



**PROVIDER REIMBURSEMENT GUIDANCE  
Urine Drug Test Payment Policy**

**Original Date Approved**

**Effective Date**

**Revision Date**

04/08/2022

07/01/2026

04/21/2026

**Scope:** Commonwealth Care Alliance (CCA) Product Lines

Senior Care Options (FIDE-SNP)

One Care (FIDE-SNP)

**PAYMENT POLICY SUMMARY:**

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CCA reimburses contracted providers for medically necessary urine drug testing (UDT) to detect drugs/drug metabolites as part of medical treatment for alcohol or substance abuse, or the abuse of prescription medications including medical pain management. Urine drug testing services include clinical studies and testing of urine obtained from the patient to monitor and/or detect drug levels for medical treatment purposes related to the above.

**Definitions:**

Presumptive/Qualitative Drug Testing (hereafter called "presumptive" UDT) - Covered when medically necessary to immediately determine the presence or absence of drugs or drug classes in a urine sample; results expressed as negative or positive or as a numerical result; includes competitive immunoassays (IA) and thin layer chromatography.

Definitive/Quantitative/Confirmation (hereafter called "definitive" UDT) - Covered when clinically indicated and medically reasonable and necessary based on this LCD to identify specific medications, illicit substances, and metabolites; reports the results of analytes absent or present typically in concentrations such as ng/mL; definitive methods include but are not limited to GC-MS and LC-MS/MS testing methods only.

Drug test coding involves CPT codes for presumptive (qualitative) screening and definitive (quantitative/confirmation) testing. Common presumptive codes are 80305–80307 (based on method), while definitive testing uses G0480–G0483 (based on drug classes) or specific drug tests (e.g., 82145 for amphetamines) to determine exact levels.

**Standing Orders** - Test request for a specific patient representing repetitive testing to monitor a condition or disease for a limited number of sequential visits; individualized



orders for certain patients for pre-determined tests based on historical use, risk, and community trend patient profiles; clinician can alter the standing order. Note: A profile is developed based on specific characteristics of a specific patient, while a panel is a general non-specific group of tests that may have unnecessary tests for the specific patient being treated.

**(GC-MS) & (LC-MS/MS)** - Gas Chromatography coupled with Mass Spectrometry (GC-MS) and Liquid Chromatography coupled with Mass Spectrometry (LC-MS/MS) are complex technologies that use the separation capabilities of gaseous or liquid chromatography with the analytical capabilities of mass spectrometry. These methodologies require the competency of on-site highly trained experts in this technology and interpretation of results. While these tests require different sample preparation and analytical runs, they identify specific drugs, metabolites, and most illicit substances and report the results as absent or present typically in concentrations of ng/mL.<sup>2</sup>

#### **AUTHORIZATION GUIDELINES:**

Applicable CCA referral, notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

#### **REIMBURSEMENT GUIDELINES:**

##### **CCA Reimburses:**

- Up to 1 unit of presumptive testing or 1 unit of definitive testing per date of service.
- Up to 20 dates of service for all urine drug testing tests per calendar year. Testing beyond this is subject to medical review and requires clear documentation of medical necessity.
- Standing orders for urine drug testing up to 30 days, provided tests are medically necessary and required as part of the members treatment plan.
- Standing orders for urine drug testing which do not exceed 30 days, provided tests are medically necessary and required as part of the members treatment plan.

##### **CCA Generally Does Not Reimburse:**

- Definitive drug testing where there has been no underlying presumptive test or where the presumptive test is consistent with expected findings
- Presumptive, definitive, or confirmatory testing ordered by or on behalf of a provider or facility that receives per-diem reimbursement for a service which includes clinical diagnostic laboratory testing as an integral component (i.e., Inpatient Hospital Stay, Skilled Nursing Facility, or Behavioral Health Facility-Based Treatment Program)



- For residential monitoring when testing is mandatory for participation in the program
- Specimen validity/adulteration testing
- Mandated drug testing (e.g., court-ordered, residential monitoring, non-medically necessary testing)
- Blanket Orders – test request that is not for a specific patient; rather, it is an identical order for all patients in a clinician’s practice without individualized decision making at every visit
- Urine specimen collection
- Employment or job screening testing

**REQUIRED DOCUMENTATION:**

Requests or laboratory services must be in writing to the lab and include the following information:

- The clinical rationale for ordering UDT, including risk assessment and medication review.
- The reason definitive testing was required, if applicable.
- How test results were used to modify or confirm the treatment plan.
- Documentation supporting standing orders and frequency of testing.

**NOTE\*\*** If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. Both laboratories must keep a record of each request for laboratory services, each specimen, and each test result for at least six years from the date on which the results were reported to the authorized prescriber.

**RELATED SERVICE POLICIES:**

Laboratory and Pathology

**AUDIT and DISCLAIMER INFORMATION:**

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to a refund of all payments related to non-compliance. CCA reserves the right to amend this payment policy at its discretion,



to be binding on Provider. ICD, CPT/HCPCS codes are updated as applicable and such updates shall be deemed automatically incorporated into this Policy; providers must adhere to the most recent ICD, CPT/HCPCS coding guidelines, as applicable.

**REFERENCES:**

- Payment Policies:  
Massachusetts
- Provider Manuals:  
Massachusetts
- Prior Authorization Forms:  
Massachusetts  
130 CMR, § 401.416

**POLICY TIMELINE DETAILS:**

1. Effective 08/01/2022
  2. Effective 7/1/2026
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