

PROJECT FOR REDUCING INEFFECTIVE MEDICAID EXPENDITURES

Urine Drug Screening

Urine drug screening is common in clinical practice, despite limited evidence supporting its benefits and concerns about overuse and potential harms. In an analysis of available evidence, clinical guidelines, payer policies, and Medicaid data from 2024, we found ongoing evidence of potential overuse estimated at \$245.2 million nationally (state and federal share), with significant state-by-state variation. We found multiple state Medicaid programs working to address overuse of urine drug testing through differing approaches. From this brief, state Medicaid program administrators can assess whether overuse of urine drug screening is an issue in their state and identify potential policy solutions.

BACKGROUND

Drug testing refers to testing of biological specimens (e.g., hair, saliva, or urine) for the presence or absence of specific drugs.¹ It is most commonly performed on urine, and used during treatment with controlled substances (e.g., treatment of chronic pain with opioid pain relievers) as well as substance use disorder treatment.¹ Drug testing is divided into 2 types: presumptive and definitive.¹ Presumptive testing produces a qualitative result on the presence of the drug (i.e., yes or no) and methods include point-of-care urine testing cups and testing on laboratory-based chemistry analyzer machines.¹ Definitive testing produces quantitative results (i.e., measures the exact level) for each class of drugs tested and is performed using laboratory-based methods such as liquid chromatography with tandem mass spectroscopy.¹

Drug testing, in combination with a patient's reported history, is used to identify illicit substance use, monitor adherence to prescribed medications, or both.^{1,2} Despite the seemingly straightforward use

case, there are significant issues in practice, such as inaccurate interpretation by ordering providers, inconsistent responses to test results, and punitive use of results, such as expelling patients from treatment.³⁻⁶ These concerns are all underscored by a general lack of evidence that drug testing improves outcomes.^{3,5,6} Beyond clinical practice issues, drug testing has been a frequent target of fraud, waste, and abuse schemes.^{3,7-12}

Presumptive drug testing is coded as direct observation (e.g., a point-of-care dipstick or cup), instrument-assisted observation, or via chemistry analyzer (Table 1).¹³ Historically, definitive drug testing was coded by listing each drug class tested using Common Procedural Terminology (CPT) codes 80320–80377.¹⁴ Due to inappropriately broad tests (i.e., excessive drug classes on a single test), the Centers for Medicare & Medicaid Services (CMS) created Healthcare Common Procedure Coding System G-codes for definitive testing that defined a test by the number of classes.¹⁴ Effectively, the G-codes capped the maximum reimbursement of definitive drug tests to no more than 22 classes at a time.¹⁴ Despite this change, a subsequent Office of Inspector General report identified up to \$216 million of “at-risk payments to at-risk providers” for definitive drug testing in Medicare from 2016 to 2020.¹⁵

TABLE 1
Medicare Reimbursement for Drug Testing, 2026

Procedure Code(s)	Brief Description	Fee
Presumptive testing		
80305	Presumptive test, by direct observation	\$12.60
80306	Presumptive test, by instrument assisted observation	\$17.14
80307	Presumptive test, by chemistry analyzer	\$62.14
Definitive drug testing		
G0480	Definitive drug test, 1 to 7 classes	\$114.43
G0481	Definitive drug test, 8 to 14 classes	\$156.59
G0482	Definitive drug test, 15 to 21 classes	\$198.74
G0483	Definitive drug test, 22 or more classes	\$246.92
G0659	Definitive drug test, simple, per class ^a	\$62.14

Note. ^a This code was created for tests using less complex methods than those typically used by drug testing laboratories.¹⁴

Source. Adapted from the January 2026 Medicare Clinical Laboratory Fee Schedule.¹³

Given its issues in clinical practice and potential for overuse, we selected this service for review in the Project for Reducing Ineffective Medicaid Expenditures (PRIME). The purpose of PRIME is to identify Medicaid-covered services that may warrant coverage limitations due to limited or no demonstrated benefit relative to harms. For this topic, we conducted a review of available evidence, guidelines, and payer policies, and estimated potential overuse of drug testing in Medicaid along with potential savings on a state-by-state basis.

EVIDENCE, GUIDELINE, AND PAYER POLICY LANDSCAPE

Evidence

Despite widespread use, the clinical evidence supporting drug testing in routine clinical practice is limited. A 2014 systematic review identified “few studies” having “poor quality” and noted that they were insufficient to determine the impacts of drug testing.⁵ We conducted an updated search and were unable to identify any additional relevant clinical evidence (e.g., studies comparing the effect of more intensive versus less intensive drug testing on health outcomes).

To assess the impact of limiting drug testing coverage, including any unintended consequences (e.g., increased overdose rates), we reviewed findings from a 2026 study of a Medicaid coverage policy change in Louisiana.¹⁶ In July 2019, Louisiana Medicaid implemented a change to drug testing coverage to limit the number of presumptive (24) and definitive tests (18) per year, and limit the number of drug classes for definitive tests to no more than 14 at one time.¹⁶ Analyzing data from January 2017 to February 2020, researchers identified significant reductions in utilization and expenditures, estimating a total savings of \$14.8 million (state and federal share) in the 7-month post-implementation period.¹⁶ To evaluate for potential unintended consequences, researchers also examined prescriptions for medications for opioid use disorder and overdose rates, and did not find a significant association with the policy implementation.¹⁶ In summary, this study suggested that limiting coverage of drug testing in a state Medicaid program can produce significant savings without significant unintended consequences.

Guidelines

We identified 7 clinical practice guidelines:

- American Society of Addiction Medicine (2 guidelines alone^{1,17} and 1 guideline in collaboration with the American Academy of Addiction Psychiatry¹⁸)
- American Society of Interventional Pain Physicians¹⁹
- US Substance Abuse and Mental Health Services Administration²⁰
- US Department of Veterans Affairs²¹
- US Centers for Disease Control and Prevention²

Generally, guidelines recommended initial and then ongoing drug testing.^{1,2,17-20} They recommended individualizing the use of drug testing to the patient, without providing specific quantitative recommendations or limits.^{1,2,17-20} The Veterans Affairs guideline was primarily limited to contingency management and noted that frequent drug testing is required for that approach to treatment.²¹ Some guidelines considered harms of drug testing, recommending against using tests punitively or to expel patients from treatment and advising caution when performing drug testing in adolescents, young adults, and during pregnancy.^{1,2,17,18} A 2026 update of the American Society of Addiction Medicine guideline on drug testing, in conjunction with the American College of Medical Toxicology, is pending finalization.²²

Payer Policies

We reviewed 10 payer policies; 3 commercial payers (Aetna²⁸, Anthem²⁹, and UnitedHealthcare³⁰) and 7 Medicare Administrative Contractors (MACs).^{23-27,31,32} All of the policies explicitly required that testing be part of an individualized treatment plan and that there be documentation of the clinical rationale for testing. Five of the MACs worked together to develop a common policy (Box 1).²³⁻²⁷ Coverage policies are described in more detail in Appendix Table A1.

Box 1. Summary of Medicare Administrative Contractor Coverage Limits for Drug Testing²³⁻²⁷

Presumptive Testing

Divided by days of abstinence:

- 0–30 days: no more than 3 tests per week
- 31–90 days: no more than 3 tests per week
- > 90 days: no more than 3 tests per month

Definitive Testing

Divided by days of abstinence:

- 0–30 days: no more than 1 test per week
- 31–90 days: no more than 3 tests per month
- > 90 days: no more than 3 tests per 90 days

MEDICAID DATA ANALYSIS

To estimate potential overuse of drug testing, we analyzed data from Transformed Medicaid Statistical Information System Analytical Files for 50 states and the District of Columbia for 2024, the most recent year available from CMS. For each state, we identified fully adjudicated paid fee-for-service (FFS) claims and managed care encounters representing potential overuse, defined in Box 2. Because CMS suppresses paid amounts for managed care encounters, we estimated payments based on FFS claims.

Box 2. Definition of Potential Overuse

Based on a recent study of a Medicaid coverage policy limitation,¹⁶ we defined potential overuse as:

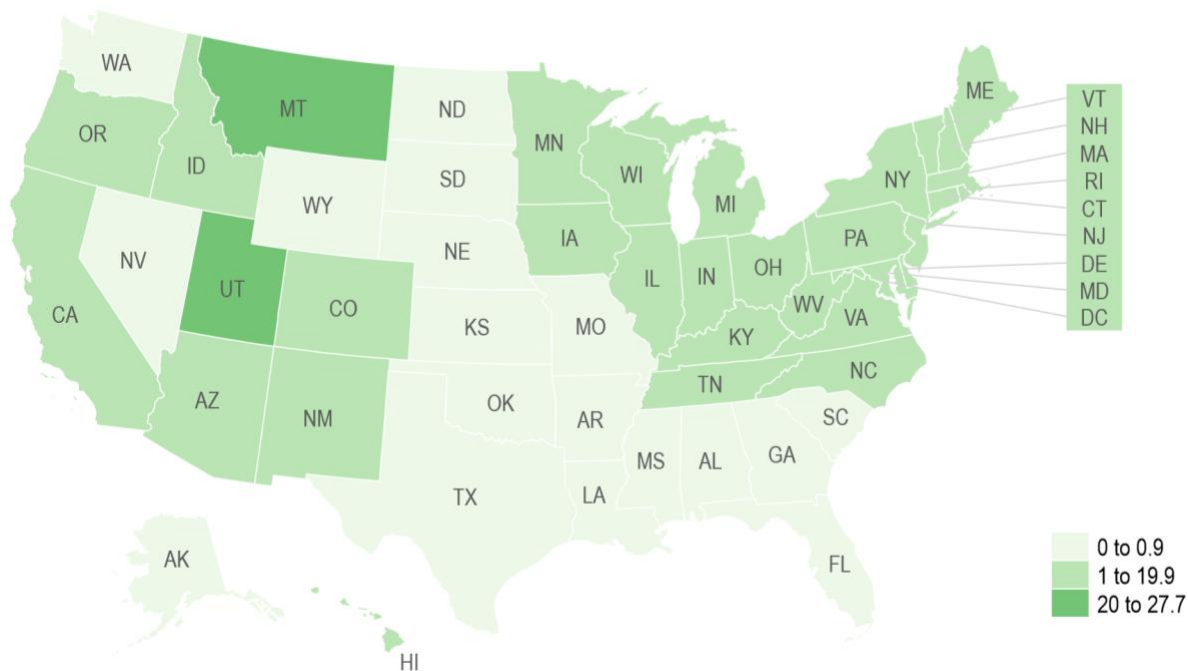
- More than 24 presumptive tests in a year for a single member
- More than 18 definitive tests in a year for a single member
- Definitive testing of more than 14 classes at one time

Presumptive Testing

Nationally, we estimated that 6.8% of presumptive tests represented potential overuse. There was significant state-by-state variation in this percentage, ranging from less than 0.1% to 27.7% (Figure 1). We estimated the potential savings associated with addressing overuse of presumptive testing to be \$37.7 million (state and federal share). Full results, including state-by-state estimates of savings, are detailed in Appendix Table A2.

FIGURE 1

Percentage of Presumptive Drug Tests Identified as Potential Overuse, by State, 2024

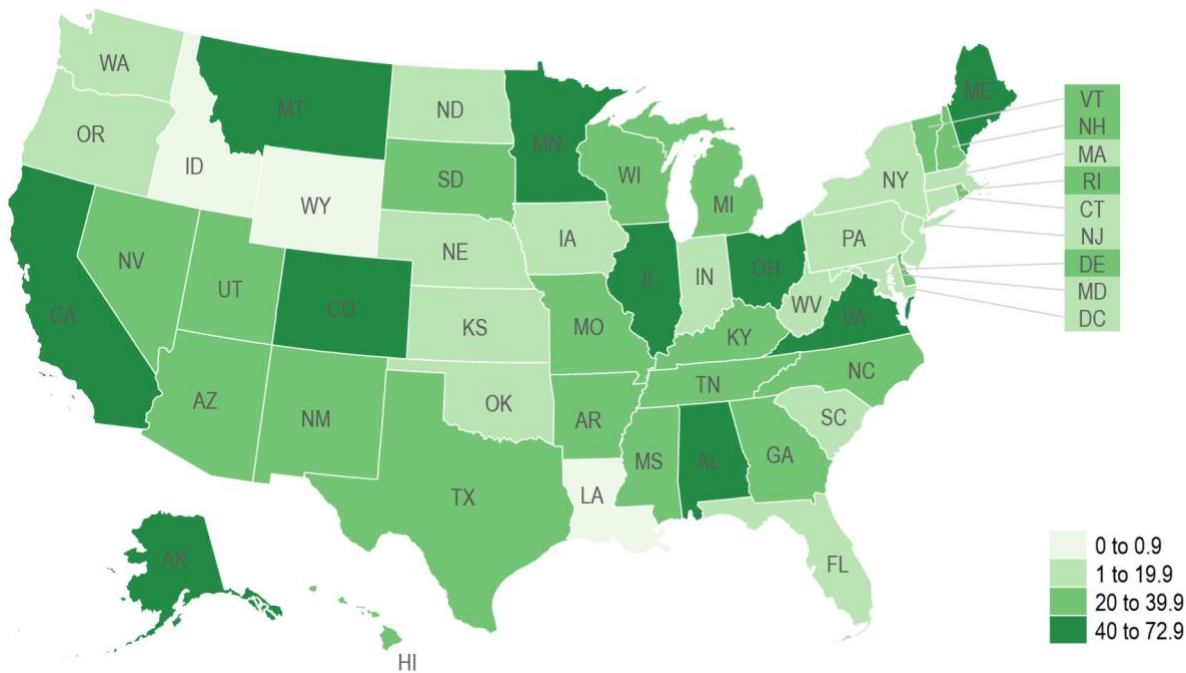


Definitive Testing

Nationally, we estimated that 32.1% of definitive tests represented potential overuse. There was also significant state-by-state variation in this percentage, from 0.5% to 72.9% (Figure 2). We estimated the potential savings associated with addressing overuse of definitive testing to be \$207.5 million (state and federal share). Full results, including state-by-state estimates of savings, are detailed in Appendix Table A2.

FIGURE 2

Percentage of Definitive Drug Tests Identified as Potential Overuse, by State, 2024



STATE POLICY ACTIONS

Several state Medicaid programs have implemented more restrictive limits than the definition of overuse we used, for example:

- **Colorado** implemented a phase-down in definitive drug testing limits, decreasing to 12 per year, effective July 1, 2026³³
- **Idaho** allows only 1 definitive test per month (i.e., 12 per year)³⁴
- **Louisiana** decreased its limit for definitive drug testing to 12 per year effective January 1, 2021³⁵
- **Oregon's** Health Evidence Review Commission previously voted to limit definitive drug testing to 12 tests per year³⁶ and recently voted to decrease the number of drug classes allowed per definitive test to no more than 7 classes³⁷
- **Washington** allows only 12 definitive tests per year and, while there is no limit on the number of drug classes per definitive test, all definitive tests are reimbursed at the same rate as definitive tests including 7 classes or fewer^{38,39}

STATE CONSIDERATIONS

With limited evidence of benefit, concerns over potential harms, and evidence of ongoing overuse, state Medicaid program administrators can consider evaluating whether limiting drug testing coverage may be warranted. State Medicaid program administrators interested in addressing overuse of drug testing can consider:

- Adopting the Medicare G-codes for definitive drug testing, if not already implemented
 - » Allowing reimbursement of definitive drug testing using CPT codes may result in higher reimbursement for a test than would be allowed in Medicare under its highest-level G-code (i.e., G0483)
 - » Section 1903(i)(7) of the Social Security Act prohibits federal matching funds for Medicaid payments for clinical diagnostic laboratory tests in excess of what would be paid under Medicare⁴⁰
- Establishing or reducing annual quantity limits for presumptive testing
- Establishing or reducing annual quantity limits for definitive testing
- Limiting the number of drug classes allowed per definitive test or setting a flat reimbursement rate for definitive tests above a certain number of classes
 - » States that have not yet implemented the Medicare G-codes for reimbursement of definitive drug testing can consider doing so to facilitate implementation of this coverage limitation
- Determining if and how to allow limits to be overridden when medically necessary

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APPENDIX A: RESULTS

TABLE A1

Coverage Policies for Commercial Payers and Medicare

Payer, Year	Presumptive Testing	Definitive Testing
Commercial		
Aetna ²⁸	“Drug testing more frequently than once weekly, should be part of a comprehensive and individualized patient treatment plan that outlines the rationale for more frequent testing. Frequency of testing should be dictated by patient acuity and level of care. Generally, ordering a definitive test should have an individualized patient treatment plan that outlines the rationale for this type of testing on each occasion.”	
Anthem ²⁹	No specific limit	• “When [definitive testing] exceeds 24 per year, review of medical records may be requested.” • “Definitive testing for more than 7 classes of drugs (including metabolites) would be unusual for most individuals.”
UnitedHealthcare ³⁰	“UnitedHealthcare will not reimburse more than one presumptive and/or one definitive drug test per day regardless of the number of billing providers.”	
Medicare Administrative Contractors (MAC)		
First Coast Service Options, Inc. ³¹ (Florida, Puerto Rico, Virgin Islands)	For SUD: • 0–90 days abstinent: 1 to 3/week • > 90 days abstinent: 1 to 3/month For chronic opioid therapy: based on validated risk assessment; does not differentiate presumptive and definitive testing • Low risk: 1 to 2 tests every 12 months • Moderate risk: 1 to 2 tests every 6 months • High risk: 1 to 3 tests every 3 months	For SUD: • 0–30 days abstinent: no more than 1/week • 31–90 days abstinent: 1 per month expected, no more than 3/month • > 90 days abstinent: 1–3 month expected, no more than 3/month

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Payer, Year	Presumptive Testing	Definitive Testing
Novitas Solutions, Inc. (Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas)	“The contractor will consider presumptive UDT testing in excess of 12 per calendar year not reasonable and necessary....An exception to the above limitation will be made when patients have documented diagnoses consistent with” SUD: • 0–30 days abstinence: 1 to 3 tests per week, no more than 3 tests per week • 31–90 days abstinence: 1 to 3 tests per week, no more than 3 tests per week • > 90 days abstinence: 1 to 3 tests per month, no more than 3 tests per month	For COT: up to 12 definitive tests per year
Common drug testing policy for CGS Administrators, ²³ National Government Services, Inc., ²⁴ Noridian Healthcare Solutions, ²⁵ Palmetto GBA, ²⁶ and Wisconsin Physicians Service Insurance Corporation ²⁷	For SUD: • 0–30 days abstinent: no more than 3/week • 31–90 days abstinent: no more than 3/week • >90 days abstinent: no more than 3/month For COT: based on validated risk assessment; does not differentiate presumptive and definitive testing • Low risk: no more than 2 per year • Moderate risk: no more than 2 per 180 days • High risk: no more than 3 per 90 days	For SUD: • 0–30 days abstinent: no more than 1/week • 31–90 days abstinent: no more than 3/month • > 90 days abstinent: no more than 3/90 days

Abbreviations. COT: chronic opioid therapy; SUD: substance use disorder; UDT: urine drug testing.

TABLE A2

Potential Overuse of Presumptive and Definitive Drug Tests in 50 State Medicaid Programs and the District of Columbia, 2024

State	Presumptive Tests Meeting Criteria for Potential Overuse, %	Estimated Savings for Presumptive Tests, Total Means of Financing, \$	Definitive Tests Meeting Criteria for Potential Overuse, %	Estimated Savings for Definitive Tests, Total Means of Financing, \$	Estimated Savings for Presumptive and Definitive Tests, Total Means of Financing, \$
US	6.8%	\$37,719,344	32.1%	\$207,477,440	\$245,196,784
AK	0.2%	\$9,160	49.8%	\$1,277,871	\$1,287,032
AL	—	—	47.7%	\$1,066,242	\$1,066,242
AR	0.5%	\$20,539	27.9%	\$3,583,632	\$3,604,171
AZ	2.2%	\$383,503	36.7%	\$7,830,670	\$8,214,173
CA	3.6%	\$1,220,072	48.1%	\$25,067,443	\$26,287,515
CO	9.1%	\$1,331,492	72.9%	\$25,170,696	\$26,502,188
CT	5.3%	\$468,982	14.8%	\$706,606	\$1,175,588
DC	2.0%	\$10,713	19.5%	\$155,122	\$165,835
DE	3.8%	\$126,679	21.3%	\$1,982,613	\$2,109,291
FL	0.2%	\$6,648	18.3%	\$1,796,126	\$1,802,774
GA	0.1%	\$6,956	37.2%	\$1,520,461	\$1,527,417
HI	7.6%	\$102,441	22.0%	\$379,228	\$481,669
IA	3.3%	\$127,614	12.1%	\$404,886	\$532,500
ID	1.1%	\$27,078	0.5%	\$17,081	\$44,159
IL	6.4%	\$1,062,860	54.7%	\$11,206,250	\$12,269,110
IN	9.1%	\$1,617,705	4.9%	\$789,701	\$2,407,406
KS	0.1%	\$906	6.3%	\$67,766	\$68,672
KY	5.7%	\$2,327,330	29.0%	\$15,096,282	\$17,423,612
LA	0.2%	\$25,990	0.5%	\$80,068	\$106,058
MA	4.2%	\$556,645	13.2%	\$972,392	\$1,529,037
MD	8.8%	\$1,142,261	12.6%	\$3,784,979	\$4,927,240
ME	9.1%	\$302,119	43.5%	\$1,935,618	\$2,237,737
MI	3.8%	\$461,515	27.8%	\$7,155,165	\$7,616,680
MN	9.9%	\$1,703,293	40.3%	\$9,801,535	\$11,504,828
MO	0.3%	\$18,577	32.2%	\$1,417,241	\$1,435,818
MS	0.1%	\$4,093	35.7%	\$710,414	\$714,507
MT	20.1%	\$462,210	72.3%	\$7,452,549	\$7,914,759

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State	Presumptive Tests Meeting Criteria for Potential Overuse, %	Estimated Savings for Presumptive Tests, Total Means of Financing, \$	Definitive Tests Meeting Criteria for Potential Overuse, %	Estimated Savings for Definitive Tests, Total Means of Financing, \$	Estimated Savings for Presumptive and Definitive Tests, Total Means of Financing, \$
NC	1.9%	\$479,967	36.9%	\$8,023,520	\$8,503,487
ND	0.6%	\$4,500	14.3%	\$93,108	\$97,608
NE	—	—	10.1%	\$54,018	\$54,018
NH	19.6%	\$746,282	28.3%	\$718,589	\$1,464,871
NJ	16.7%	\$4,840,533	8.7%	\$6,038,433	\$10,878,966
NM	15.4%	\$2,224,233	35.2%	\$3,767,007	\$5,991,241
NV	0.8%	\$29,540	34.1%	\$921,602	\$951,142
NY	5.5%	\$368,518	7.6%	\$1,389,511	\$1,758,029
OH	6.1%	\$2,970,540	49.3%	\$20,311,640	\$23,282,180
OK	<0.1%	\$2,168	7.7%	\$60,533	\$62,701
OR	12.9%	\$1,660,154	15.5%	\$3,272,563	\$4,932,717
PA	2.4%	\$760,809	11.0%	\$6,209,674	\$6,970,483
RI	7.2%	\$85,250	20.9%	\$1,370,079	\$1,455,329
SC	0.5%	\$5,527	2.8%	\$58,176	\$63,703
SD	—	\$265	22.3%	\$28,162	\$28,427
TN	1.1%	\$53,645	33.8%	\$995,212	\$1,048,857
TX	—	\$115	34.5%	\$1,453,973	\$1,454,088
UT	27.7%	\$3,049,732	20.5%	\$34,596	\$3,084,327
VA	18.8%	\$5,064,165	47.6%	\$16,560,713	\$21,624,878
VT	12.1%	\$364,273	21.0%	\$844,631	\$1,208,904
WA	0.8%	\$131,541	18.6%	\$522,886	\$654,426
WI	9.9%	\$1,135,559	30.1%	\$2,072,642	\$3,208,201
WV	3.0%	\$214,646	18.8%	\$1,245,425	\$1,460,070
WY	0.7%	\$0	—	\$2,113	\$2,113

Note. “—” indicates that there were either no claims identified or fewer claims identified than are allowed to be reported according to the Centers for Medicare & Medicaid Services’ privacy policy; the value is therefore suppressed.

Source. Center analysis of Medicaid claims and encounter data from the Transformed Medicaid Statistical Information System maintained by the Centers for Medicare & Medicaid Services for calendar year 2024.

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The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

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