CareSource

REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Drug Testing		PY-0020	01/01/2021-06/30/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

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.
- **Qualified Laboratories** - When an out-of-network qualified laboratory provides toxicology test results to the referring health care provider within two business days of receipt of the test specimen, the MCP shall pay that laboratory at least sixty percent of the Medicaid laboratory services fee schedule. For the purposes of this

requirement, a qualified laboratory is a laboratory that is enrolled with Medicaid as an independent laboratory, and that meets all of the following conditions:
1. Is accredited by the College of American Pathologists; and
2. Is approved by the New York Clinical Laboratory Evaluation Program; and
3. Indicates to the MCP that it is providing services and billing as a qualified laboratory

- **Residential services** - Ohio Administrative code defines residential services as "These services are co-occurring capable, co-occurring enhanced, and complexity capable in nature and provided by addiction treatment, mental health and general medical personnel in a twenty four hour treatment setting. Services are provided in Ohio department of mental health and addiction services certified permanent facilities which are staffed twenty four hours a day."[1]

NOTE: Clinical guidelines, definitions, standards, and scenarios for drug testing are outlined in detail within the CareSource Drug Testing Medical Policy, MM-0054. 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 an 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 UDT tests >30 presumptive and/or > 12 confirmatory UDT per member per calendar year. Prior authorization will be required for confirmatory drug tests involving 22 or more drug classes. (G0483).
         a. The Ohio Department of Medicaid Standard UDT PA Form must be provided along with the appropriate supporting documentation when requesting a PA.
         b. Appropriate clinical documentation must be included with PA request to determine appropriate medical necessity.
            01. PA needs to make a clear case for medical necessity for the level of testing being requested, it may include but is not limited to:
               (1) Phase of treatment (e.g. assessment, early recovery, induction, stabilization, maintenance).

[1] http://codes.ohio.gov/oac/5160-27-09v1

(2) Current level of care (e.g. use of ASAM levels).
(3) Member drug(s) of choice.
(4) Days since last drug test with unexpected results.
(5) Current prescribed drugs including over-the-counter drugs and illicit drugs that have had unexpected results in recent tests.
(6) Member current active symptoms that led to the request.
(7) Provider actions taken on recent unexpected test results and member response to that action.
(8) The clinical documentation shows that the member is contesting the result of an unexpected presumptive test.
(9) The test is not being requested for third party reasons, or as a condition to stay in sober housing or residential facility (see additional information below).
(10) Results of any pill counts performed by treatment team.

2. PA is also required for
   a. Any non-participating provider with CareSource for non-emergency room setting.
   b. Any non-participating, non-qualified lab/facility with CareSource for non-emergency room setting.
   c. Any non-participating, qualified lab/facility with CareSource for non-emergency room setting.
3. PA is NOT required in an emergency room setting. Confirmatory testing is rarely needed in this setting. UDT utilization will be monitored by CareSource.

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. 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 cover up to 30 presumptive and 12 definitive UDT per member per calendar year.
   1. CareSource will cover up to 30 presumptive UDT per member per calendar year.
   2. CareSource will cover up to 12 definitive UDT per member per calendar year.
B. Each CPT code is counted as one test.

IV. Laboratory
A. 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 or body fluid testing for controlled substance monitoring has limited support in medical evidence and is not covered.
  1. Point-of-service testing (H0048), which includes both urine and saliva, is a covered service for Community Behavioral Health Centers (CBHCs).

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; or
  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; or
11. Routine physical/medical examination EXCEPT for the EPSDT program.

C. Testing for validity of specimen
   1. 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 or other body fluid testing for controlled substance monitoring, except for point-of-service testing (H0048), which includes both urine and saliva, when rendered by a CBHC.
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.

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-0054

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	11/29/2017	
Date Revised	03/08/2017 05/31/2017 10/01/2017 11/29/2017 02/16/2018 05/13/2019 07/01/2019	

	07/08/2019 09/24/2019 06/10/2020 08/19/2020 11/12/2020	Updated clinical indications, quantity limits, and PA requirements Updated qualified laboratories per ODM guidance Added ODM PA form Update with ODM requirement to allow saliva for point-of-service testing (H0048) for CBHCs. Removed codes. Updated per ODM Medicaid Advisory Letter 650. Removed appendix A.
Date Effective	01/01/2021	
Date Archived	06/30/2021	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.