MEDICAL POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Drug Testing-WI MP-MM-1638	09/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Drug Testing

B. Background
Drug testing is part of medical care and an important component of effective substance use disorder (SUD) treatment and pain management, providing valuable information for both members and providers. Testing supports accountability, enhances safety and contributes to better treatment outcomes. The integration of drug testing into treatment planning assists healthcare professionals in supporting members with tailored interventions, objectively monitoring abstinence and can help identify co-occurring mental health disorders that may complicate treatment.

Providers requesting drug testing should have proficiency in drug test interpretation and an understanding of tests that need ordered. Urine testing is the most common method for monitoring drug use with 2 main types, presumptive and confirmatory. Ethical use of drug testing requires a testing panel and frequency justified by the clinical condition and the ordering provider's need for information.

This policy establishes evidence-based criteria for the medical necessity of urine drug testing (UDT) in 2 distinct clinical populations: members receiving chronic opioid therapy for pain management and members in SUD treatment, including office-based opioid treatment (OBOT) with buprenorphine and opioid treatment programs (OTP) utilizing methadone. CareSource explicitly distinguishes between evidence derived from controlled clinical outcome studies and recommendations derived solely from professional society guidelines or expert consensus. Where those 2 sources diverge, this policy is governed by clinical outcome evidence. Guidelines are cited for informational context and are labeled by evidence level accordingly.

This policy applies to all clinicians ordering UDT within pain management and SUD treatment settings, both presumptive (immunoassay) and definitive (confirmatory) UDT, and point-of-care (POC) and send-out laboratory testing in Medicare, Medicaid and commercial lines of business within the scope of covered services.

C. Definitions
- **Aberrant Drug-Related Behavior (ADRB)** – A pattern of behaviors inconsistent with the therapeutic use of controlled substances, including but not limited to, multiple early refill requests, lost/stolen prescriptions, unsanctioned dose escalation, or obtaining controlled substances from multiple providers.
- **Risk Stratification** – A documented clinical assessment of patient-specific factors associated with higher probability of controlled substance misuse, abuse, or diversion, including history of SUD, concurrent psychiatric comorbidity, prior ADRB, and social determinants.
- **Stable SUD Patient** – A patient in SUD treatment with consistently expected UDT results (ie, prescribed medication present, no illicit substances detected) for a defined observation period (eg, 90 days or longer).

- **Testing Modalities** – Methods used to detect the presence of drugs or metabolites in the body (eg, urine, blood, hair, saliva), as well as the specific technological or procedural techniques employed within those tests.
  - **Definitive (Confirmatory) Testing (LC-MS/MS)** – Liquid chromatography-tandem mass spectrometry (LC-MS/MS) provides definitive drug identification at the individual compound level with high sensitivity and specificity and is the reference standard for legal, regulatory and high-stakes clinical decisions. GC-MS is an accepted alternative.
  - **Presumptive Testing (Immunoassay)** – Immunoassay-based UDT, whether performed as a point-of-care (POC) "dipstick" test in the clinical setting or processed in a CLIA-certified laboratory, detects drug classes using antibody-antigen reactions, providing rapid, cost-effective presumptive results appropriate for routine clinical monitoring.
    - **Immunoassay Limitations** – Documented false-positive rates (up to 34% for opiates in some analyses), false-negative rates, and lack of ability to distinguish individual drugs within a class are common and dictate that clinicians not take adverse clinical action (ie, medication discontinuation, patient dismissal) based solely on an immunoassay result without confirmatory testing when that result is unexpected and will alter the treatment relationship.
  - **Reflexive Confirmatory Testing** – Automatic send-out of every specimen for LC-MS/MS regardless of immunoassay result or clinical context, as confirmatory testing must be triggered by documented clinical criteria as defined in Section III.
- **Unexpected Negative** – Absence of a prescribed controlled substance on immunoassay, raising concern for non-adherence or diversion.
- **Unexpected Positive** – An immunoassay positive result for a substance not prescribed and not otherwise clinically explained.

D. Policy
  I. Pain Management Population
    A. Indications for UDT
      1. Required Indications (Presumptive Testing)
         Presumptive (immunoassay) UDT is medically necessary and required in the following circumstances:
         a. prior to initiation of chronic opioid therapy (baseline testing)
         b. documented ADRB
         c. following a period of treatment interruption (>30 days without clinical contact) before reinstatement of controlled substance prescribing
         d. When clinical assessment reveals a change in patient status suggesting new or resumed substance use.
      2. Risk-Stratified Routine Monitoring Indications
         Routine periodic UDT is medically necessary based on the following risk-stratified criteria – any 1 of the following. Risk classification must be documented in the medical record and reassessed at least annually.
         a. High-Risk Designation Criteria
            01. history of SUD or opioid use disorder (OUD)

02. concurrent use of benzodiazepines, sedative-hypnotics, or other central nervous system (CNS) depressants
03. active psychiatric comorbidity with poor stability
04. prior ADRB
05. current high-dose opioid therapy (>90 MME/day)
06. social determinants associated with high diversion risk

b. Moderate-Risk Designation Criteria:
01. remote history of SUD (ie, >5 years in sustained remission)
02. concurrent prescribing of controlled substances by multiple providers without documented care coordination
03. significant psychosocial stressors
04. clinician-documented concern not meeting high-risk threshold

c. Low-Risk Designation Criteria:
01. no history of SUD
02. stable, long-term opioid therapy with consistent adherence documentation
03. no ADRB
04. low-to-moderate opioid doses
05. structured care with regular clinical contact.

B. Testing Frequency

CareSource will cover up to 30 presumptive tests and definitive testing as outlined below per member per calendar year before a review of medical necessity is required, unless different review criteria are listed below. A review of medical necessity is not required in an emergency department (ED) setting, but confirmatory testing is rarely needed in the ED. Utilization will be monitored by CareSource. Blood testing is considered medically necessary when in an ED.

Code	Short Description	Review Information
G0480	Drug test, definitive, 1-7 classes	Required after 12 tests.
G0481	Drug test, definitive, 8-14 classes	Required after 12 tests.
G0482	Drug test, definitive, 15-21 classes	Required for all tests.
G0483	Drug test, definitive, 22+ classes	Required for all tests.

The following frequency recommendations are based on outcome evidence, where available, and deviate from guideline recommendations where evidence does not support more frequent testing. The basis for deviation is stated explicitly. Testing more frequently than below requires clinical documentation of specific factors driving increased frequency. Routine "protocol" testing at frequencies exceeding these thresholds without documented clinical justification does not meet medical necessity criteria and will not be authorized for reimbursement.

Risk Level	Evidence Level	Guideline Frequency (Level IV)	CareSource Frequency
Low Risk - Stable	Level III (observational)	Every 3-6 months	Every 6-12 months. If stable (> 12 consecutive months with no ADRB),

			test annually. Evidence does not support quarterly testing in this population.
Moderate Risk	Level III (observational)	Every 3 months	Every 3-6 months based on documented clinical reassessment of risk factors.
High Risk or Active ADRB	Level III-IV	Every 1-3 months	Every 1-3 months with frequency determined by clinical judgment and documentation of specific risk factors.

Key: Green = less frequent than guidelines (evidence-supported reduction)
Yellow = consistent with or slightly below guidelines
Red = consistent with guidelines only where evidence supports or where patient safety requires.

II. Substance Use Disorder (SUD) Treatment Population

A. Indications for UDT

UDT is medically necessary when used as a clinical management tool, not as a punitive or forensic mechanism, in the following circumstances:

1. At intake or initiation, a baseline is required for opioid agonist therapy (OAT) or other medication-assisted treatment (MAT) to characterize the substance use profile and inform treatment planning.
2. Qualified provider is transitioning a treatment phase to advance or reduce treatment intensity (e.g., transition from supervised to unsupervised dosing, take-home methadone eligibility determination).
3. A provider has a clinical concern, including specific, documented clinical observation that raises concern about relapse, undisclosed substance use, or medication diversion.
4. Routine monitoring is occurring as specified by phase-based frequency criteria below.

B. Testing Frequency

CareSource will cover up to 30 presumptive tests and definitive testing as outlined below per member per calendar year before a review of medical necessity is required, unless different review criteria are listed below. A review of medical necessity is not required in an emergency department (ED) setting, but confirmatory testing is rarely needed in the ED. Utilization will be monitored by CareSource. Blood testing is considered medically necessary when in an ED.

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Given the absence of Level I or Level II evidence linking specific UDT frequency to improved health outcomes in OAT populations, this policy adopts a conservative, phase-based frequency framework informed by available

observational evidence and the principle that testing frequency should be clinically justified rather than administratively mandated.

For patients in stable OAT with consistently expected results, testing more frequently than every 4 weeks does not meet medical necessity criteria. The systematic review evidence base identifies the absence of any frequency-outcome association as an urgent research gap. In the absence of evidence supporting higher frequency, clinical and cost stewardship principles support the lower end of the frequency range for stable patients.

UDT results in SUD treatment must inform, not dictate, clinical decisions as consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) guidance and various State benefit requirements that UDT be supportive and non-punitive. Unexpected results should prompt clinical assessment and treatment modification, not automatic discharge.

CareSource considers the following frequency framework as medically necessary for UDT in the SUD population. Additional testing requires documentation rationale of clinical justification and will be reviewed to ensure efficacy.

Treatment Phase	Evidence Level	ASAM Guideline (Level IV)	CareSource Frequency
Induction / Early Phase (<90 days)	Level IV (Consensus)	Weekly	Every 2-4 weeks with documented clinical rationale. Evidence does not demonstrate outcome benefit of weekly testing over biweekly testing in structured programs.
Stabilization Phase (90-180 days, improving results)	Level III-IV	Monthly	Monthly to every 6 weeks based on clinical stability indicators.
Stable Maintenance (>180 days, consistently expected results)	Level III (observational — Liebschutz et al., 2021)	Monthly	Every 4-8 weeks. Evidence from Liebschutz et al. (2021) directly supports reduced frequency in stable patients. More frequent testing is not supported by outcome evidence or authorized without documented clinical justification.
Relapse / Instability (unexpected results or clinical concern)	Level IV (Consensus)	Weekly	Weekly to every 2 weeks with required documentation of clinical triggers. Revert to phase-appropriate schedule when stability is reestablished for 60+ days.

III. Confirmatory Testing Standards and Clinical Triggers
CareSource prohibits the reflexive (automatic) ordering of definitive LC-MS/MS confirmatory testing on every urine specimen regardless of immunoassay result or

clinical context. Reflexive confirmatory testing is not medically necessary, not supported by clinical outcome evidence and represents a significant source of unnecessary cost. Confirmatory testing ordered without a documented clinical trigger as defined below will be considered not medically necessary and may be subject to payer denial and provider audit.

A. Approved Clinical Triggers for Confirmatory LC-MS/MS Testing
Definitive confirmatory testing is medically necessary only when **1 or more** of the following documented clinical triggers is present. The trigger must be recorded in the clinical note at the time the confirmatory test is ordered.

Trigger Category	Description / Examples
Unexpected Positive	Immunoassay positive for a substance not prescribed or clinically expected, and the result will materially change clinical management (e.g., treatment modification, referral, documentation)
Unexpected Negative	Prescribed controlled substance absent on immunoassay; confirmation required before clinical action is taken (e.g., diversion concern, non-adherence)
Immunoassay Limitation	Prescribed agent not detectable by standard immunoassay (e.g., buprenorphine, fentanyl, tramadol, synthetic opioids, benzodiazepine specificity); confirmation required for clinical accuracy
Diversion or Safety Concern	Clinical documentation of specific behavioral indicators of diversion or patient safety risk that require forensic-level confirmation

B. Analyte Panel Scope
Confirmatory testing panels should be tailored to the clinical question. Broad, reflexive, multi-analyte panels are not medically necessary when only a specific analyte result is in question. Panel scope must be clinically justified in the ordering documentation. Specific considerations include the following:

1. Fentanyl, buprenorphine, tramadol, and synthetic opioids are not reliably detected by standard opiate immunoassays. When these agents are prescribed or suspected, immunoassay alone is insufficient and LC-MS/MS is required for clinical accuracy. This constitutes a standing trigger for confirmatory testing in patients prescribed these agents.
2. Benzodiazepine immunoassays detect drug class but cannot distinguish individual agents. Specific benzodiazepine identification requires LC-MS/MS and should be ordered when individual agent identification is clinically necessary.
3. Phencyclidine (PCP) testing panels should reflect local prevalence data rather than defaulting to legacy SAMHSA federal workplace testing panels, which include analytes rarely relevant to clinical SUD or pain management populations.

IV. Documentation Requirements for Medical Necessity
All UDT orders must be signed and dated by a qualified provider and meet the following minimum standards. Documentation must be present in the clinical record at the time of testing, not created retrospectively. All records must be legible, including the member's name and identification on each page, and list the CPT code that accurately describes the service performed.
   A. All UDT orders require the following in addition to a list of all medications prescribed to the member and the drug(s) and class(es) to be tested:
      1. Clinical indication: A statement in the clinical note identifying the specific reason for testing (eg, "routine monitoring per this policy per low-risk classification," "unexpected positive immunoassay for cocaine in patient prescribed opioids requiring confirmation," "initiation of buprenorphine treatment").
      2. Risk classification (pain management): Current risk level assignment (low/moderate/high) with supporting documentation at least annually.
      3. Expected management impact: For confirmatory testing, a brief notation of how the result is expected to alter clinical management.
      4. Patient consent: Documentation that the patient has been informed of UDT as part of a treatment agreement.
   B. Confirmatory testing documentation must include
      1. specific clinical triggers from Section III identified and documented
      2. specific analytes ordered and clinical rationale for panel scope
      3. plan for how results will be used in clinical management
   C. Frequency deviations require the following additional documentation:
      1. specific clinical circumstances justifying increased frequency
      2. expected duration of increased frequency and reassessment plan
      3. documentation of patient and clinical team awareness of the deviation and the rationale

V. Testing that is considered not medically necessary includes, but is not limited to
   A. Testing that is not individualized, including, but not limited to:
      1. reflexive testing, routine, standard and/or preprinted orders
      2. requesting all tests from a machine solely because a result *may* be positive
      3. large, arbitrary panels, universal testing, or orders for "*Conduct additional testing as needed."*
   B. Testing required by third parties, including, but not limited to:
      1. court-ordered for other medico-legal purposes (eg, child custody)
      2. pre-employment or random testing that is a requirement of employment
      3. physician's health programs (eg, recovery programs for physicians, dentists, veterinarians, pharmacists, or others)
      4. school entry, testing for athletics, and/or military service testing
      5. residential treatment facility, partial hospital, or sober living testing as a condition to remain in that community
      6. testing with a primary pay source (eg, county, state or federal agency)
      7. marriage license or other administrative purpose testing
      8. forensic testing

9. routine physical and/or medical examination conditions

C. Blood drug testing when completed outside the ED.
D. Hair, saliva, or other body fluid testing for controlled substance monitoring.
E. Any type of drug testing not addressed in this policy or without documentation of medical necessity.
F. Routine use of definitive testing following a negative presumptive result or prior to discussing results of presumptive test with member.
G. UDT completed by telehealth.

E. Evidence Summary

I. Evidence Grading Framework

All recommendations in this policy are assigned an evidence level using the following grading system. Clinicians and auditors should note that the majority of existing UDT literature in both pain management and SUD treatment is rated Level III or Level IV.

Grade	Evidence Type	Definition
Level I	Systematic Review / RCT	Randomized controlled trials or systematic reviews of RCTs with consistent findings
Level II	Prospective Cohort	Well-designed prospective cohort studies or lower-quality RCTs
Level III	Retrospective / Observational	Retrospective cohort, case-control, or cross-sectional studies
Level IV	Expert Opinion / Consensus	Expert opinion, anecdotal evidence, or consensus guidelines without rigorous supporting data

II. Pain Management Population

The evidence base for routine UDT in chronic pain management is substantially weaker than most professional guidelines imply. The following represents an honest accounting of what the literature demonstrates:

- Absence of RCT Evidence for Outcome Benefit (Level I — Not Demonstrated): No randomized controlled trial has demonstrated that routine UDT in chronic pain patients improves clinically meaningful outcomes, including pain control, functional status, quality of life, overdose reduction, or mortality. A 2014 systematic review by Dupouy et al. examined 8 studies meeting inclusion criteria. None were rated better than fair quality, and the single RCT identified was conducted in a psychiatric emergency setting unrelated to chronic pain management.
- Observational Evidence for Misuse Detection (Level III): Observational studies consistently document that 20-40% of specimens from patients on chronic opioid therapy yield unexpected results. While this supports the utility of UDT as a detection tool, it does not establish that detection alone improves patient outcomes. Detection and corrective clinical action are not equivalent to demonstrated outcome benefit.

- Modest Evidence for Misuse Reduction with Treatment Agreements + UDT (Level III): A 2010 systematic review by Starrels et al. (Ann Intern Med), the most rigorous systematic review to date, examined 11 studies. All were observational and rated poor to fair quality. In 4 studies with comparison groups, opioid misuse was modestly reduced (7-23%) after treatment agreements with or without UDT. The authors concluded that evidence supporting UDT in this setting is relatively weak. This finding has not been substantially updated by higher-quality evidence in the intervening period.
- Immunoassay Accuracy Limitations (Level III): False-positive rates for opiates on immunoassay have been reported as high as 34% in retrospective analyses (Manchikanti et al., Pain Physician, 2010). These error rates are clinically significant and support the requirement for confirmatory testing before adverse clinical action is taken on unexpected results.
- Racial Disparities in UDT Application (Level III): Observational data from labor and delivery settings (Peterson et al., Am J Obstet Gynecol MFM, 2023) and primary care demonstrate that unstructured UDT is applied disproportionately to black and other minority patients, representing a serious equity concern that structured policy is designed to mitigate.

III. Substance Use Disorder (SUD) Treatment Population
Evidence for UDT in SUD treatment is, if anything, even more limited than in pain management. The pivotal finding of a systematic review specifically examining UDT frequency in opioid agonist therapy (OAT) populations is foundational to this policy's approach.

- Critical Finding - Absence of Evidence Linking Frequency to Outcomes (Level I — Systematic Review Finding): A systematic review by Starkes et al. (PMC6500449) specifically examining UDT frequency as an independent variable in OAT populations identified only 1 eligible study from an extensive literature search. The authors concluded there is an absence of evidence for the association between frequent urine drug screening and health outcomes in OAT patients and characterized this as an "*urgent gap in research evidence underpinning an area of clinical importance*." This is the highest-quality evidence available and directly informs this policy's frequency recommendations.
- Evidence Supporting Clinical Utility of UDT (Not Frequency) in SUD (Level III): A 2021 observational study by Liebschutz et al. (Addiction Science & Clinical Practice) of 161 patients receiving buprenorphine-naloxone for OUD in a primary care setting found that the majority of UDTs yielded expected results. The authors concluded that less frequent testing may be reasonable for stable patients as a more patient-centered approach. The study also documented that UDT may be useful as a clinical engagement tool, distinct from its role as a surveillance mechanism.
- UDT as a Surveillance Tool for Emerging Drug Threats (Level III): A large cross-sectional analysis of 500,000 UDT specimens from SUD treatment practices (PMC9166618) demonstrated that UDT positivity rates at national, state, and county levels correlate with overdose mortality rates, supporting

the utility of aggregate UDT data for public health surveillance. This does not establish individual patient outcome benefit from specific testing frequencies.

- ASAM Consensus Recommendations (Level IV - Expert Consensus Only): ASAM's 2017 Consensus Statement on Appropriate Use of Drug Testing in Clinical Addiction Medicine recommends weekly testing in early recovery, decreasing to monthly in stable recovery. ASAM noted that more research on this subject would be useful. This policy treats ASAM's frequency recommendations as Level IV evidence and calibrates recommendations against the higher-quality systematic review evidence above.

IV. Summary Frequency Comparison — Guidelines vs. This Policy
The following table provides a consolidated comparison of current guideline recommendations versus this policy's evidence-based recommendations. Deviations from guidelines are based on the absence of clinical outcome evidence supporting higher-frequency testing in the specified populations.

Population/ Risk	Test Type	Guideline Recommendation (Level IV)	CareSource Policy
Pain Management: Low Risk, Stable	Immunoassay (POC)	Every 3-6 months	Every 6-12 months or annually if stable >1 year.
Pain Management: Moderate Risk	Immunoassay (POC)	Every 3 months	Every 3-6 months, risk-documented
Pain Management: High Risk / ADRB	Immunoassay (POC) + Confirmatory if triggered	Every 1-3 months	Every 1-3 months with confirmatory only on clinical trigger.
SUD/OAT - Early Phase (<90 days)	Immunoassay (POC)	Weekly to monthly	Every 2-4 weeks, clinically documented rationale.
SUD/OAT - Stable (>90 days, consistent expected results)	Immunoassay (POC)	Monthly	Every 4-8 weeks. Evidence does not support more frequent testing in stable patients.
SUD — Active Instability / Relapse Concern	Immunoassay (POC) + Confirmatory if triggered	Weekly	Weekly to every 2 weeks. Revert to stable protocol when consistent expected results resume.

Key: Green = less frequent than guidelines (evidence-supported reduction)
Yellow = consistent with or slightly below guidelines
Red = consistent with guidelines only where evidence supports or where patient safety requires.

F. Conditions of Coverage

I. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepay review.

II. CareSource may require documentation of FDA-approved complexity level for instrumented equipment, Clinical Laboratory Improvement Amendments (CLIA) Certificate of Registration, compliance, or accreditation as a high complexity lab.

III. Each CPT code is counted as 1 test. If needed, the licensed practitioner operating within an applicable scope of practice must obtain the medical necessity review.

IV. In determining medical necessity for additional tests, current clinical information will be considered. A review of medical records will be performed to determine the appropriateness of the initial drug tests ordered within a calendar year.

G. Related Polices/Rules

NA

H. Review/Revision History

	DATE	ACTION
Date Issued	12/13/2017	
Date Revised	08/01/2019 01/01/2020 09/02/2020 09/01/2021 08/31/2022 08/02/2023 07/17/2024 06/18/2025 05/20/2026	Updated clinical indications, quantity limits, PA requirements. Removed quantity limits and authorization requirements. Updated D. III., D. IV. Reformatted. Removed related reimbursement policy. Updated references. Annual review. No changes. Annual review. Updated references. Approved at Committee. Annual review. Updated background & references. Approved at Committee. Annual review. Updated references. Approved at Committee. Annual review. Policy rewritten: more specific medical necessity criteria, added E. Updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

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