

## REIMBURSEMENT POLICY STATEMENT INDIANA MEDICAID

Policy Name		Policy Number	Date Effective
Drug Testing		PY-0155	01/01/2021-12/31/2021
Policy Type			
Medical	Administrative	Pharmacy	<b>REIMBURSEMENT</b>

**Reimbursement Policy Statement:** Reimbursement Policies prepared by CareSource and its affiliates 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.

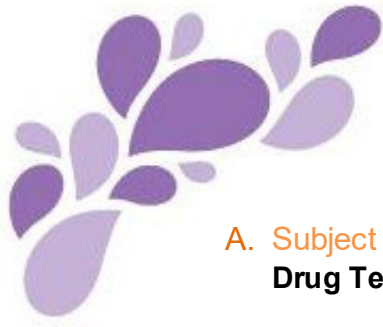
This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan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

CareSource 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.

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**

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. Claims submitted to CareSource must be complete in all respects; and all use of the Health Insurance Claim Form CMS-1500 must comply with the most recent version of the Medicare Claims Processing Manual.

Drug testing is a part of medical care during the initial assessment, ongoing monitoring, and recovery phase for members with substance use disorder (SUD); for members who are at risk for abuse/misuse of drugs; or for other medical conditions. The drug test guides a provider in diagnosing and planning the member's care when prescription medications or illegal drugs are of concern.

Urine is the most common specimen to monitor drug use. There are two main types of urine drug testing (UDT): presumptive/qualitative and confirmatory/quantitative. Drug testing is sometimes also referred to as toxicology testing.

**C. Definitions**

- **Presumptive/Qualitative test** - The testing of a substance or mixture to determine its chemical constituents, also known as qualitative testing.
- **Confirmatory/Quantitative test** - A test that determines the amount of a substance per unit volume or unit weight, also known as quantitative or definitive 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.
- **Random drug test** - A laboratory drug test administered at an irregular interval that is not known in advance by the member.
- **Independent laboratory** - A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.
- **Participating/non-participating** - Participating means in-network and contracted with CareSource. "Non-participating," means out-of-network, not contracted with CareSource.
- **Residential services** - Includes individual and group therapy, medication training and support, case management, drug testing, and peer recovery supports.



NOTE: Clinical guidelines, definitions, standards, and scenarios for drug testing are outlined in detail within the CareSource Drug Testing Medical Policy, MM-0126. Please refer to this policy for in-depth information on medical necessity for drug testing, documentation requirements, and CareSource monitoring and review of drug testing claims.

#### D. Policy

- I. General Criteria for Coverage
  - A. Documentation must support medical necessity.
  - B. Documentation must include the ICD-10 code demonstrating appropriate indication for UDT.
  - C. The submitted CPT/HCPCS code must accurately describe the service performed.
  - D. CareSource requires that the ordering provider's name appear in the appropriate lines of the claims forms.
- II. Prior Authorization (PA)
  - A. CareSource will consider all prior authorization requests when they are medically necessary to the member's treatment and care, or if they fall within the standards of care under EPDST guidelines.
    1. CareSource will require a PA for confirmatory UDT that exceed 25 confirmatory tests per member per calendar year.
    2. PA is not required in an emergency room setting. UDT utilization will be monitored by CareSource.
    3. PA needs to make a clear case for medical necessity for the level of testing being requested.
  - B. Providers and laboratories will need to ensure specimen integrity appropriate for the stability of the drug agent being tested until the PA process is complete i.e. freezing specimen.
  - C. Must submit appropriate clinical documentation with PA request to determine appropriate medical necessity.
  - D. If needed, the licensed practitioner that is operating in his/her scope of practice must obtain the prior authorization.
- III. Quantity Limitations
  - A. CareSource will require a PA for confirmatory UDT that exceed 25 confirmatory tests per member per calendar year.
  - B. Each CPT code is counted as one test.
- IV. Laboratory
  - A. Drug testing conducted for CareSource members by non-participating labs or facilities is not billable to and will not be reimbursed by CareSource, even if such tests were ordered by a participating provider.
  - B. Non-participating providers are not covered for drug testing laboratory services.
  - C. CareSource laboratories performing drug testing services must bill CareSource directly. CareSource does not allow pass-through billing of services. Any claim submitted by a provider which includes services ordered by that provider, but are



performed by a person or entity other than that provider or a direct employee of that provider, is not billable to CareSource.

- V. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is billable for comprehensive and preventive health care service for children under age 21.
  
- VI. Non-Urine Testing
  - A. CareSource will reimburse blood testing in emergency room settings.
  - B. Drug testing with blood samples performed in any other setting outside of an emergency room is a non-covered benefit.
  - C. Hair, saliva, or other body fluid testing for controlled substance monitoring has limited support in medical evidence and is not covered.
  
- VII. Confirmatory Testing
  - A. Routine multi-drug confirmatory testing is not billable and will not be reimbursed by CareSource.
  - B. Confirmatory testing must be individualized for the member and medically necessary. Routine confirmatory drug tests with negative presumptive results are not covered by CareSource.
  - C. Confirmatory testing is billable when documentation supports
    - 1. How the test results will guide plan of care (i.e. modification of treatment plan, consultation with specialist) and one of the following:
      - a. Presumptive testing was negative for prescription medications and provider was expecting the test to be positive for prescribed medication and member reports taking medication as prescribed;
      - b. Presumptive testing was positive for prescription drug with abuse potential that was not prescribed by provider and the member disputes the presumptive testing results;
      - c. Presumptive testing was positive for illegal drug and the member disputes the presumptive testing results; or
      - d. A substance or metabolite is needed to be identified that cannot be identified by presumptive testing. (e.g. semi-synthetic and synthetic opioids, certain benzodiazepines).
  
- VIII. Non-Billable Drug Testing
  - A. Testing that is not individualized such as
    - 1. Reflexive testing.
    - 2. Routine orders.
    - 3. Standard orders.
    - 4. Preprinted orders.
    - 5. Requesting a broad spectrum of tests that a machine is capable of doing solely because a result may be positive.
    - 6. Large arbitrary panels.
    - 7. Universal testing.
    - 8. Conduct additional testing as needed.
  - B. Testing required by third parties such as
    - 1. Testing ordered by a court or 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 (recovery for physicians, dentists, veterinarians, pharmacists, etc.).
  4. School entry or testing for athletics.
  5. Testing required for military service.
  6. Testing in residential 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 marriage license.
  9. Forensic.
  10. Testing for other admin purposes.
  11. Routine physical/medical examination EXCEPT for the EPSDT program.
- C. Testing for validity of specimen  
It is included in the payment for the test and will not be reimbursed separately.
- D. Blood drug testing when completed outside of the emergency room.
- E. Hair, saliva, or other body fluid testing for controlled substance monitoring.  
Testing for the same drug with both a blood or saliva test and a urine specimen simultaneously (multiple tests seeking the same outcome).
- 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.
- K. Testing paid for by another primary source (e.g. county, state or federal agency).

NOTE: 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.

### E. CONDITIONS OF COVERAGE

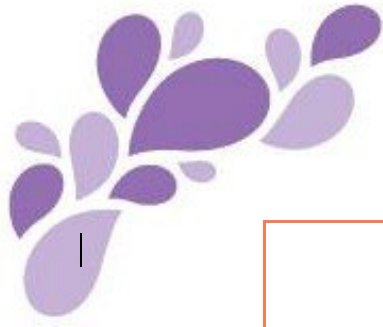
Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

### F. RELATED POLICIES/RULES

CareSource Drug Testing Medical Policy MM-0126

### G. REVIEW/REVISION HISTORY

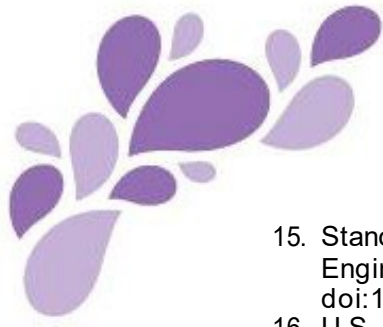
DATE		ACTION
<b>Date Issued</b>	11/29/2017	
<b>Date Revised</b>	11/01/2019	Updated clinical indications, quantity limits, and PA requirements
	01/15/2020	Updated quantity limits and PA requirements.



	03/16/2020	Updated IV
	09/02/2020	Removed codes. Updated PA requirements and quantity limits.
<b>Date Effective</b>	01/01/2021	
<b>Date Archived</b>	12/31/2021	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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The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

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