Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Urine Drug Testing

Effective: October 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care- A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Urine drug screening/testing is used in pain management and substance abuse treatment settings to assess and monitor drug misuse and/or abuse. Members in these settings are at risk for abusing or misusing prescribed opioids and/or non-prescribed drugs and should be assessed at the initiation of treatment as well as monitored while they are receiving treatment. Urine drug testing is a widely utilized method for monitoring opioid use in chronic pain individuals. It is used for tracking member compliance and exposing possible drug misuse and abuse. Urine drug testing should not routinely include a panel of all drugs of abuse. The test should be focused on the detection of specific drugs/drug metabolites. The frequency of testing should be at the lowest level to detect the presence of drugs.

Presumptive/Qualitative urine drug testing/screening (UDT) is used to determine the presence or absence of drugs in a urine sample. A positive test result is conveyed when the drug concentration is above the cut-off value. Definitive/Quantitative/Confirmatory urine drug testing (UDT) recognizes medication, illicit substances and metabolites. In contrast to presumptive UDT, definitive testing is performed using a highly sensitive method that specifies particular drugs and drug quantities.

NOTE

- All urine drug testing should be performed at an appropriate frequency based on clinical needs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.
- The preferred method of urine drug testing for a member with a history of poly-substance abuse during the monitoring period is by utilization of a multi-drug screening kit (qualitative analysis by multiplex method for 2-15 drugs or drug

classes).

- A full panel screen should only be considered for initial testing when appropriate or when the Member's behavior suggests the use of drugs not identified on the original screening. Medical documentation must support the justification for conducting a full panel screening. Subsequent testing should only be conducted for those substances identified on the Member's initial profile
- Lab conducting the urine drug test must be certified through the Clinical Laboratory Improvement Amendments (CLIA-certified). Medical record documentation should include rationale for ongoing testing and indicate how results are used to manage member treatment and care.

Clinical Guideline Coverage Criteria

Presumptive Testing

The Plan considers presumptive testing as reasonable and medically necessary for individuals with chronic pain when documentation confirms **One** of the following:

1. Member is initiating treatment in a pain management or substance abuse program; **or**
2. Member's clinical history and evaluation suggests use of non-prescribed medications or illegal substances; **or**
3. Member is on chronic opioid therapy and has a history of substance abuse and is at high risk for medication abuse due to psychiatric reasons; **or**
4. Ongoing monitoring when medical record documentation supports testing is part of an active treatment plan.

The Plan considers presumptive testing as reasonable and medically necessary for individuals with suspected drug overdose when documentation confirms **One** of the following:

1. Unexplained coma; **or**
2. Altered mental status in the absence of a clinically defined toxic syndrome or toxidrome; **or**
3. Severe or unexplained cardiovascular instability (cardiotoxicity); **or**
4. Unexplained metabolic or respiratory acidosis in the absence of a clinically defined toxic syndrome or toxidrome; **or**
5. Seizures with an undetermined history; **or**
6. To provide antagonist to specific drug; **or**
7. Acute psychiatric events due to stimulant induced psychosis; **or**
8. Drug use screening for member awaiting organ transplant; **or**
9. Member under the age of 18 with a sibling with a positive urine drug test; **or**
10. Fetal withdrawal syndrome; **or**
11. Possible exposure of the fetus to illicit drugs taken by the mother; **or**
12. A child with history for suspected use of non-prescribed medications or illegal substance.

Definitive Testing

The Plan considers definitive or confirmatory testing for the treatment planning by the ordering physician (written orders) as reasonable and medically necessary when **One** of the following indications are met:

1. Immunoassays for the relevant drug(s) are not commercially available; **or**
2. A presumptive screen was negative for prescribed medications [Testing should ONLY be ordered for the prescribed drug]; **or**
3. A presumptive screen was positive for a prescription with abuse potential not prescribed to the member; **or**
4. A presumptive screen was inconclusive or inconsistent; **or**
5. Qualitative test was positive for an illegal drug; **or**
6. Therapeutic Drug Assays when performed to monitor a clinical response to a known, prescribed medication.

Documentation Requirements

- All documentation must be maintained in the Member's medical record and available to the Plan upon request.
- The record must include the identity of the physician or non-physician practitioner responsible for and providing the care of the Member.
- If requested for review, the submitted medical record should support the use of the selected ICD-CM code(s). The submitted CPT/HCPCS code should describe the service performed. Documentation maintained by the ordering

physician/treating physician must indicate the medical necessity for performing a qualitative drug test. All tests must be ordered in writing by the treating provider and all drugs/drug classes to be tested must be indicated in the order. Orders which include statements such as “conduct additional testing as needed or custom profile” will not be accepted by The Plan.

- If the provider of the service is other than the ordering/referring physician, that provider must maintain printed copy documentation of the lab results, along with printed copies of the ordering/referring physician’s order for the qualitative drug test. The physician must include the clinical indication/medical necessity in the order for the qualitative drug test.

Limitations

The Plan considers urine drug testing as not medically necessary for all other indications. In addition, HPHC does not cover:

1. Specimen validity or adulteration testing
2. Continuous urine drug testing (e.g., Litholink Urine Test)
3. Mandated drug testing (e.g., court-ordered, residential monitoring, non-medically necessary testing)
4. Employment or job screening testing
5. Blanket orders (i.e., identical orders for all members in a clinician’s practice without individualized decision making at every visit
6. Aspenti Test

Note: Use of non-contracting labs may have the unintended consequence of subjecting the Member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the non-participating lab that you selected.

For information regarding billing and compensation, refer to the Laboratory and Pathology Payment Policy for HPHC and THP

Codes

The following code(s) are associated with the service:

Table 1: CPT/HCPCS Codes

Code	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, 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 (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
G0480	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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	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

Code	Description
	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); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	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) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

References:

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3. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD): Drug Testing (L34645). Centers for Medicare and Medicaid Services (CMS). Revised November 12, 2023. Accessed April 24, 2025.
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5. Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, Safe, and Effective Prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. *Pain Physician*. 2017;20(2S):S3-S92.
6. Urine Drug Testing. UpToDate.com/login [via subscription only]. Published October 7, 2024. Accessed April 24, 2025.
7. Veteran's Affairs (VA) and Department of Defense (DoD) Opioid Therapy for Chronic Pain Work Group. Clinical practice guideline for the use of opioids in the management of chronic pain. 2022; https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf. Accessed September 21, 2023.
8. Washington State Agency Medical Directors' Group. Interagency guideline on prescribing opioid dosing for pain. 2015; 3rd: http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf. Accessed April 24, 2025.
9. Washington State Agency Medical Directors' Group. Interagency guideline on opioid prescribing: long-term opioid therapy report and recommendations. 2020;https://www.qualityhealth.org/bree/wpcontent/uploads/sites/8/2020/05/Bree-Long-Term-Opioid-Use-Recommendations-FINAL-20-05.pdf. Accessed April 24, 2025.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 5, 2020: Fax number for Unify updated
- August 18, 2021: Reviewed by IMPAC, language updated for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan, effective October 1, 2021
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- December 1, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes effective December 1, 2024
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- September 15, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- September 17, 2025: Reviewed by the UM Committee, renewed without changes effective October 1, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.