HAP CareSource™

MEDICAL POLICY STATEMENT
Michigan Marketplace

Policy Name & Number	Date Effective
Drug Testing-MI MP-MM-1637	10/01/2025
Policy Type	
MEDICAL	

Medical Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract 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 multiple phases for members with substance use disorder (SUD) or those at risk for abuse/misuse or diversion of drugs. The testing process assists providers in member care and serves a variety of purposes, including enhancing patient care, reducing health risk, justifying continued therapy, and providing rationale for changing or altering treatment. The assessment process, including initial drug testing, aids providers in individualizing treatment plans for members.

Drug testing may help determine if a member is adhering to prescription medication, reveal nonprescribed drugs or illicit drugs, and/or provide 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, presumptive and confirmatory testing, also referred to as toxicology testing.

Presumptive testing identifies the use or non-use of a drug or class of drugs and are more commonly routine due to speed of testing, accuracy, and accessibility in a wide variety of settings. Definitive tests are more specific, can refine test results, and allow for the detection of specific drugs or metabolites of interest. Definitive testing may be needed when presumptive results are not sufficient to guide clinical care, but definitive testing must be clinically meaningful with documentation that supports the specific necessity of each definitive assay performed. Ethical use of drug testing requires a testing panel and frequency justified by the clinical condition and the ordering provider's need for information.

C. Definitions

- **Aberrant Behavior** – Behaviors indicating medication/drug abuse or misuse (ie, losing prescriptions, early refill requests, multiple prescribers for controlled substances on the state's Prescription Drug Monitoring Program).
- **Chronic Opioid Therapy** – The use of opioids to treat chronic pain at intervals longer than 3 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.
- **Definitive (Confirmatory/Quantitative) Test** – A test determining the amount of a substance per unit volume or unit weight of specific drugs or metabolites.
- **Presumptive (Qualitative) Test** – Testing of a substance or mixture to determine the presence or absence of a drug or drug class.
- **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. Medical Necessity Review and Quantity Limitations
    A. HAP CareSource will review medical necessity on a case-by-case basis. Presumptive testing should be the initial test considered. Higher number drug panels are rarely indicated for routine UDT as lower number panels are sufficient for modifying treatment plans.
    B. HAP 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
        a. phase of treatment (eg, assessment, early recovery, stabilization, maintenance) and current level of care (ASAM level)
        b. member drug(s) of choice
        c. days since last drug test with unexpected results
        d. current prescribed drugs, including over-the-counter drugs and illicit drugs with unexpected results in recent tests
        e. member's current, active symptoms that led to the request
        f. provider actions taken on recent unexpected test results and member response to that action
        g. clinical documentation showing member contesting the result of an unexpected presumptive test
        h. 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. Blood drug testing is considered medically necessary when in an ED setting.
    C. If needed, the licensed practitioner operating within an applicable scope of practice must obtain the medical necessity review.
    D. Each CPT code is counted as 1 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 drug tests ordered within a calendar year.
    F. Confirmatory testing should not routinely be utilized as the first choice for UDT. Medical necessity criteria for confirmatory testing are met when **1** of the following is documented in the medical record:
      1. Member reports taking medication as prescribed, but presumptive testing was negative for prescription medications. The provider was expecting a positive result for prescribed medication.
      2. Member disputes the following presumptive test results:
        a. positive results for prescription drug with abuse potential that was not prescribed by provider

b. positive results for an illegal drug

3. 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.

II. Documentation Requirements

A. Drug Test Order

Copies of test results without the provider's order are not sufficient documentation of medical necessity to support a claim. UDT orders must include, at a minimum, **all** the following:

1. type of test to be performed (presumptive or confirmatory)
2. all medications currently prescribed to the member
3. drug and drug class to be tested
4. clinical indication
5. signature and date of qualified provider
6. must specifically match the number, level and complexity of testing components performed

B. Provider Documentation in the Member Medical Record

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. Providers must maintain a complete, legible medical record for the member and include the following:

1. complete member name and identification on each page of record
2. identification of the provider responsible for providing member care
3. appropriate indication for UDT
4. how the UDT result will guide the plan of treatment
5. CPT code that accurately describes the service(s) performed

C. Laboratory Documentation

Documentation maintained must include the following:

1. physician's order for testing
2. test results
3. all records pertinent to billing

III. Clinical Indications

Testing should be completed randomly within a specific time frame to produce a sample and analytes tested based on the member's drug(s) of choice. Periodically, drugs commonly used or regionally prevalent may be rotated into the testing schedule. The rationale is not meant to include all drugs all the time, rather the drugs most likely to be present in the member to assist clinical care regarding specific treatment.

Providers should understand windows of detection time to determine frequency of testing, know detection windows for drugs, and be aware of the potential for cross-reactivity when using presumptive tests. Testing does not have to be associated with

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

A. Drug testing in addiction treatment
    1. UDT frequency is more frequent early in treatment or when tapering and expected to decrease as a member stabilizes.
    2. Prior to initiation or in the early recovery phase and including members who have relapsed:
        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. Discuss results with member.
        f. Agree on plan of care, including treatment interventions and goals.
        g. 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 requires 1 initial UDT per member.
    3. Long-term detoxification treatment includes an initial and monthly random UDT(s) 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 (eg, Screener and Opioid Assessment for Patient with Pain-Revisited [SOAPP-R], 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 abuse
   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 a 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. Adjust dosage and/or collaborate with specialist.
      e. Change the level of care, intensity of treatment, or plan of treatment (ie, addition of behavioral therapy or community supports).
      f. Attend to psychosocial barriers (eg, transportation, finances) to promote a change in lifestyle (eg, housing, support system).
      g. Address co-occurring medical or behavioral needs.
      h. Obtain a confirmatory UDT.

IV. 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:
      1. reflexive testing, routine, standard and/or preprinted orders
      2. requesting all tests from a machine solely because a result *may* be positive
      3. large, arbitrary panels, universal testing, or orders for "*Conduct additional testing as needed.*"
   B. Testing required by third parties, including, but not limited to:
      1. court-ordered for other medico-legal purposes (eg, child custody)
      2. pre-employment or random testing that is a requirement of employment

3. physician's health programs (eg, recovery programs for physicians, dentists, veterinarians, pharmacists, or others)
4. school entry, testing for athletics, and/or military service testing
5. residential treatment facility, partial hospital, or sober living testing as a condition to remain in that community
6. testing with a primary pay source (eg, county, state or federal agency)
7. marriage license or other administrative purpose testing
8. forensic testing
9. routine physical and/or medical examination conditions

C. Blood drug testing when completed outside the ED.
D. Hair, saliva, or other body fluid testing for controlled substance monitoring.
E. Any type of drug testing not addressed in this policy or without documentation of medical necessity.
F. Routine use of definitive testing following a negative presumptive result or prior to discussing results of presumptive test with member.

E. Conditions of Coverage

I. 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.

II. HAP 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.

F. Related Polices/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	07/31/2024	New policy. Approved at Committee.
Date Revised	06/18/2025	Annual review. Updated references. Approved at Committee.
Date Effective	10/01/2025	
Date Archived		

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