Welcome & Meeting Information

• WebEx participants are muted
• Please use the Q & A feature or the Chat feature if you have a question

• The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

• We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

• Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS every Wednesday
  ▪ [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    • Register and enter your zip code to access free online training

• Medicaid provides naloxone to members at no cost and without prior authorization!

• Call your pharmacy before you go to pick it up!

• Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    • Available only to Virginia residents, intramuscular administration
SUPPORT ACT GRANT WEBSITE - HTTPS://WWW.DMAS.VIRGINIA.GOV/#/ARTSSUPPORT
Hamilton Relay Transcriber (CC)

• The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings

• We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars

• The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. https://redcap.vcu.edu/surveys/?s=C8HERT9N3P

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
• When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
• You are able to complete one pre and post survey per each webinar topic you attend.
• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Winter 2022 Webinars

- Urine Drug Screenings: Purpose & Practice: 2-1, 10 – 11 AM & 2-3, 1 – 2 PM
- ASAM Criteria Assessment Dimension 3: 2-8, 10 – 11 AM & 2-10, 1 – 2 PM
- Suicide Assessment: 2-15, 10 – 11 AM & 2-17, 1 – 2 PM
- SUD & Trauma: 2-22, 10 – 11 AM & 2-24, 1 – 2 PM
- Co-occurring Disorders, Part 1: 3-1, 10 – 11 AM & 3-3, 1 – 2 PM
- Co-occurring Disorders, Part 2: 3-8, 10 – 11 AM & 3-10, 1 – 2 PM
- ASAM Criteria Assessment Dimension 4: 3-15, 10 – 11 AM & 3-17, 1 – 2 PM
- SUD Treatment for Adolescents: 3-22, 10 – 11 AM & 3-24, 1 – 2 PM
- ASAM Criteria Assessment Dimensions 5 & 6: 3-29, 10 – 11 AM & 3-31, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
We want to use “Person-Centered language”
- Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
- Not “Addiction,” but Substance Use Disorder (SUD)
- Not “Abuse,” but Use
- Not “Clean,” but In Recovery or Testing Negative
- Not “Dirty,” but Testing Positive
- Not “Relapse,” but Return to Use

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
Abbreviations

- ARTS: Addiction and Recovery Treatment Services
- MOUD: Medication for Opioid Use Disorder (formerly called Medication-Assisted Treatment)
- OBOT: Office-Based Opioid Treatment Program
- OTP: Opioid Treatment Program (formerly called Methadone Clinics)
- OUD: Opioid Use Disorder (formerly Opioid Addiction, Opioid Misuse, Opioid Dependence)
- SUD: Substance Use Disorder (formerly Addiction, Abuse, Dependence)
- UDS: Urine Drug Screens
URINE DRUG SCREENS

Brasler
Urine Drug Screens

Drug testing can be a part of the therapeutic process, and should **not** be used punitively.

UDS are the most common form of drug testing.
UDS Can Be Divided into Two Types

• **Immunoassay (also called Point-of-Care)**
  • Cheap, easy to conduct in your practice
  • Higher possibility of false-positive AND false-negative results
  • In regulations, these are called **Presumptive** tests

• **Lab Testing: Gas Chromatography/Mass Spectrometry Combined (GC/MS)**
  • Very sensitive and accurate
  • More expensive and time-consuming than immunoassay testing
  • GC/MS can also provide levels of a drug in the sample
    • Understand that drug levels can decrease and increase without the client consuming more of a substance between tests
  • In regulations, these are called **Definitive** tests
Before Integrating Urine Drug Screens into Your Practice Setting, Ask Yourself:

Why are we testing?

What are we testing for?

What does this have to do with treatment?
WHY ARE WE TESTING?
Common Answers

- “Because we’ve always tested…”
- “Drug testing is always a part of SUD treatment” (Is it?)
- “To meet our licensure/program/legal requirements” (What is really required?)
- “To protect the integrity of our program?” (How do UDS do that?)
- “To reduce incidents of diversion” (Some merit here)
- “To see if the client is taking their medication(s)” (Depends on the medication)
- “To see if clients have relapsed” (Are there other ways to deduce this?)
ARTS DRUG TESTING REQUIREMENTS CAN BE FOUND AT THE END OF THIS PRESENTATION
Before You Test

There need to be testing policies and procedures in place that follow Medicaid guidelines and clients should be aware of these policies and procedures.

This includes having staff trained in UDS administration.

Have a physical space that allows you to conduct the test and provides privacy for clients (e.g., I recommend against clients having to use a restroom in the agency lobby to provide a sample; it is not dignified).
Conducting a UDS in the Clinic

1. Explain to clients the purpose of the UDS and how it is part of the treatment process. I encourage clients to let us know if they have used anything recently.
2. Have the client leave their purse, backpack, or coat outside the restroom.
3. Ask the client to empty their pockets and leave any contents outside the bathroom.
4. Have the client wash their hands.
5. Give them a sealed specimen cup.
6. Have them go to the restroom, which should be free of cleaning items which could be added to a screen.
7. Some providers put blue dye in the toilet to discourage clients dipping the cup into the water; others have clinic staff flush the toilet—I think both unnecessary.
Conducting a UDS in the Clinic

8. Client brings the capped sample cup back to the clinic medical staff

9. Urine temperature indicator on the cup should read between 90 – 100 degrees Fahrenheit within four minutes of collection

10. Have the client wash their hands

11. If an immunoassay test, wait the required time to check the results

12. If ‘negative’ is denoted by the presence of a line, then any line, no matter how faint, indicates a negative screen. (Remember that indicators will change once the sample sits for long)

13. Depending on the testing system you use, the same sample could be sent to a lab for GC/MS testing

14. Results should be used to guide treatment, including discussions about treatment direction and efficacy
UDS Results I Recommend Focusing On

1. **Is the client testing positive for BUP and Norbuprenorphine?** If yes, it would indicate they are taking their prescribed MOUD. If negative, this should lead to a discussion about why they are not taking the medication and what the plan is moving forward.

2. **Is the client testing positive for METHADONE**, if enrolled in an OTP, the results should be positive.

3. **Is the client testing positive for BZO** when they are not prescribed benzodiazepines? This is concerning given than benzodiazepine use alongside opioid use can increase the risk of overdose. Positive BZO results should precipitate a conversation between client and prescriber.

4. Testing positive for COC and/or mAMP/AMP are also worth discussing with the client given the common co-use of these substances with opioids AND potential contamination with fentanyl/fentanyl analogues in stimulants when they are packaged for sale.
In the U.S. about 18% of people enrolled in outpatient opioid agonist programs have shared or received prescribed medications (Lofwall & Walsh, 2014).

Many people who receive diverted suboxone are trying to manage their withdrawal from illicit and more dangerous opioids.

In areas where there is greater access to MOUD, there is less diversion (Doernberg, et al., 2019), especially in areas where MOUD is time-limited or there are barriers to access.

If clients test negative for BUP but are filling their prescriptions, have a conversation with them. To be clear, if this develops into a pattern, consider a higher level of treatment for the client.
WHAT ARE WE TESTING FOR?
What A Typical UDS Tells Us

- AMP: Amphetamines (can also detect most methamphetamines)
- BAR: Barbiturates (rarely used illicitly)
- BZO: Benzodiazepines
- COC: Cocaine
- METHADONE: Methadone only
- OPI: Usually only opiates (morphine-based medications only, not synthetic or semi-synthetic opioids)—see next slide
- PCP: Phencyclidine (dextromethorphan can cause a false +)
- THC: Delta-9-Tetrahydrocannabinoid (not CBD or synthetic cannabinoids)
UDS: Cutoff (Threshold)

“A cutoff or threshold is a defined concentration of an analyte in a specimen at or above which the test result in an immunoassay is reported as positive. If a substance is detected in concentrations lower than the set cutoff, the test is reported as negative” (Herron & Brennan, 2020, p. 130)
Substance-Specific Tests: Alcohol (ETOH)

“Blood alcohol concentration (BAC) reflects alcohol ingestion in the preceding few hours” (Herron & Brennan, 2020, p. 131)

Breath alcohol testing can be utilized, but a client’s failure to take a deep breath may result in an underestimation of BAC

Urine testing for alcohol is sometimes used as “Metabolites of ethanol can be detected in urine from 24 hours to five days depending on the amount of alcohol ingested but have high false-positive rates” (p. 132)
Substance-Specific Tests: Amphetamines (AMP)

Includes methamphetamine (mAMP), and can include Methyleneoxymethamphetamine (MDMA; “Ecstasy”), and MDA & MDEA (both are entactogens)

“Methylphenidate (Ritalin, Concerta) is not metabolized to amphetamine or methamphetamine and is not detected in confirmatory testing for either” (Herron & Brennan, 2020, p. 132)

Compared with other commonly tested substances, amphetamines have the most false-positive test results
Substance-Specific Testing: Benzodiazepines (BZO)

• “The parent substance is seldom present in the urine, and many benzodiazepines cross-react poorly with common immunoassays, leading to false-negative results” (Herron & Brennan, 2020, p. 133)

• Many BZO immunoassays are less likely to detect Klonopin (clonazepam), Ativan (lorazepam) or Halcion (triazolam)
## Substance-Specific Testing: Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Opiate Immunoassay Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Positive</td>
</tr>
<tr>
<td>Heroin</td>
<td>Positive</td>
</tr>
<tr>
<td>Codeine</td>
<td>Positive</td>
</tr>
<tr>
<td>Hydrocodone (Vicodin, Norco)</td>
<td>Positive</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>Positive</td>
</tr>
<tr>
<td>Oxycodone (Percocet, OxyContin)</td>
<td>Positive/Negative</td>
</tr>
<tr>
<td>Oxymorphone (Opana)</td>
<td>Negative</td>
</tr>
<tr>
<td>Methadone</td>
<td>Negative</td>
</tr>
<tr>
<td>Buprenorphine (Suboxone, Subutex)</td>
<td>Negative</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Negative</td>
</tr>
</tbody>
</table>
Substances Most UDS Will Not Detect

- Caffeine
- Oxymorphone (Opana)
- Buprenorphine (Suboxone)
- Fentanyl
- Kratom
- Ketamine
- Psilocybin
- DMT

- “Z Hypnotics” (Ambien)
- GHB (Gamma Hydroxybutyric Acid)
- Cathinones/Methcathinones (“Bath Salts”)
- Ultram/Tramadol
- JWH Series (Synthetic cannabinoids, “Spice”)
- LSD
- MDMA (Ecstasy)
Substances Reported to Cause False-Positive Results in UDS (Herron & Brennan, 2020, p. 131)

- Bupropion (Wellbutrin)
- Ephedrine
- Pseudoephedrine
- Trazodone
- Vicks inhaler
- Sertraline (Zoloft)
- Amitriptyline
- Doxepin
- Fluoxetine (Prozac)
- Risperidone
- Haldol
- Quetiapine (Seroquel)
- Poppy seeds
- Naloxone
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Venlafaxine (Effexor)
- Numerous antibiotics
- Propranolol
### Approximate Detection Time Using Screening Urine Immunoassays (with Commonly Used Cutoffs)

(Herron & Brennan, 2020, p. 131)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration of Detection (Approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>1 – 3 Days</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>3 Days</td>
</tr>
<tr>
<td>Barbiturate/Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td>• Short acting</td>
<td>1 – 4 Days</td>
</tr>
<tr>
<td>• Long acting</td>
<td>Several weeks</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3 Days</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
</tr>
<tr>
<td>• Single joint</td>
<td>2 Days</td>
</tr>
<tr>
<td>• Heavy Use</td>
<td>Up to 27 Days</td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
</tr>
<tr>
<td>• Heroin, codeine, morphine</td>
<td>1 – 2 Days</td>
</tr>
<tr>
<td>• Methadone (using a specific assay)</td>
<td>2 – 3 Days</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>7 Days</td>
</tr>
</tbody>
</table>
What a UDS Does Not Tell You

• The source(s) of the metabolite that caused the positive results
• If the substance was taken therapeutically
• How much of a substance was taken
• When the substance was taken
• If the individual is currently intoxicated
• If the person has substance use disorder (SUD)
Scheduled vs. Random Testing

**Scheduled**

- Easy for the clinic to staff as these usually take place during business hours
- Easier for clients to prepare for, and this could include water-loading, purchasing items to create a false-negative
- The appearance of trying to “catch” clients is diminished

**Random**

- More difficult for the clinic to staff, especially if outside business hours; would also need to have staff to call clients in on short notice
- More likely to get accurate results as clients are less prepared to tamper with the results
- Could create a system that mimics the legal system as opposed to a system that is treatment and recovery focused
How to ‘Pass’ a UDS While Using

• Use someone else’s urine

• Use a urine substitute
  • Synthetic urine is available for purchase online

• Add a substance to the urine
  • Dishwashing detergent or other cleaners can be on the person’s hand or finger and dipped into the sample
  • Always have the person wash their hands before (and after) providing a sample

• Attempt to dilute the sample by drinking a lot of water
  • Or dipping the sample cup in the toilet

• Taking vitamin supplements (B-complex vitamins are commonly used) to mask the presence of drugs
Ways to Limit False-Negative Results
(Herron & Brennan, 2020, p. 130)

Valid specimens are between 90 – 100 degrees Fahrenheit within four minutes of collection

- Lower temperatures suggest the addition of a liquid other than urine to the sample
- Higher temperatures suggest that something has been added to the sample that was over-heated

Have a specific gravity over 1.003

Have creatine concentrations greater than 5 ng/ml

- Decreased results in these measures suggest “water loading” or another attempt to elicit a false negative
UDS RESULTS FROM TREATMENT PROGRAMS ARE GENERALLY NOT ADMISSIBLE IN COURT
WHAT DOES THIS HAVE TO DO WITH TREATMENT?
“That’s a Good Question…”

...and it is an important one that needs to be answered before you start conducting UDS

How will positive screens impact the treatment plan?

How will negative screens impact the treatment plan?

Positive or negative results can be a means to talk about what the results mean, including possible client needs (support) or praise for the client’s efforts to make changes

UDS results should not result in a client being terminated from treatment
Other Ways to Assess for Substance Use

Ask the client:

- “What substances are you using now?”
- “How much (of each substance) do you use per day?”
- “How long have you been using (each substance)?”
- “When was the last time you used (each substance)?”
- “How are you feeling now?”

Physical exam to assess for intoxication symptoms:

- Dilated versus pin-point pupils
- Blood pressure and/or heart rate
- Behavioral abnormalities (hyperactivity, somnolence, etc.)
Other Types of Drug Screens

• Hair testing
  • Chemical traces are stored in hair cells and can be detected for years, providing a sample of the person’s drug use over an extended time

• Saliva & Breath
  • Less invasive than UDS; harder to detect THC in saliva testing
  • More susceptible to environmental conditions and false positive (or false negative) results
  • However, breathalyzer results are admissible in court in most states

• Sweat
  • Collected over a period of time as the client wears a transdermal patch
Terminating Clients

“There is no other major health problem for which one is admitted for professional care and then punitively discharged from treatment for becoming symptomatic in the service setting. For other healthcare problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment and alternative approaches to patient education and motivation are needed.”

(White, 2014, p. 519)
Continued use of substances may indicate a need for a higher level of care, and should NOT be used as a reason to terminate treatment.

In my opinion there are only a few reasons to terminate a client, specifically:

1. Violence, or threatened violence, (and this could include verbal threats) toward peers and/or staff
2. Distributing illicit substances on clinic property
DMAS DRUG SCREENING REGULATIONS
ARTS Drug Testing Requirements

• Per the September 2020 DMAS memo titled *Guidance for the use of Urine Drug Testing in Substance Use Disorder (SUD) Treatment*:
  • Centers for Medicare & Medicaid Services (CMS), current coding for testing for drugs of SUD relies on a structure of “screening” known as “presumptive” testing or “definitive” testing (Gas Chromatography/Mass Spectrometry Combined (GC/MS)) that identifies the specific drug and quantity in the patient. Urine Drug Testing (UDT) is used to monitor patients treated for SUD. Their use should be supportive and non-punitive: providers are encouraged to consider both positive and negative UDT results in shaping and informing current and future treatment to best support their patients. Drug test frequency is based on the practitioner's best clinical judgment and use of unannounced or random screening schedule rather than a mandated or fixed schedule.
ARTS Drug Testing Requirements

• Per the September 2020 DMAS memo titled *Guidance for the use of Urine Drug Testing in Substance Use Disorder (SUD) Treatment:*
  
  • The primary purposes of UDTs in a SUD treatment environment include:
    
    • To determine if the patient is taking the buprenorphine as prescribed (Note: this can only be determined through GC/MS testing and should include a test for the presence of buprenorphine and norbuprenorphine, a metabolite of buprenorphine, the presence of which would indicate that the client has taken their medication and metabolized it);
    
    • To assess if the patient is taking medications which have a higher risk of overdose when taken with buprenorphine, such as benzodiazepines; and
    
    • If the patient is not taking their medication but still getting their prescription filled, this may indicate diversion.
    
    • Likewise, a patient’s continued use of benzodiazepines or other substances could suggest a need for a higher level of care. Results of point of care tests should be considered presumptive. Definitive screening (GC/MS) should be performed prior to changes in clinical care. GC/MS testing provides exact levels of specific substances found in samples, and it is up to the treatment provider, in coordination with the lab, determine if a sample is ‘positive or negative’. This is done by selecting a cut-off level for each substance.
ARTS Drug Testing Requirements

- Per the September 2020 DMAS memo titled *Guidance for the use of Urine Drug Testing in Substance Use Disorder (SUD) Treatment*:
  - Virginia practice guidelines require drug tests or serum medication levels for addiction treatment with buprenorphine at least every three months for the first year of treatment and at least every six months thereafter. A sample schedule for urine screening is initially weekly for four to six weeks but no more than three per week, then biweekly to every three weeks for four to six weeks and then monthly as the patient becomes stable on buprenorphine. On a case-by-case basis, an individualized clinical review might be indicated to determine whether exceeding these limits is justified. High-acuity and high frequency testing should be based on medical necessity and medical records should support services rendered.
  - Providers should consult with their respective MCOs for Medicaid members if they have additional questions about specific member situations. Services should be based on individual patient needs and may vary.
Presumptive Drug Screens & CPT Codes

80305 → (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures [e.g., immunoassay]; capable of being read by direct optical observation only [e.g., 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 read by instrument-assisted direct optical observation, (e.g., 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** [e.g., utilizing immunoassay (e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA)], chromatography [e.g., GC, HPLC], and **mass spectrometry either with or without chromatography**, [e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF] includes sample validation when performed, per date of service).

• Use one of these codes for urine drug screening and/or alcohol mouth swab

• CPT code 82075 (Alcohol (ethanol), breath) is to be used to bill for the Alcohol Breathalyzer
Definitive Drug Screens & CPT Codes

• Bill G codes for definitive drug screens:

  • **G0480** → Drug test (definitive), utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers...; includes specimen validity testing, per date **1-7 drug class(es)**, including metabolite(s) if performed

  • **G0481** → Drug test (definitive), utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers...; includes specimen validity testing, per date **8-14 drug class(es)**, including metabolite(s) if performed

  • **G0482** → Drug test (definitive), utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers...; includes specimen validity testing, per date **15-21 drug class(es)**, including metabolite(s) if performed

  • **G0483** → Drug test (definitive), utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers...; includes specimen validity testing, per date **22 or more drug class(es)**, including metabolite(s) if performed
Clinical Laboratory Improvement Amendments (CLIA) Questions

The Virginia CLIA state contact is:
Kim Beazley, Virginia Department of Health
(804) 367-2102

Note: In order to look up the test and assist with questions related to CLIA level, providers must provide the name of the analyzer/instrument or the name of the test kit/dipstick
Here is the link to the Post-Webinar Survey. It should take you less than 5 minutes to complete: https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7
• Your name and contact information will not be linked to your survey responses.
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If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Contact Information

Paul Brasler:
Paul.Brasler@dmas.virginia.gov

SUPPORT Act Grant Questions:
SUPPORTGrant@dmas.virginia.gov

ARTS Billing Questions
SUD@dmas.Virginia.gov
References


