitative drug testing **is not reimbursable** when laboratory-based definitive drug testing is requested for larger than seven drug classes panels.
5. Confirmatory/definitive qualitative or quantitative or presumptive (qualitative, semi-quantitative or quantitative) drug testing using proprietary tests such as RiskViewRx Plus **is not reimbursable** because those tests have predetermined drug panels that are not based on the patient's unique medical history, presumptive screening results or current clinical presentation.

Specific Validity Testing

6. Specific validity testing, including, but not limited to the following tests, such as urine specific gravity, urine creatinine, pH, urine oxidant level, and genetic identity testing, including the use of NextGen Precision™ Testing, **is included in the base code and therefore will not be separately reimbursed.**

Documentation Requirements

The patient'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 (i.e., 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

The following **IS reimbursed** (see complete Coverage Criteria above) for:

1. Presumptive drug screening based upon appropriate clinical criteria (qualitative, semi-quantitative or quantitative);
2. Definitive drug testing (qualitative or quantitative) for up to seven drug classes when the presumptive drug screening meets one of the following criteria:
 - a. The test was negative for prescribed medications, or
 - b. Positive for a prescription drug with abuse potential which was not prescribed, or
 - c. Positive for an illegal drug with patient denial of using the drug, or
 - d. A presumptive test does not exist or does not adequately detect the specific drug or metabolite to be tested
3. Blood specimens in patients with anuric Chronic Renal Failure.

The following **will not be reimbursed**:

1. Any AMA definitive drug class codes;
2. 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;
3. Blanket orders or routine standing orders for all patients in the physician's practice;
4. Samples with abnormal validity tests;
5. Drug testing for patients in a facility setting (inpatient or outpatient) are not separately billable from the facility fee.

Only urine or oral fluid specimens will be covered - except blood specimen will be covered for patients with anuric Chronic Renal Failure.

Confirmatory/definitive testing should be supported by documentation of rationale in the patient's medical record.

More than one presumptive test result per patient 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

Codes
80305, 80306, 80307, 80320-80377, 0007U, 0011U, 0051U, 0054U, 0082U, 0093U, 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U, 0227U, G0480, G0481, G0482, G0483, G0659

References:

AACC. (2017). Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. Retrieved from <https://www.aacc.org/science-and-practice/practice-guidelines/using-clinical-laboratory-tests-to-monitor-drug-therapy-in-pain-management-patients>

AAFP. (2020). Clinical Preventive Service Recommendation Opioid Use Disorder (OUD): Screening. Retrieved from <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/oud.html>

AAN. (2018). Diagnostic Assessment Of The Child With Status Epilepticus. Retrieved from http://tools.aan.com/professionals/practice/guidelines/Status_Epilepticus_clinician.pdf

AAPM. (2013). Use of Opioids for the Treatment of Chronic Pain. Retrieved from <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/pain-management-toolkit/docs/use-of-opioids-for-the-treatment-of-chronic-pain.ashx>

AATOD. (2017). Guidelines for Addressing Benzodiazepine Use in Opioid Treatment Programs (OTPs). Retrieved from <http://www.aatod.org/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps/>

ACOG. (2017). Opioid Use and Opioid Use Disorder in Pregnancy. Retrieved from <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf>

ALFA. (2019). CLIawaived.com. Retrieved from https://www.cliawaived.com/web/items/pdf/ALF_03_3152_1_Panel_Drug_Test_Insert~493file1.pdf

Algren, D. A., & Christian, M. R. (2015). Buyer Beware: Pitfalls in Toxicology Laboratory Testing. *Mo Med*, 112(3), 206-210. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170116/>

Altunkaya, D., & Smith, R. N. (1990). Aberrant radioimmunoassay results for cannabinoids in urine. *Forensic Sci Int*, 47(3), 195-205.

AMDG. (2015). Interagency Guideline on Prescribing Opioids for Pain. Retrieved from <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

AMDG. (2018). Supplemental Guidance on Prescribing Opioids for Postoperative Pain. Retrieved from <http://www.agencymeddirectors.wa.gov/Files/FinalSupBreeAMDGPostopPain091318wcover.pdf>

APA. (2016). The American Psychiatric Association Practice Guidelines For The Psychiatric Evaluation Of Adults. Retrieved from <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>

Argoff, C. E., Alford, D. P., Fudin, J., Adler, J. A., Bair, M. J., Dart, R. C., . . . Webster, L. R. (2018). Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. *Pain Med*, 19(1), 97-117. doi:10.1093/pm/pnx285

ASAM. (2013). Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM). Retrieved from <https://www.asam.org/docs/default-source/public-policy-statements/drug-testing-a-white-paper-by-asam.pdf>

Becker, W., & Starrels, J. (2018, 07/05/2018). Prescription drug misuse: Epidemiology, prevention, identification, and management. Uptodate.com. Retrieved from <https://www.uptodate.com/contents/prescription-drug-misuse-epidemiology-prevention-identification-and-management>

Becker, W., & Starrels, J. (2020, 12/8/2020). Prescription drug misuse: Epidemiology, prevention, identification, and management. Uptodate.com. Retrieved from <https://www.uptodate.com/contents/prescription-drug-misuse-epidemiology-prevention-identification-and-management>

Bertron, J. L., Seto, M., & Lindsley, C. W. (2018). DARK Classics in Chemical Neuroscience: Phencyclidine (PCP). *ACS Chem Neurosci*, 9(10), 2459-2474. doi:10.1021/acscchemneuro.8b00266

Blank, A., Hellstern, V., Schuster, D., Hartmann, M., Matthee, A. K., Burhenne, J., . . . Mikus, G. (2009). Efavirenz treatment and false-positive results in benzodiazepine screening tests. *Clin Infect Dis*, 48(12), 1787-1789. doi:10.1086/599109

Böttcher, M., Lierheimer, S., Peschel, A., & Beck, O. (2019). Detection of heroin intake in patients in substitution treatment using oral fluid as specimen for drug testing. *Drug Alcohol Depend*, 198, 136-139. doi:10.1016/j.drugalcdep.2019.02.011

Brahm, N. C., Yeager, L. L., Fox, M. D., Farmer, K. C., & Palmer, T. A. (2010). Commonly prescribed medications and potential false-positive urine drug screens. *Am J Health Syst Pharm*, 67(16), 1344-1350. doi:10.2146/ajhp090477

CDC. (2015, June 2015). Nationwide Trends. Drug Facts. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/nationwide-trends>

CDC. (2017a, 12/19/2017). Drug Overdose Death Data. Retrieved from <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

CDC. (2017b, 02/09/2017). Opioid Data Analysis and Resources. Retrieved from <https://www.cdc.gov/drugoverdose/data/analysis.html>

CDC. (2017c, 08/30/2017). Prescription Opioid Data. Retrieved from <https://www.cdc.gov/drugoverdose/data/prescribing.html>

CDC. (2017d). U.S. Opioid Prescribing Rate Maps. Retrieved from <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>

CDC. (2018a, December 2018). Monitoring the Future Survey: High School and Youth Trends. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends>

CDC. (2018b). Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain Retrieved from <https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf>

CDC. (2019a). Drug Overdose Deaths. Retrieved from <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

CDC. (2019b). Other Drugs. Retrieved from <https://www.cdc.gov/drugoverdose/data/otherdrugs.html>

Chou, R., Fanciullo, G. J., Fine, P. G., Adler, J. A., Ballantyne, J. C., Davies, P., . . . Miaskowski, C. (2009). Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *The Journal of Pain*, 10(2), 113-130.e122. doi:10.1016/j.jpain.2008.10.008

Christo, P. J., Manchikanti, L., Ruan, X., Bottros, M., Hansen, H., Solanki, D. R., . . . Colson, J. (2011). Urine drug testing in chronic pain. *Pain Physician*, 14(2), 123-143. Retrieved from <https://www.painphysicianjournal.com/current/pdf?article=MTQ0NA%3D%3D&journal=60>

Cone, E. J., Bigelow, G. E., Herrmann, E. S., Mitchell, J. M., LoDico, C., Flegel, R., & Vandrey, R. (2015). Non-smoker exposure to secondhand cannabis smoke. I. Urine screening and confirmation results. *J Anal Toxicol*, 39(1), 1-12. doi:10.1093/jat/bku116

Couto, J. E., Webster, L., Romney, M. C., Leider, H. L., & Linden, A. (2009). Use of an algorithm applied to urine drug screening to assess adherence to an oxycontin regimen. *J Opioid Manag*, 5(6), 359-364.

Couto, J. E., Webster, L., Romney, M. C., Leider, H. L., & Linden, A. (2011). Use of an algorithm applied to urine drug screening to assess adherence to a hydrocodone regimen. *J Clin Pharm Ther*, 36(2), 200-207. doi:10.1111/j.1365-2710.2010.01236.x

Decker, S. E., Frankforter, T., Babuscio, T., Nich, C., Ball, S. A., & Carroll, K. M. (2014). Assessment concordance and predictive validity of self-report and biological assay of cocaine use in treatment trials. *Am J Addict*, 23(5), 466-474. doi:10.1111/j.1521-0391.2014.12132.x

DOD. (2017). VA/DoD Clinical Practice Guideline For Opioid Therapy For Chronic Pain. Retrieved from <https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf>

DOD. (2018). VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF PREGNANCY. Retrieved from <https://www.healthquality.va.gov/guidelines/WH/up/VADoDPregnancyCPG4102018.pdf>

Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. *MMWR Recomm Rep*, 65(1), 1-49. doi:10.15585/mmwr.rr6501e1

Drake, L. R., & Scott, P. J. H. (2018). DARK Classics in Chemical Neuroscience: Cocaine. *ACS Chem Neurosci*, 9(10), 2358-2372. doi:10.1021/acchemneuro.8b00117

DVA, & DOD. (2015). VA/DoD Clinical Practice Guideline For The Management Of Substance Use Disorders Retrieved from <https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf>

DWD. (2013). Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. Retrieved from <https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf>

Eaton, K., & Lyman, G. (2019, 8/15/2019). Dosing of anticancer agents in adults. UpToDate. Retrieved from <https://www.uptodate.com/contents/dosing-of-anticancer-agents-in-adults>

Eskridge, K. D., & Guthrie, S. K. (1997). Clinical issues associated with urine testing of substances of abuse. *Pharmacotherapy*, 17(3), 497-510.

FDA. (2018). DRI Cocaine Metabolite Assay. Retrieved from https://www.accessdata.fda.gov/cdrh_docs/pdf18/K181499.pdf

FDA. (2019). 510(k) Substantial Equivalence Determination Decision Summary Assay Only Template Retrieved from https://www.accessdata.fda.gov/cdrh_docs/reviews/K112395.pdf

Fleming, M. F., Balousek, S. L., Klessig, C. L., Mundt, M. P., & Brown, D. D. (2007). Substance use disorders in a primary care sample receiving daily opioid therapy. *J Pain*, 8(7), 573-582. doi:10.1016/j.jpain.2007.02.432

FSMB. (2017). Guidelines for the Chronic Use of Opioid Analgesics. Retrieved from https://www.fsmb.org/globalassets/advocacy/policies/opioid_guidelines_as_adopted_april-2017_final.pdf

Fucci, N. (2012). False positive results for amphetamine in urine of a patient with diabetes mellitus. *Forensic Sci Int*, 223(1-3), e60. doi:10.1016/j.forsciint.2012.08.010

Grant, C. N., & Bélanger, R. E. (2017). Position Statement: Cannabis and Canada's children and youth. *Pediatric Child Health*, 22(2), 98-102. Retrieved from <https://www.cps.ca/en/documents/position/cannabis-children-and-youth>

Gray, C., Korczak, D., Andrews, D., & Bélanger, S. A. (2018). ADHD in children and youth: Part 1—Etiology, diagnosis, and comorbidity. *Paediatrics & Child Health*, 23(7), 447-453. doi:10.1093/pch/pxy109

Greller, H., & Gupta, A. (2020, 10/20/2020). Benzodiazepine poisoning and withdrawal. Uptodate.com. Retrieved from https://www.uptodate.com/contents/benzodiazepine-poisoning-and-withdrawal?topicRef=13846&source=see_link#H9

Herrmann, E. S., Cone, E. J., Mitchell, J. M., Bigelow, G. E., LoDico, C., Flegel, R., & Vandrey, R. (2015). Non-smoker exposure to secondhand cannabis smoke II: Effect of room ventilation on the physiological, subjective, and behavioral/cognitive effects. *Drug Alcohol Depend*, 151, 194-202. doi:10.1016/j.drugalcdep.2015.03.019

HHS. (2017). New HHS Guidelines for Drug Testing Panels Effective 10/1/17. Retrieved from <https://www.federalregister.gov/documents/2017/01/23/2017-00979/mandatory-guidelines-for-federal-workplace-drug-testing-programs#h-114>

Hoffman, R. (2021, 1/15/2021). Testing for drugs of abuse (DOA). Uptodate.com. Retrieved from <https://www.uptodate.com/contents/testing-for-drugs-of-abuse-doa>

Jamison, R. N., Ross, E. L., Michna, E., Chen, L. Q., Holcomb, C., & Wasan, A. D. (2010). Substance misuse treatment for high-risk chronic pain patients on opioid therapy: a randomized trial. *Pain*, 150(3), 390-400. doi:10.1016/j.pain.2010.02.033

Jannetto, P., Bratanow, N., Clark, W., Hamill-Ruth, R., Hammett-Stabler, C., Huestis, M., . . . Langman, L. (2017). Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. Practice Guidelines. Retrieved from <https://www.aacc.org/science-and-practice/practice-guidelines/using-clinical-laboratory-tests-to-monitor-drug-therapy-in-pain-management-patients>

Jannetto, P. J., & Langman, L. J. (2018). Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. *The Journal of Applied Laboratory Medicine: An AACC Publication*, 2(4), 471-472. doi:10.1373/jalm.2017.025304

Jarvis, M., Williams, J., Hurford, M., Lindsay, D., Lincoln, P., Giles, L., . . . Safarian, T. (2017). Appropriate Use of Drug Testing in Clinical Addiction Medicine. *J Addict Med*, 11(3), 163-173. doi:10.1097/adm.0000000000000323

Jones, C. M., Mack, K. A., & Paulozzi, L. J. (2013). Pharmaceutical overdose deaths, United States, 2010. *Jama*, 309(7), 657-659. doi:10.1001/jama.2013.272

Jones, J. (2016, 07/28/2016). Clinical vs. Forensic: The Differences Cost More Than Just Money. NeoTox. Retrieved from <http://www.usdtl.com/media/mediaarticles/clinical-vs-forensic-the-differences-cost-more-than-just-money>

Kale, N. (2019). Urine Drug Tests: Ordering and Interpreting Results. *Am Fam Physician*, 99(1), 33-39. Retrieved from <https://www.aafp.org/afp/2019/0101/p33.pdf>

Kampman, K. (2018, 7/9/2018). Approach to treatment of stimulant use disorder in adults. Retrieved from https://www.uptodate.com/contents/approach-to-treatment-of-stimulant-use-disorder-in-adults?search=stimulant%20abuse&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Kandel, D. B., Hu, M. C., Griesler, P., & Wall, M. (2017). Increases from 2002 to 2015 in prescription opioid overdose deaths in combination with other substances. *Drug Alcohol Depend*, 178, 501-511. doi:10.1016/j.drugalcdep.2017.05.047

Katz, N. P., Sherburne, S., Beach, M., Rose, R. J., Vielguth, J., Bradley, J., & Fanciullo, G. J. (2003). Behavioral monitoring and urine toxicology testing in patients receiving long-term opioid therapy. *Anesth Analg*, 97(4), 1097-1102, table of contents.

Katzman, M. A., Bleau, P., Blier, P., Chokka, P., Kjernisted, K., Van Ameringen, M., . . . Walker, J. R. (2014). Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC psychiatry*, 14 Suppl 1(Suppl 1), S1-S1. doi:10.1186/1471-244X-14-S1-S1

Kell, M. J. (1994). Utilization of plasma and urine methadone concentrations to optimize treatment in maintenance clinics: I. Measurement techniques for a clinical setting. *J Addict Dis*, 13(1), 5-26. doi:10.1300/J069v13n01_02

Knezevic, N. N., Khan, O. M., Beiranvand, A., & Candido, K. D. (2017). Repeated Quantitative Urine Toxicology Analysis May Improve Chronic Pain Patient Compliance with Opioid Therapy.

Pain Physician, 20(2s), S135-s145.

Krasowski, M. D., McMillin, G. A., Melanson, S. E. F., Dizon, A., Magnani, B., & Snozek, C. L. H. (2020). Interpretation and Utility of Drug of Abuse Screening Immunoassays: Insights From Laboratory Drug Testing Proficiency Surveys. *Arch Pathol Lab Med*, 144(2), 177-184. doi:10.5858/arpa.2018-0562-CP

Langman, L. J., & Jannetto, P. J. (2018). Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. Retrieved from <https://www.aacc.org/-/media/Files/Science-and-Practice/Practice-Guidelines/Pain-Management/LMPGPain-Management20171220.pdf?la=en&hash=19670524407619F78999AB60731A24CB4901939D>

Levine, B. S., & Smith, M. L. (1990). Effects of diphenhydramine on immunoassays of phencyclidine in urine. *Clin Chem*, 36(6), 1258.

Levy, S., Sherritt, L., Vaughan, B. L., Germak, M., & Knight, J. R. (2007). Results of random drug testing in an adolescent substance abuse program. *Pediatrics*, 119(4), e843-848. doi:10.1542/peds.2006-2278

Ly, B. T., Thornton, S. L., Buono, C., Stone, J. A., & Wu, A. H. (2012). False-positive urine phencyclidine immunoassay screen result caused by interference by tramadol and its metabolites. *Ann Emerg Med*, 59(6), 545-547. doi:10.1016/j.annemergmed.2011.08.013

Manchikanti, L., Abdi, S., Atluri, S., Balog, C. C., Benyamin, R. M., Boswell, M. V., . . . Wargo, B. W. (2012). American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. *Pain Physician*, 15(3 Suppl), S67-116.

Manchikanti, L., Malla, Y., Wargo, B. W., Cash, K. A., Pampati, V., Damron, K. S., . . . Brandon, D. E. (2010). Protocol for accuracy of point of care (POC) or in-office urine drug testing (immunoassay) in chronic pain patients: a prospective analysis of immunoassay and liquid chromatography tandem mass spectrometry (LC/MS/MS). *Pain Physician*, 13(1), E1-e22. Retrieved from <https://www.painphysicianjournal.com/current/pdf?article=MTMwMg%3D%3D&journal=53>

McClellan, J., & Stock, S. (2013). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Schizophrenia. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(9), 976-990. doi:10.1016/j.jaac.2013.02.008

McEvoy, J., Millet, R. A., Dretchen, K., Morris, A. A., Corwin, M. J., & Buckley, P. (2014). Quantitative levels of aripiprazole parent drug and metabolites in urine. *Psychopharmacology (Berl)*, 231(23), 4421-4428. doi:10.1007/s00213-014-3781-1

Michna, E., Jamison, R. N., Pham, L. D., Ross, E. L., Janfaza, D., Nedeljkovic, S. S., . . . Wasan, A. D. (2007). Urine toxicology screening among chronic pain patients on opioid therapy: frequency and predictability of abnormal findings. *Clin J Pain*, 23(2), 173-179. doi:10.1097/AJP.0b013e31802b4f95

Microgenics. (2015). CEDIA(r) Phencyclidine (PCP) Assay. Retrieved from <http://tools.thermofisher.com/content/sfs/manuals/10007400-CEDIA-Phencyclidine-PCP-Assay-EN.pdf>

Microgenics. (2016). DRI(r) Amphetamines Assay. Retrieved from

<http://tools.thermofisher.com/content/sfs/manuals/0138-DRI-Amphetamines-Assay-EN.pdf>

Moeller, K. E., Kissack, J. C., Atayee, R. S., & Lee, K. C. (2017). Clinical Interpretation of Urine Drug Tests: What Clinicians Need to Know About Urine Drug Screens. *Mayo Clin Proc*, 92(5), 774-796. doi:10.1016/j.mayocp.2016.12.007

Nafziger, A. N., & Bertino, J. S., Jr. (2009). Utility and application of urine drug testing in chronic pain management with opioids. *Clin J Pain*, 25(1), 73-79. doi:10.1097/AJP.0b013e31817e13cc

Nelson, L., & Odujebi, O. (2019, 1/11/2019). Cocaine: Acute intoxication. Retrieved from https://www.uptodate.com/contents/cocaine-acute-intoxication?search=drugs%20of%20abuse%20testing&topicRef=13846&source=see_link

NICE. (2018, April 2018). Epilepsies: diagnosis and management. Retrieved from <https://www.nice.org.uk/guidance/cg137/chapter/1-Guidance>

NICE. (2020). Epilepsies: diagnosis and management. Retrieved from <https://www.nice.org.uk/guidance/cg137/chapter/1-Guidance>

Nuckols, T. K., Anderson, L., Popescu, I., Diamant, A. L., Doyle, B., Di Capua, P., & Chou, R. (2014). Opioid prescribing: a systematic review and critical appraisal of guidelines for chronic pain. *Ann Intern Med*, 160(1), 38-47. doi:10.7326/0003-4819-160-1-201401070-00732

Ordean, A., Wong, S., & Graves, L. (2017). No. 349-Substance Use in Pregnancy. *J Obstet Gynaecol Can*, 39(10), 922-937.e922. doi:10.1016/j.jogc.2017.04.028

Owen, G. T., Burton, A. W., Schade, C. M., & Passik, S. (2012). Urine drug testing: current recommendations and best practices. *Pain Physician*, 15(3 Suppl), Es119-133.

Owusu Obeng, A., Hamadeh, I., & Smith, M. (2017). Review of Opioid Pharmacogenetics and Considerations for Pain Management. *Pharmacotherapy*, 37(9), 1105-1121. doi:10.1002/phar.1986

Palamar, J. J., Le, A., Guarino, H., & Mateu-Gelabert, P. (2019). A comparison of the utility of urine- and hair testing in detecting self-reported drug use among young adult opioid users. *Drug Alcohol Depend*, 200, 161-167. doi:10.1016/j.drugalcdep.2019.04.008

Pesce, A., West, C., Egan City, K., & Strickland, J. (2012). Interpretation of urine drug testing in pain patients. *Pain Med*, 13(7), 868-885. doi:10.1111/j.1526-4637.2012.01350.x

Phan, H. M., Yoshizuka, K., Murry, D. J., & Perry, P. J. (2012). Drug testing in the workplace. *Pharmacotherapy*, 32(7), 649-656. doi:10.1002/j.1875-9114.2011.01089.x

Rengarajan, A., & Mullins, M. E. (2013). How often do false-positive phencyclidine urine screens occur with use of common medications? *Clin Toxicol (Phila)*, 51(6), 493-496. doi:10.3109/15563650.2013.801982

Rollins, D. E., Jennison, T. A., & Jones, G. (1990). Investigation of interference by nonsteroidal anti-inflammatory drugs in urine tests for abused drugs. *Clin Chem*, 36(4), 602-606.

SAMHSA. (2007). Guidelines for the Accreditation of Opioid Treatment Programs Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/2007-otp-accreditation-guidelines.pdf

- SAMHSA. (2015). Federal Guidelines For Opioid Treatment Programs. Retrieved from <https://store.samhsa.gov/system/files/pep15-fedguideotp.pdf>
- SAMHSA. (2017). Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>
- SAMHSA. (2020). Mandatory Guidelines for Federal Workplace Drug Testing Programs—Oral/Fluid Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/division_workplace_programs/final-mg-oral-fluid.pdf
- Smith, P. E., & McBride, A. (1999). Illicit drugs and seizures. *Seizure*, 8(8), 441-443. doi:10.1053/seiz.1999.0346
- Snyder, M. L., Fantz, C. R., & Melanson, S. (2017). Immunoassay-Based Drug Tests Are Inadequately Sensitive for Medication Compliance Monitoring in Patients Treated for Chronic Pain. *Pain Physician*, 20(2s), Se1-se9. Retrieved from <https://www.painphysicianjournal.com/current/pdf?article=NDIwNw%3D%3D&journal=103>
- Starrels, J. L., Becker, W. C., Alford, D. P., Kapoor, A., Williams, A. R., & Turner, B. J. (2010). Systematic review: treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. *Ann Intern Med*, 152(11), 712-720. doi:10.7326/0003-4819-152-11-201006010-00004
- Trescot, A. M., Datta, S., Lee, M., & Hansen, H. (2008). Opioid pharmacology. *Pain Physician*, 11(2 Suppl), S133-153.
- Vohra, V., Marraffa, J. M., Wojcik, S. M., & Eggleston, W. (2019). An assessment of urine THC immunoassay in healthy volunteers receiving an oral proton-pump inhibitor. *Clin Toxicol (Phila)*, 1-3. doi:10.1080/15563650.2019.1662917
- Vopat, M. L., Messamore, W. G., Trent, J. J., Schmanke, K. E., Zackula, R., Yang, S. Y., & Bhargava, T. (2020). Urine Screening for Opioid and Illicit Drugs in the Total Joint Arthroplasty Population. *Kans J Med*, 13, 71-76.
- Weaver, M. F. (2015). Prescription Sedative Misuse and Abuse. *Yale J Biol Med*, 88(3), 247-256. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4553644/>
- WFSBP. (2015). 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 Retrieved from http://www.wfsbp.org/fileadmin/user_upload/Treatment_Guidelines/Hasan_et_al__2015_.pdf
- WHO. (2016). mhGAP Intervention Guide. Retrieved from <https://apps.who.int/iris/bitstream/handle/10665/250239/9789241549790-eng.pdf?sequence=1>
- Wilfong, A. (2020, 12/1/2020). Management of convulsive status epilepticus in children. Uptodate.com. Retrieved from <https://www.uptodate.com/contents/management-of-convulsive-status-epilepticus-in-children?search=epilepsy>

Wondfo. (2020). DRUG TESTS STRIP. Retrieved from <http://wondfousa.com/test/strip/>

Wong, S., Ordean, A., & Kahan, M. (2011). Substance use in pregnancy. *J Obstet Gynaecol Can*, 33(4), 367-384. doi:10.1016/s1701-2163(16)34855-1

Xlar. (2002). THC One Step Marijuana Test Strip Package Insert. Retrieved from xlar.com/I/THC-STRIP-2.pdf

Policy Update History:

1/1/2023	New policy
----------	------------