REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
10/31/2013	03/08/2018	07/31/2017
Policy Name		**Policy Number**
Drug Testing		PY-0020
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Drug Testing

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

Monitoring for controlled substances is performed to detect the use of prescription medications and illegal substances of concern for the purpose of medical treatment. Monitoring for controlled substances plays a key role particularly in the care of persons undergoing medical treatment with chronic pain therapy and substance use disorder (SUD). CareSource will reimburse charges for drug testing that are medically necessary for the management of members being treated with drugs that are potentially abusive or addictive such as opioids and related medications, or for members suspected of using illicit drugs solely or in combination with prescribed controlled substances. CareSource will also reimburse for qualitative/presumptive drug testing performed as part of routine, prenatal care for pregnant members.

Providers should have a working knowledge of analytic detection including primary agents, metabolites, lab threshold concentrations, and time periods involved in detection. The combination of a patient's self-report and drug testing results serve as important tools in controlled substance monitoring, as well as a point of patient engagement.

Qualitative/presumptive testing is a routine part of care, used when immediate results are needed, knowing results may be less accurate than quantitative/confirmatory tests. Quantitative/confirmatory testing is used when results may affect changes in medication, when patients dispute qualitative/presumptive results, or in treatment transitions.

Anecdotal evidence to support testing for individual patients should be balanced with the limited population evidence for added value of multiple tests for chronic pain patients or SUD patients. For example, in a 2015 evaluation of 2,551,611 de-identified patients' urine drug test results over four years in the U.S., Quest Diagnostics identified that the best achieved yearly inconsistency rate (when the results of a drug screen are not consistent with the patient's history and prescribed medicines) in all urine drug tests was 53% (in 2014 vs 63% in 2011).

C. DEFINITIONS

- **Intensive Outpatient Services** (**IOP**) generally provide increased weekly services consisting primarily of counseling and education for Substance Abuse Disorder (SUD). Ohio Administrative Code (OAC) defines IOP as structured individual and group activities provided a minimum of 8 hours per week with services provided at least 3 days per week. Also, in IOP,
    - Individual has a minimal risk of severe withdrawal;
    - Generally provide 9-19 hours of structured programming per week for adults;
    - Generally provide 6-19 hours of structured programming per week for adolescents;
    - Fewer hours possible in final week or two transitioning back to lower level of care;
    - Requires structured programming of counseling and education.

- **Partial Hospital Program** (**PH** or **PHP**), sometimes known as "Day Treatment" is characterized by:
    - Individual has a moderate risk of severe withdrawal;
    - Generally features 20 or more hours per week of clinically-intensive programming;
    - Adolescents receive services often during school hours and typically have access to educational services (or are coordinated with school);
    - Psychiatric and medical consultation usually within 8 hours by phone or 48 in person;
    - Highly structured, distinct clinical services required.
- **Clinically-managed, low-intensity residential services**
    - No withdrawal risk, or minimal or stable withdrawal;
    - Typically in a halfway house, group or other supportive living environment with 24-hour staff;
    - Individuals who because of specific functional limitations need safe and stable living environment and 24-hour care;
    - Services are community based, not hospital based;
    - Clinical services usually no less than 5 hours per week;
    - Community and house meetings, emphasis on community recovery.
- **Qualitative analysis** - The testing of a substance or mixture to determine its chemical constituents, also known as presumptive testing.
- **Quantitative test** - A test that determines the amount of a substance per unit volume or unit weight, also known as confirmatory testing.
- **Early and Periodic Screening, Diagnostic and Treatment** (**EPSDT**) - this benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPDST is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services through early diagnosis and treatment. The program specifically covers comprehensive health and developmental histories, immunizations, health education, vision services, dental services, hearing services, and any additional health care diagnostic and treatment services for physical and mental illnesses that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan. Under the EPSDT program, any Medicaid provider can find a problem, make a referral or provide treatment. This includes doctors, nurses, dentists, physical therapists, occupational therapists, speech therapists, psychologists, psychiatrists and other health care professionals.**Random alcohol and drug screen** – a lab test administered at a regular interval which is not announced in advance to the person being tested, and which detects the presence of alcohol, drugs or substances in the individual.
- **Outpatient Treatment Programs** (**OTP**) **drug testing requirements** – for substance use disorder treatment, in the US Federal Code, "OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient."
- **Medication Assisted Treatment** (**MAT**) – treatment of opioid SUD with buprenorphine, methadone, or Vivitrol.
- **Multi-Panels** – Orders that automatically create multiple CPTs in a request.

D. POLICY

I. Prior Authorization (PA) is not required for drug testing under this policy.

II. Clinical scenarios for drug testing have general and specific considerations for medical necessity criteria, to justify coverage according to this policy.
    A. Specific criteria for coverage:

1. Clinical scenarios for medically necessary drug testing warrant special considerations. The following circumstances describe medical documentation needs to justify coverage based upon medical necessity related to clinical scenarios where drug testing is applied.
    1.1. Member is receiving Intensive Outpatient (IOP) or PH Services for Substance Abuse Disorder (SUD). ASAM Consensus Statement (23) recommends a minimum of weekly testing. Members in IOP undergo medically necessary drug testing if ALL of the FOLLOWING criteria are met:
        a. Member meets state or plan criteria for this level of care (e.g. state regulation/provider manual/guidance such as ASAM, MCG)
        b. Provider documents reason for drug test(s) requested (e.g. member drug of choice, locally prevalent drug, common drugs of abuse, test adherence to prescribed drug)
        c. Provider documents planned clinical consequence of unexpected result
        d. If requesting confirmatory test from a presumptive positive, provider must document that unexpected qualitative/presumptive result was first discussed with member and member contested result and provider is validating only the contested result.
    1.2. Member is receiving Induction phase of MAT for Substance Abuse Disorder (SUD) with buprenorphine/naloxone products, buprenorphine products, or methadone. ASAM Consensus Statement (23) recommends a minimum of weekly testing. Members in MAT Induction phase undergo medically necessary drug testing if ALL of the FOLLOWING criteria are met:
        a. Member meets criteria for Opioid Use Disorder
        b. Provider has documented assessment of member readiness for treatment
        c. Provider documents in assessment that member is appropriate for office based level of care
        d. There is documentation to show that member is in mild or higher withdrawal prior to induction (using a validated clinical scale such as COWS or CINA)
    1.3. Member with Substance Use Disorder and demonstrating signs of relapse and at risk of dropping out of care undergoes medically necessary drug testing if ALL of the FOLLOWING are met:
        a. ASAM Consensus Statement (23) recommends minimum of weekly testing. Additional testing beyond limits is reasonable if ALL of the FOLLOWING criteria are met:
            i. Member meets criteria for Opioid Use Disorder
            ii. Provider has documented assessment of member readiness for treatment
            iii. Provider documents in assessment that member is appropriate for office-based level of care
            iv. There is documentation to show that member is in mild of higher withdrawal prior to induction (using a validated clinical scale such as COWS or CINA)
        b. ASAM Consensus Statement (23) recommends that members at relapse should be treated as if in early recovery. Provider documents signs of relapse or unstable recovery, including at least ONE OF THE FOLLOWING:
            i. Poor participation in services
            ii. Collateral information from member's support network
            iii. Evidence of intoxication or behavior suggesting renewed use
            iv. Deterioration in functioning (loss of job, school, active BH symptoms
            v. OARRS report result demonstrates recent controlled substance prescription not reported to provider

c. Provider documents reason for drug test(s) requested (e.g. member drug of choice, locally prevalent drug, common drugs of abuse)
d. Provider documents planned clinical consequence of an unexpected result

1.4. Member behaviors demonstrate potential risk of diversion undergo medically necessary drug testing if ALL of the FOLLOWING criteria are met:
a. Provider has made an assessment and documented risk factors with ALL of the FOLLOWING including:
i. Unexpected findings on OARRS report (Note: provider cannot show the actual report)
ii. Provider documented risk factors include THREE of the FOLLOWING:
1. Requests for early refills
2. Recent drug screen does not show MAT
3. Member claims lost prescription, lost medication, stolen medication
4. Provider documents pill counts (or film counts) are not correct
5. Collateral information from member's support network suggesting diversion
6. Increased ED visits for pain symptoms
7. Involvement in criminal justice system
iii. Provider has documented planned clinical consequence if diversion confirmed, up to and including discharge of member (not just more drug testing)

1.5. Members being treated for chronic pain undergo medically necessary drug testing and medical records document ALL of the FOLLOWING criteria are met:
a. Provider has documented use of a valid risk tool for risk of substance-related disorder such as Screener and Opioid Assessment for Patients with Pain (SOAPP-R) or Opioid Risk Tool (ORT)
b. If provider makes a substance-related disorder diagnosis, there is documentation of referral for further evaluation and services
c. Unexpected findings on OARRS report (Note: provider cannot show the actual report)

1.6. Member receiving Residential Level of Service for Substance Use Disorder undergo medically necessary drug testing if ALL of the FOLLOWING criteria are met:
a. Member meets state or plan criteria for this level of care (e.g. state regulation/provider manual/guidance such as ASAM, MCG)
b. Provider documents reason for drug test(s) requested (e.g. member drug of choice, locally prevalent drug, common drugs of abuse)
c. Provider documents planned clinical consequence of an unexpected result
d. Provider documents symptoms of suspected intoxication when member returns from community unaccompanied by staff

1.7. Member is pregnant or is under the age of 21 and the medical record documentation meets criteria in the following section D.II.B. "General criteria for coverage."

B. General criteria for coverage
1. An analyte being tested is medically necessary when a specific rationale as documented in the medical record and testing includes ONE of the FOLLOWING criteria:
1.1. A qualitative/presumptive test was performed, and ONE of the FOLLOWING criteria are met:
a. Request for testing must be based on a current qualitative urine test result that shows an inconclusive or unexpected finding.
b. The member contests a presumptive result in a qualitative/presumptive urine drug test

c. Additional presumptive/qualitative testing may be medically necessary for members in treatment scenarios listed in D.I.B. when policy limits have been exhausted.

1.2. Specific synthetic or semi-synthetic agent(s) in a medically necessary test has no qualitative/presumptive test equivalent and ONE of the FOLLOWING criteria are met for coverage:
   a. An MAT drug or metabolite (for example, buprenorphine or methadone)
   b. A chosen agent of abuse, as reported by the patient and documented in the medical record, without available detection by qualitative/presumptive testing (e.g. fentanyl)

2. ALL of the FOLLOWING criteria are met:
   2.1 Documentation requirements are present in the medical record
   2.2 Reason for test is documented (rationale for the specific test ordered) including TWO or MORE OF THE FOLLOWING CRITERIA:
      a. Member's history of drug of choice
      b. Drugs prevalent in the member's geographic region for testing periodically for cause
      c. More commonly abused drugs to be tested periodically for cause
      d. Use of presumptive/qualitative testing for naturally occurring opioids
      e. Use of confirmatory/quantitative testing for synthetic or semi-synthetic opioids
   2.3 Signed and dated physician's order is present WITH ALL OF THE FOLLOWING CRITERIA:
      a. Order matches the number of tests performed, without a multi-panel profile involving many CPT's.
      b. Order matches the level of test performed (presumptive vs confirmatory)
      c. Order includes list of all medications currently prescribed for the patient as of the test date (and over the counter medications)
   2.4 Provider's plan for the clinical consequence(s) of an unexpected result(s)
   2.5 Member was informed of the test results including unexpected result(s)
   2.6 Presence or absence of signs and symptoms of renewed use of agent in relapse, including intoxication.

III. **Individualized Testing**: In all cases other than routine qualitative drug testing as part of prenatal care, medical necessity for submitted charges must be individualized and documented in the member's medical record and included in the treatment plan of care. CareSource does not provide coverage for drug testing for forensic, legal, employment, transportation, or school purposes.

IV. **Non-Urine Testing:** CareSource will reimburse blood testing in emergency department settings only, to evaluate acute overdose. Drug testing with blood samples performed in any other setting outside of an ER requires that medical record documentation meets criteria in the above section D.II.B. "General criteria for coverage", and, if applicable, also in the above section D.II.A. "Specific criteria for coverage. Hair, saliva, or other body fluid testing for controlled substance monitoring has limited support in medical evidence and is not covered unless medical record documentation meets criteria in the above section D.II.B. "General criteria for coverage", and, if applicable, also in the above section D.II.A. "Specific criteria for coverage. If covered, non-urine drug testing is reimbursed at the lesser of coverage amounts per CPT for urine testing and non-urine testing.

NOTE: Drug testing codes listed in this policy which may include blood or other non-urine bodily fluids, or other physical samples in their coding definitions, will nevertheless not be reimbursed by CareSource unless (1) the test is performed in the ER setting AND the sample used is blood, as stated above; or, (2) medical record documentation meets

criteria in the above section D.II.B. “General criteria for coverage”, and, if applicable, also in the above section D.II.A. “Specific criteria for coverage.

V. **Urine Testing**: Urine for clinical drug testing is the specimen of choice because of its high drug concentrations and well-established testing procedures. Nevertheless, urine is one of the easiest specimens to adulterate.
   A. If the clinician suspects such an occurrence, the clinician may choose to evaluate specimen validity using validity tests. Specimen validity testing is considered to be a quality control issue and should not be separately billed. Failure to document customized test panels with medical necessity information for each individual member and for each of the drug test panels ordered will result in the denial of the claim for reimbursement, audit, and/or overpayment requests, and any other program means for enforcing this policy.
   B. Urine Drug testing should be focused on the detection of specific drugs and not routinely include a panel of all drugs of abuse.
   C. Orders for “custom profiles,” “standing orders,” “drug screen panel”, “custom panel”, “blanket orders,” “reflex testing” or to “conduct additional testing as needed,” are not sufficiently detailed and coverage for such testing will be denied by CareSource since they would not verify medical necessity for the specific tests.
   D. Testing on a routine basis is neither random nor individualized. Routine or reflex testing are not covered by CareSource. A random basis is defined as a basis which the patient cannot predict ahead of time. For example, testing performed at every clinical visit is not random.
   E. CareSource does not provide coverage for testing as a requirement to stay in a facility, for example, in sober living or residential locations.
   F. Providers and laboratories will need to ensure specimen integrity appropriate for the stability of the drug agent being tested, until the prior authorization process is completed, for example, freezing a specimen.

VI. **Physician Orders:** A signed and dated physician order for the drug testing is required. For In-Network Providers, the physician’s order must specifically match the number, level and complexity of the testing panel components performed.

VII. **Out-of-Network lab service providers**: Out-of-network providers are not covered for urine drug testing laboratory services. Out-of-network clinicians may use par laboratories for drug testing services.

VIII. **Additional Documentation Requirements**: All documentation must be maintained in the member’s medical record and available to CareSource upon request. The following additional documentation requirements apply:
   A. Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative/presumptive drug test.
   B. Every page of the record must be legible and include appropriate member identification information (e.g., complete name, dates of service(s)).
   C. The record must include the identity of the physician or non-physician practitioner responsible for and providing the care of the member.
   D. The submitted medical record should support the use of the selected ICD-10-CM code(s) with appropriate indications for urine drug testing.
   E. The submitted CPT/HCPCS code should accurately describe the service performed.
   F. Copies of test results alone without the proper clinician’s order for the test are not sufficient documentation of medical necessity to support a claim.
   G. Urine drug testing records and related entries in a member’s medical record shall be provided to CareSource upon request for auditing of medical necessity. Documentation must support medical necessity and specify why each test is ordered. Documentation must also support the number of analytes requested for testing, and what action the

provider will take upon the findings.

IX. **Testing by Non-ordering Providers**:
- A. If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the drug test. The ordering/referring physician must include the clinical indication/medical necessity in the order for the drug test as outlined above.
- B. Laboratories performing drug testing services must bill CareSource directly. CareSource does provide coverage for claims from clinicians for drug testing services ordered by clinicians but performed by laboratories.

X. **Confirmatory and Duplicative Testing**
- A. Prior authorization is not required. CareSource will not reimburse for routine multi-drug quantitative/confirmatory testing. Quantitative/confirmatory testing must be individualized for the member and medically necessary. Routine confirmations (quantitative) of drug screen tests with negative results are not covered by CareSource. Quantitative/confirmatory testing is covered for a negative drug/drug class screen when the negative finding is inconsistent with the member's documented medical history and/or current documented chronic pain medication list, and indications substantiated in the medical record
- B. CareSource will not reimburse for routine nonspecific or wholesale orders for drug testing (qualitative), confirmation or (quantitative) drugs of abuse testing.

XI. **Drug Testing Laboratories**
- A. CareSource will not reimburse drug testing conducted for its members by non-participating labs or facilities, even if such tests were ordered by a participating provider or physician.
- B. CareSource may require documentation of FDA-approved complexity level for instrumented equipment, and/or CLIA Certificate of Registration, Compliance, or Accreditation as a high complexity lab.
- C. Both participating (contracted) physicians with CareSource, as well as, non-participating (not contracted) physicians may potentially order laboratory tests for CareSource members
- D. Those participating physicians with Practice Services Agreements only, may not bill CareSource for quantitative/confirmatory drug screen testing.
- E. Only providers with an Independent Laboratory Contract with CareSource can bill for quantitative/confirmatory drug screens.
- F. Laboratories MUST be both CLIA certified AND contracted (participating) with CareSource.
- G. Claims submitted by laboratories that are non-participating (not contracted) with CareSource will NOT be reimbursed.
- H. CareSource will not reimburse drug testing if required by a third party such as:
  1. Medico-legal purposes (e.g., court-ordered drug test) or
  2. For employment purposes (e.g., as a pre-requisite for employment or as a requirement for continuation of employment).
  3. As a condition of:
     - 3.1 Participation in school or community athletic activities or programs
     - 3.2 Participation in school or community extra circular activities or programs
  4. As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.), EXCEPT for once yearly screening in EPSDT programs.
  5. As a component of medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.).

6. As a requirement to live in sober housing or residential services, unrelated to medically necessary indications for testing.

NOTE: Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting Ohio Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Ohio Medicaid fee schedule.
http://medicaid.ohio.gov/Portals/0/Providers/FeeScheduleRates/App-DD.pdf

The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.

NOTE: Drug testing codes listed in this policy which may include blood or other non-urine bodily fluids, or other physical samples in their coding definitions, will nevertheless not be reimbursed by CareSource unless (1) the test is performed in the ER setting AND the sample used is blood, as stated above; or, (2) medical record documentation meets criteria in the above section D.II.B. "General criteria for coverage", and, if applicable, also in the above section D.II.A. "Specific criteria for coverage." If covered, non-urine drug testing is reimbursed at the lesser of coverage amounts per CPT for urine testing and non-urine testing.

Codes	Description
80155	Drug screen quant caffeine
80159	Drug screen quant clozapine
80171	Gabapentin, drug screen quant
80173	Assay of haloperidol
80184	Phenobarbitol
80299	Quantitation of drug, not elsewhere specified
Codes	**Qualitative/Presumptive Tests-Description**
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 (e.g., immunoassay); 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
Codes	**Quantitative/Confirmatory Tests-Description**
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	Alcohol biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamines; 3 or 4
80326	Amphetamines; 5 or more

80327	Anabolic steroids; 1 or 2
80328	Anabolic steroids; 3 or more
80329	Analgesics, non-opioid; 1 or 2
80330	Analgesics, non-opioid; 3-5
80331	Analgesics, non-opioid; 6 or more
80332	Antidepressants, serotonergic class; 1 or 2
80333	Antidepressants, serotonergic class; 3-5
80334	Antidepressants, serotonergic class; 6 or more
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 6 or more
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1-3
80340	Antiepileptics, not otherwise specified; 4-6
80341	Antiepileptics, not otherwise specified; 7 or more
80342	Antipsychotics, not otherwise specified; 1-3
80343	Antipsychotics, not otherwise specified; 4-6
80344	Antipsychotics, not otherwise specified; 7 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids, synthetic; 7 or more
80353	Cocaine
80354	Fentanyl
80355	Gabapentin, non-blood
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80366	Pregabalin
80367	Propoxyphene
80368	Sedative hypnotics (non-benzodiazepines)
80369	Skeletal muscle relaxants; 1 or 2
80370	Skeletal muscle relaxants; 3 or more
80371	Stimulants, synthetic
80372	Tapentadol
80373	Tramadol
80374	Stereoisomer (enantiomer) analysis, single drug class
83992	Phencyclidine (PCP)
84311	Spectrophotometry, analyte not elsewhere specified
Codes	**Qualitative/Presumptive OR Quantitative/Confirmatory-Description**
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3

80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
83789	Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

See Drug Testing Medical Policy (MM-0054)

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2014	
Date Reviewed	03/08/2017	
Date Revised	03/08/2017 5/31/2017	• added presumptive/confirmatory language clarifications • defined outpatient treatment programs • clarified coverage for individualized testing • updated language prohibiting blanket orders, routine testing • inserted language that CS may audit for medical necessity • updated quantity limits of tests to 5 per type per quarter per member (regardless of provider) • updated ICD-10 codes. • Changes to language regarding potential Prior Authorization
Effective Date	07/31/2017	Changes to language regarding Prior Authorization, updated codes.

H. REFERENCES

1. Ohio Administrative Code, Medicaid Alcohol and Drug Addiction Services. (2012, October 1). Retrieved on 8/15/2016 from http://codes.ohio.gov/oac/5160-30
2. Ohio Administrative Code, Medicaid Treatment services. (2012, July 1). Retrieved from on 8/15/2016 from http://codes.ohio.gov/oac/3793%3A2-1-08
3. Ohio Medicaid Fee Schedule Rates. (2016, August). Retrieved on 8/15/2016 from http://medicaid.ohio.gov/Portals/0/Providers/FeeScheduleRates/App-DD.pdf
4. Ohio Medicaid Fee Schedule Rates and Covered CPT Codes. (2016, January). Retrieved from on 8/15/2016 http://medicaid.ohio.gov/Portals/0/Providers/FeeScheduleRates/CPT-HCPS-2016.pdf
5. A. Barthwell, "Statement of Consensus on the Proper Utilization of Urine Testing in Identifying and Treating Substance Use Disorders," 2015. [Online]. Available: http://farronline.org/wp-content/uploads/2015/11/Final-Report-Statement-of-Consensus-on-the-Proper-Utilization-of-Urine-Testing-in-Identifying-and-Treating-Substance-Abuse-Disorders.pdf
6. A. Pesce, C. West, K. Egan City and J. Strickland, "Interpretation of urine drug testing in pain patients," Pain Medicine, vol. 13, no. 7, pp. 868-85, 2012.
7. Mayo Clinic, "Approximate detection times of drugs of abuse," Oct 2016. [Online]. Available: http://www.mayomedicallaboratories.com/test-info/drug-book/viewall.html

8. K. E. Moeller, K. C. Lee and J. C. Kissack, "Urine drug screening: Practical guide for clinicians," Mayo Clinic Proceedings, vol. 83, no. 1, pp. 66-76, Jan 2008.
9. S. Vakili, S. Currie and N. el-Guebaly, "Evaluating the utility of drug testing in an outpatient addiction program," Addictive Disorders and their Treatment, vol. 8, no. 1, pp. 22-32, 2009.
10. A. Jaffe, S. Molnar, N. Williams, E. Wong, T. Todd, C. Caputo, J. Tolentino and S. Ye, "Review and recommendations for drug testing in substance use treatment contexts," Journal of Reward Deficiency Syndrome and Addiction Science, vol. 2, no. 1, pp. 28-45, 2016.
11. K. Dolan, D. Rouen and J. Kimber, "An overview of the use of urine, hair, sweat and saliva to detect drug use," Drug and Alcohol Review, vol. 23, no. 2, pp. 213-217, 2004.
12. A. G. Verstraete, "Detection times of drugs of abuse in blood, urine, and oral fluid," Therapeutic Drug Monitoring, vol. 26, no. 2, pp. 200-205, 2004.
13. ASAM, Principles of Addiction Medicine, 5th Edition ed., R. K. Ries, D. A. Fiellin, S. C. Miller and R. Saitz, Eds., Philadelphia, PA: Lippincott Williams & Wilkins, 2014.
14. A. Rzetelny, B. Zeller, N. Miller, K. E. City, K. L. Kirsh and S. D. Passik, "Counselors' clinical use of definitive drug testing results in their work with substance-use patients: A qualitative study, "International Journal of Mental Health and Addiction, vol. 14, no. 1, pp. 64-80, 2016.
15. J. Dupouy, V. Macmier, H. Catala, M. Lavit, S. Oustric and M. Lapeyre-Mestre, "Does urine drug abuse screening help for managing patients? A systematic review," Drug and Alcohol Dependence, vol. 136, pp. 11-20, 2014.
16. E. Y. Hilario, M. L. Griffin, R. K. McHugh, K. A. McDermott, H. S. Connery, G. M. Fitzmaurice and R. D. Weiss, "Denial of urinalysis-confirmed opioid use in prescription opioid dependence, "Journal of Substance Abuse Treatment, vol. 48, no. 1, pp. 85-90, 2015.
17. ASAM, "Drug Testing: A White Paper of the American Society of Addiction Medicine," American Society of Addiction Medicine, Chevy Chase, MD, 2013.
18. Quest Diagnostics Health Trends™ Prescription Drug Monitoring Report 2015, Prescription Drug Misuse in America, Diagnostic Insights in the Continuing Drug Epidemic Battle. Accessed on December 8, 2016. Located at https://www.questdiagnostics.com/dms/Documents/health-trends/Health_Trends_27281_MI4854_V5_LG_082715_Small.pdf
19. Ohio Administrative Code, Chapter 4723-6 Alternative Program for Chemical Dependency/Substance Use Disorder Monitoring "Random alcohol and drug screen" definition. Retrieved 3/2/2017 from http://codes.ohio.gov/oac/4723-6 .
20. Drug abuse testing services, in the United Stated Federal Code, CFR 42, Part 8 § 12(f)(6) Retrieved on 3/2/2017 from https://www.law.cornell.edu/cfr/text/42/8.12
21. Early and Periodic Screening, Diagnostic, and Treatment | Medicaid.gov. (n.d.). Retrieved from https://www.medicaid.gov/medicaid/benefits/epsdt/index.html
22. Ohio Department of Medicaid - Healthchek.(n.d.). Retrieved from http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthchek.aspx
23. Consensus Statement. **Appropriate Use of Drug Testing in Clinical Addiction Medicine**. *Journal of Addiction Medicine*, June 2017

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.