



MEDICAL POLICY STATEMENT

Arkansas PASSE

Policy Name & Number	Date Effective
Drug Testing-AR PASSE-MM-1332	02/01/2023-10/31/2023
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.

Table of Contents

A.	Subject.....	2
B.	Background.....	2
C.	Definitions	2
D.	Policy	3
E.	Conditions of Coverage.....	7
F.	Related Polices/Rules	8
G.	Review/Revision History.....	8
H.	References.....	8

A. Subject
Drug Testing

B. Background

Drug testing is a part of medical care during initial assessment, ongoing monitoring, and recovery phases for members with substance use disorder (SUD) or members who are at risk for abuse/misuse or diversion of drugs. The drug test assists providers in diagnosing and planning a member's care when prescription medications or illegal drugs are of concern. The assessment process, including initial drug testing, will aid the treatment provider in individualizing the drug testing plan for a member.

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. There are two main types of urine drug testing (UDT): presumptive and confirmatory testing, also referred to as toxicology testing.

C. Definitions

- **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.
- **Diagnostic and Statistical Manual of Mental Disorders 5th Edition, Text Revised (DSM 5-TR)** - The standard language by which clinicians, researchers, and public health officials in the United States communicate about mental disorders, substance use disorders, and subsequent criteria and classification of these disorders.
- **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 and including physician offices.
- **Confirmatory/Quantitative Test** - A test determining the amount of a substance per unit volume or unit weight, also known as definitive testing.
- **Extension of Benefits** - A review of medical necessity and authorization to exceed an annual maximum benefit.
- **Independent Laboratory** - A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.
- **Medication Assisted Treatment (MAT)** - Use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
- **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.
- **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.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** - An agency within the U.S. Department of Health and Human Services leading public health efforts to advance behavioral health and creating scientific resources, including toolkits and clinical practice guidelines.
- **X-Drug Enforcement Agency (DEA) Number** - A “data-waived” registration allowing providers to avoid U.S. DEA registration requirements for narcotic treatment programs, such as organized methadone clinics.

D. Policy

- I. Providers of medication assisted treatment (MAT) for substance use disorders must be licensed in Arkansas and have a current X-DEA identification number on file with Arkansas Medicaid.
 - A. MAT providers are required to follow SAMHSA guidelines.
 - B. MAT providers are responsible for case management and adjusting the treatment plan for the member’s maximum progress. Monitoring and addressing non-compliance must be documented in the member’s record and can be requested for review by CareSource.
 - C. MAT providers must coordinate all follow-up and referrals for counseling and other services.
 - D. If counseling or other components of treatment are being referred to other providers, those providers’ records are also subject to post payment review and recoupment for services not documented as compliant with SAMHSA guidelines.
 - E. MAT providers will not be reimbursed for the prescribing of FDA-approved MAT medications for the practice of pain management.
- II. Medical Necessity (Extension of Benefits)
 - A. Participating/In-Network Providers: For members 21 years of age and older, a review of medical necessity is required after reaching \$500, unless codes are billed with modifiers X2 or X4 to indicate medication assisted treatment for opioid use disorder.
 - B. Non-Participating/Out of Network Providers: A review of medical necessity is required for all testing.
 - C. Presumptive drug testing via CPT codes 80305 - 80307, which differ based on the level of complexity of the testing methodology, may be billed one code per date of service. Providers performing validity testing on urine specimens shall not separately bill for validity testing of the specimen, including a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests.
- III. General documentation requirements include the following for providers:
 - A. Member name and identification on each page of record.
 - B. History and physical examinations.
 - C. Chief complaint on each visit.
 - D. Tests and results, including review of results with member and any follow-up or recommendations based on results.

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

- E. Diagnoses.
 - F. Service or treatment, including prescriptions and referrals for other services.
 - G. Signature or initials of the physician after each visit.
 - H. Copies of records pertinent to services delivered by or under the supervision of the physician and billed to Medicaid.
 - I. Service dates of any services billed to Medicaid, including service dates for all components of global services billed.
 - J. Copies of any service plans, treatment plans and plans of care physicians have authorized that are developed by non-physician providers, including any subsequent revisions of those plans.
- IV. Independent lab services required documentation must include the following:
- A. The physician's order for laboratory tests
 - B. Test results
 - C. All records pertinent to billing
- V. In accordance with SAMHSA guidelines, MAT requires at a minimum:
- A. Initial evaluation and diagnosis of Opioid Use Disorder, including:
 - 1. Drug screening tests to accompany proper medication prescribing for MAT. Buprenorphine mono-therapy is typically reserved only for pregnant women and members with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone combinations.
 - 2. Lab screening tests for communicable diseases, as appropriate based on the patient's history.
 - 3. Use of all necessary consent forms for treatment and HIPAA compliant communication.
 - 4. Execution of a treatment agreement or contract. Providers may develop an agreement or contract that contains all elements listed within SAMHSA's sample agreement or may use SAMHSA's sample treatment agreement.
 - 5. Development of a Person-Centered Service Plan (PCSP) or individualized treatment plan.
 - 6. Referral for independent clinical counseling or documented plan for integrated follow-up visit, including counseling.
 - 7. Identification of a MAT team member to function as the case manager for support services.
 - B. Continuing treatment (first year):
 - 1. Regular outreach to the member to determine need for assistance in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.
 - 2. At least one (1) follow-up MAT office visit per month for medication and treatment management.
 - 3. Drug testing in conjunction with each monthly visit.
 - 4. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit, including counseling, per month.
 - C. Maintenance treatment (subsequent years):
 - 1. Regular outreach to the member to determine need for assistance in

- accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.
2. At least one (1) follow-up MAT office visit quarterly (every three months) for medication and treatment management.
 3. Drug testing in conjunction with each quarterly visit.
 4. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit, including counseling, at an amount and duration medically necessary for continued recovery.

VI. Drug Test Order and Documentation

Copies of test results without the provider's order are not sufficient documentation of medical necessity to support a claim.

A. Drug test orders must include, at a minimum, all the following:

1. Type of test to be performed (presumptive or confirmatory).
2. A diagnosis (ICD coding) for each test ordered *and* pertinent supplemental diagnoses supporting the need for the test(s).
3. All medications currently prescribed to the member.
4. Drug and drug class to be tested.
5. Clinical indication.
6. Signature and date of qualified provider and the referring physician's individual provider identification number.
 - If the member's Primary Care Physician (PCP) referred the client to the physician ordering the tests, the ordering physician must include with the order the PCP's individual provider identification number (PIN) in addition to the ordering physician's individual PIN.
 - The reference facility retains the ordering physician's provider information with the member's medical record for the medical necessity audit trail.

B. All components of a drug testing panel must be supported by medical necessity in the provider's documentation. Appropriate clinical documentation must be included with the request and should provide clear evidence for the level of testing requested, including, at a minimum, all the following:

1. Phase of treatment (e.g., assessment, continuing, maintenance).
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 (i.e., not correlated with member history, positive when member indicates no substances used, etc.) results.
5. Current prescribed drugs, including over-the-counter drugs and illicit drugs that have had unexpected results in recent tests.
6. Member's current, active symptoms that led to the request, including how a test result will guide the plan of care.
7. Provider actions taken on recent unexpected test results and member response to that action.
8. Clinical documentation showing member contesting the unexpected result of a presumptive test.
9. Results of any pill counts performed by treatment team.

- VII. Providers are encouraged to use presumptive drug testing methods as these are clinically appropriate for detecting nearly all prescription opioids, benzodiazepines and illicit drugs.
- A. The use of definitive testing should be used to detect specific opioids unidentified by presumptive urine drug tests (UDTs) or in the presence of unexpected results.
 - B. Confirmatory testing can assess for drug metabolites, which may help identify if the member has been consistently taking prescribed medications as intended.
 - C. Providers should not test for substances for which results would not affect patient management.
 - D. The provider billing for UDT has the responsibility of ensuring that services were billed in accordance with these requirements.

VIII. Laboratory Testing

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 may be required. Laboratories must maintain hard copy documentation of lab results with copies of the order for the drug test and any required medical necessity review.

IX. Clinical Indications

Testing should be individualized to the member and analytes tested 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 with 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 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.
 - B. Drug testing in an opioid treatment program (OTP)
 - 1. In maintenance treatment, federal regulations governing OTP require initial toxicology plus 8 random UDT screens per year per member.
 - 2. In short-term detoxification treatment, one initial UDT per member.
 - 3. In long-term detoxification treatment, an initial and monthly random UDT(s) per member.
- X. Blood Testing
Blood drug testing is considered medically necessary when it is in the emergency department setting.
- XI. Testing 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, such as child custody.
 - 2. Pre-employment or random testing that is a requirement of employment.
 - 3. Physician’s health programs, such as recovery programs for physicians or other medical professionals.
 - 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 (i.e., 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.
 - F. Routine nonspecific or wholesale orders, including routine drug panels.
 - G. Routine use of confirmatory testing following a negative presumptive result.
 - H. Custom profiles, standing orders, drug screen panel, custom panel, blanket orders, reflex testing or “*Conduct additional testing as needed orders.*”
 - I. 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 Policies/Rules

Medical Necessity Determinations
Behavioral Health Service Record Documentation Standards

G. Review/Revision History

	DATE	ACTION
Date Issued	11/09/2022	
Date Revised		
Date Effective	02/01/2023	
Date Archived	10/31/2023	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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