MEDICAL POLICY STATEMENT
Indiana Marketplace

Policy Name & Number	Date Effective
Drug Testing-IN MP-MM-0130	11/01/2023-09/30/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement 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. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Drug Testing

B. Background

Drug testing is part of medical care during initial assessment, ongoing monitoring, and recovery phases for members with substance use disorder (SUD), members who are at risk for abuse/misuse or diversion of drugs, and/or for other medical conditions. Drug testing assists providers in diagnosing and planning member care when prescription medications or illegal drugs are of concern.

Drug testing is one component of a comprehensive clinical approach during the initial assessment, stabilization, maintenance and recovery phase for members with an SUD. The assessment process, including initial drug testing, will aid the treatment provider in individualizing the drug testing plan for a member. Testing is also used for the periodic screening of members who are prescribed chronic opioid therapy (COT) for pain based on a risk score and helps determine if a member is adhering to prescription medication, reveals nonprescribed drugs or illicit drugs, and/or provides evidence to suggest diversion.

Providers requesting drug testing should have proficiency in drug test interpretation and an understanding of tests that need ordered. Urine testing is the most common method for monitoring drug use with two main types, presumptive and confirmatory. Drug testing is sometimes referred to as toxicology testing.

C. Definitions

- **Aberrant Behavior** - Behaviors indicating medication/drug abuse or misuse (i.e., losing prescriptions, early refill requests, multiple prescribers for controlled substances on the state's Prescription Drug Monitoring Program).
- **American Society of Addiction Medicine (ASAM)** - A professional medical society representing associated professionals in the field of addiction medicine dedicated to increasing access and improving the quality of addiction treatment.
- **Chronic Opioid Therapy** - The use of opioids to treat chronic pain at intervals longer than three months or past the time of normal tissue healing.
- **Clinical Laboratory Improvement Amendments (CLIA**) - The Centers for Medicare & Medicaid Services (CMS) regulates programs that test human specimens to ensure accurate, reliable and timely patient test results, regardless of where a test is performed, including physician offices.
- **Confirmatory (Quantitative) Test** - A test determining the amount of substances per unit volume or unit weight, also known as quantitative or definitive testing.
- **Diversion** - Unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace.
- **Independent Laboratory** - A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.

- **Opioid Treatment Program (OTP)** - Program or qualified provider delivering opioid treatment to members with an opioid agonist treatment medication.
- **Presumptive (Qualitative) Test** - The testing of a substance or mixture to determine its chemical constituents, also known as qualitative testing.
- **Random Drug Test** - A laboratory drug test administered at an irregular interval that is not known in advance by the member.
- **Relapse** - A person with addiction issues returns to use after a period of sobriety.
- **Residential Treatment Services** - Health care services that can include individual and group psychotherapy, family counseling, nursing services, and pharmacological therapy with 24-hour support.

D. Policy

I. Copies of test results without the provider's order are not sufficient documentation of medical necessity to support a claim. Urine drug testing (UDT) orders must include, at a minimum, **all** the following:
   A. type of test to be performed (presumptive or confirmatory)
   B. all medications currently prescribed to the member
   C. drug and drug class to be tested
   D. clinical indication
   E. signature and date of qualified provider
   F. must specifically match the number, level and complexity of testing components performed

II. Provider Documentation
   All components of a UDT panel must be supported by medical necessity in the provider's documentation. A panel of drugs may be performed as part of an initial assessment to develop a monitoring plan but should only be conducted based on an individualized treatment plan noting the need for confirmatory test with greater than 14 drug tests, which are rarely indicated for routine UDT. Providers must maintain a complete, legible medical record for the member and include the following:
   A. complete member name and identification on each page of record
   B. identification of the provider responsible for providing member care
   C. appropriate indication for UDT
   D. how the UDT result will guide the plan of treatment
   E. CPT code that accurately describes the service(s) performed

III. Medical Necessity Review and Quantity Limitations
   A. CareSource will review medical necessity on a case-by-case basis. Presumptive testing should be the initial test considered, as often a positive result of a drug class informs the provider about a need to change the treatment plan. Higher number drug panels are rarely indicated for routine UDT as lower number panels are sufficient for modifying treatment plans in most cases.
   B. CareSource will cover up to 30 presumptive and 12 definitive UDT per member per calendar year before a review of medical necessity is required.

1. Appropriate clinical documentation must be included with request and should provide clear evidence for the level of testing requested, including but not limited to:
   a. phase of treatment (e.g., assessment, early recovery, induction, stabilization, maintenance)
   b. current level of care (e.g., use of ASAM levels)
   c. member drug(s) of choice
   d. days since last drug test with unexpected results
   e. current prescribed drugs, including over-the-counter drugs and illicit drugs that have had unexpected results in recent tests
   f. member's current, active symptoms that led to the request
   g. provider actions taken on recent unexpected test results and member response to that action
   h. clinical documentation showing member contesting the result of an unexpected presumptive test
   i. test is not being requested for third party reasons or as a condition to stay in sober housing or residential facility
   j. results of any pill counts performed by treatment team
2. A review of medical necessity is not required in an emergency department (ED) setting. Confirmatory testing is rarely needed in this setting. UDT utilization will be monitored by CareSource.

C. If needed, the licensed practitioner operating within his/her scope of practice must obtain the medical necessity review.
D. Each CPT code is counted as one test.
E. In determining medical necessity for additional tests, current clinical information will be considered. A review of medical records will be performed to determine the appropriateness of the initial 30 presumptive and 12 definitive drug tests ordered within a calendar year.

IV. Providers and laboratories will ensure specimen integrity appropriate for the stability of the drug being tested (i.e., freezing specimen). Diluted, substituted or adulterated urine samples will alter a test result. If tampering is suspected, the sample should be discarded. When possible, the member should remain at the provider facility until a new specimen is obtained and can be tested.

CareSource may require documentation of FDA-approved complexity level for instrumented equipment, and/or Clinical Laboratory Improvement Amendments (CLIA) Certificate of Registration, compliance, or accreditation as a high complexity lab. Laboratories must maintain hard copy documentation of lab results with copies of the order for the drug test.

V. Clinical Indications
Testing should be individualized to the member, including analytes testing that will be ordered based on the member's drug(s) of choice. Periodically, drugs commonly used and/or regionally prevalent drugs may be rotated into the random testing

schedule. The rationale for tests is not meant to include all drugs all of the time, rather the drugs most likely to be present in the individual to assist provider focus regarding specific treatment. Testing should be at the lowest level and inform the provider that an intervention is needed based on the member's history of use.

Drug testing is ideally performed on a random schedule within a specific time frame to produce a specimen. ASAM recommends a random-interval schedule to a fixed-interval schedule to eliminate known non-testing periods. Providers should understand windows of detection time to determine frequency of testing and know detection windows for drugs. Providers should also be aware of the potential for cross-reactivity when using presumptive tests. Drug testing does not have to be associated with an office visit.

A. Drug testing in addiction treatment
    1. UDT frequency is expected more frequently early in treatment or when tapering and is expected to decrease as a member stabilizes.
    2. Prior to Initiation or in the Induction Phase (early recovery):
        a. Obtain history, as well as a medical and psychological assessment.
        b. Review approximate time frame of drug detected in urine.
        c. Identify questions to answer, as well as treatment planning options based on potential UDT results.
        d. Obtain an individualized baseline UDT based on member's unique clinical presentation, prescribed medications, member's self-reported drugs of choice, and regional drug trends.
        e. Test at least weekly, citing ASAM consensus guidelines.
        f. Discuss results with member.
        g. Agree on plan of care, including treatment interventions and goals.
        h. This phase includes members that have relapsed.
    3. Maintenance phase: Test at least once per month.
    4. Intensive outpatient: Test at least weekly.
    5. Substance use disorder residential treatment program: Test at least monthly.
    6. Stable recovery: Drug testing may be done less frequently.
    7. Members taking long-acting naltrexone: Test at least monthly.

B. Drug testing in an opioid treatment program (OTP)
    1. maintenance treatment - federal regulations governing OTP require initial toxicology plus 8 random UDT screens per year per member
    2. short-term detoxification treatment - one initial UDT per member
    3. long-term detoxification treatment - an initial and monthly random UDTs per member

C. Drug testing by advanced practice registered nurse (APRN)
    1. Prescribing naltrexone to treat opioid use disorder: Complete UDT or serum medication levels at least every 3 months for the first year and then at least every 6 months thereafter.
    2. Prescribing buprenorphine products: Complete UDT or serum medication levels at least twice per quarter for the first year of treatment and once per quarter thereafter.

D. Chronic pain management
   1. Prior to or upon initiation of treatment
      a. Complete an assessment for risk of substance abuse using a validated risk assessment screening tool, such as Screener and Opioid Assessment for Patient with Pain-Revisited (SOAPP-R) or the Opioid Risk Tool (ORT).
      b. Review the state prescription drug monitoring program data (PDMP).
      c. Obtain baseline UDT screening and discuss results with the member.
      d. Agree on plan of care, including treatment goals, and provide education on risks and benefits with strategies to mitigate risks.
      e. Combine evidence-based non-pharmacologic and non-opioid pharmacologic therapy, as necessary.
   2. Ongoing monitoring of treatment determined by level of risk for substance use
      a. low risk - UDT once a year
      b. moderate risk - UDT twice a year
      c. high risk - UDT up to 4 times a year
      d. UDT when member shows aberrant drug-related behavior
      e. review PDMP data every 1-3 months
      f. evaluate benefits and risks of treatment at least every 3 months

E. Unexpected results
   1. Discuss any possible member aberrant behavior.
   2. Potential reasons for unexpected results may include the following:
      a. nonadherence (either recently or not at all)
      b. member utilizing drug amount below detection threshold
      c. substance cannot be identified by the type of test performed
      d. lab errors, adulterated specimens and/or cross-reactivity
      e. member absorbs, excretes, and/or metabolizes at different rate
      f. not member's urine sample or diluted urine from water loading
      g. diversion
   3. Potential interventions for unexpected results are dependent on assessment and may include the following:
      a. Evaluate and discuss factors contributing to relapse.
      b. Minimize tampering opportunities during collection of sample.
      c. Monitor pill counts and/or review PDMP.
      d. Dose adjustment and/or collaboration/referral with specialist.
      e. Change in level of care, intensity of treatment, or plan of treatment (i.e., addition of behavioral therapy or community supports).
      f. Change in lifestyle (i.e., housing, support system) and/or attending to psychosocial barriers, such as transportation and/or financial needs.
      g. Address co-occurring medical or behavioral needs.
      h. Obtain confirmatory UDT.

VI. Confirmatory Testing

Confirmatory testing should not routinely be utilized as the first choice for UDT. Medical necessity criteria for confirmatory testing are met when **one** of the following is in the medical documentation:

1. Presumptive testing was negative for prescription medications, and provider was expecting a positive result for prescribed medication. Member reports taking medication as prescribed.
2. Presumptive testing was positive for prescription drug with abuse potential that was not prescribed by provider, and the member disputes the presumptive testing results.
3. Presumptive testing was positive for an illegal drug, and the member disputes the presumptive testing results.
4. A specific substance or metabolite needs identified that cannot be identified by a presumptive testing, such as semi-synthetic and synthetic opioids or particular benzodiazepines.

VII. Blood Testing

Blood drug testing is considered medically necessary when it is in an emergency department (ED) setting.

VIII. Testing that is considered not medically necessary for presumptive and/or confirmatory testing, includes, but is not limited to, the following:

A. Testing that is not individualized, including, but not limited to, the following:
   1. reflexive testing
   2. routine, standard and/or preprinted orders
   3. requesting all tests a machine can do solely because a result may be positive
   4. large, arbitrary panels and/or universal testing
   5. orders for "*Conduct additional testing as needed.*"

B. Testing required by third parties, including, but not limited to, the following:
   1. testing ordered by a court for other medico-legal purpose, such as child custody
   2. testing for pre-employment or random testing that is a requirement of employment
   3. physician's health programs, such as recovery programs for physicians, dentists, veterinarians, pharmacists, or others
   4. school entry or testing for athletics
   5. testing required for military service
   6. testing in residential treatment facility, partial hospital, or sober living as a condition to remain in that community
   7. testing with another pay source that is primary, such as a county, state or federal agency
   8. testing for a marriage license or for other administrative purposes
   9. forensic testing
   10. routine physical and/or medical examination conditions

C. Testing for validity of specimen is included in the payment for the test and will not be reimbursed separately.
D. Blood drug testing when completed outside the ED.
E. Hair, saliva, or other body fluid testing for controlled substance monitoring.
F. Any type of drug testing not addressed in this policy.
G. Routine nonspecific or wholesale orders, including routine drug panels.
H. Routine use of confirmatory testing following a negative presumptive expected result.
I. Custom profiles, standing orders, drug screen panel, custom panel, blanket orders, reflex testing or conduct additional testing as needed orders.
J. A confirmatory test prior to discussing results of presumptive test with member.

E. Conditions of Coverage

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepay review.

F. Related Polices/Rules

CareSource Evidence of Coverage, Indiana

G. Review/Revision History

	DATE	ACTION
Date Issued	12/13/2017	
Date Revised	08/01/2019	Updated clinical indications, quantity limits, and prior authorization requirements
	01/01/2020	Removed quantity limits and prior authorization requirements. Updated D. III. & D. IV.
	09/02/2020	Reformatted. Removed related reimbursement policy.
	09/01/2021	Updated references.
	08/31/2022	Annual review. No changes.
	08/02/2023	Annual review. Updated references. Approved at Committee.
Date Effective	11/01/2023	
Date Archived	09/30/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

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