



MEDICAL POLICY STATEMENT Arkansas PASSE

Policy Name & Number	Date Effective
Drug Testing-AR PASSE-MM-1332	06/01/2026
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 and an important component of effective substance use disorder (SUD) treatment, providing valuable information for both members and providers. Testing supports accountability, enhances safety and contributes to better treatment outcomes. The integration of drug testing into treatment planning assists healthcare professionals in supporting members with tailored interventions, objectively monitoring abstinence and can help identify co-occurring mental health disorders that may complicate the treatment of SUD.

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 2 main types, presumptive and confirmatory. Drug testing is sometimes referred to as toxicology testing. Ethical use of drug testing requires a testing panel and frequency justified by the clinical condition and the ordering provider's need for information. CareSource follows the Arkansas Department of Human Services (DHS) *Independent Laboratory Provider Manual (ILPM)* and guidance from the American Society of Addiction Medicine (ASAM) for the treatment of SUD.

C. Definitions

- **Definitive (Confirmatory/Quantitative) Test** – A test determining the amount of a substance per unit volume or unit weight of specific drugs or metabolites.
- **Extension of Benefits** – A review of medical necessity and authorization to exceed an annual maximum benefit.
- **Medication Assisted Treatment (MAT)** – The use of Food and Drug Administration (FDA)-approved medications in conjunction with counseling and behavioral therapies to treat substance use.
- **Presumptive (Qualitative) Test** – Testing of a substance or mixture to determine the presence or absence of a drug or drug class.

D. Policy

- I. Providers of MAT for SUD must be licensed in Arkansas and authorized to provide services within the Arkansas Medicaid system. Providers are encouraged to use telemedicine services when in-person treatment is not readily accessible. For guidance, providers should refer to 203.271, 272.600 and 292.920 of the *ILPM*.
 - A. MAT providers are required to follow Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines, at a minimum, those listed in section 230.
 - B. MAT providers will not be reimbursed for the prescribing of FDA-approved MAT medications for the practice of pain management.

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

- 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 a limit of \$500 per calendar year for all laboratory services, unless codes are billed with appropriate modifiers to indicate MAT for OUD. Additional instructions are located in *ILPM* 225.100.
 - 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 1 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. Documentation Requirements
 - A. Physicians and laboratories are required to maintain records listed in 202.000 and 229.120 of the *ILPM*, *Section II*.
 - B. 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.
 - 1. Drug test orders must include, at a minimum, all the following:
 - a. type of test to be performed (presumptive or confirmatory) with drug and drug class to be tested
 - b. diagnosis (ICD coding) for each test ordered *and* pertinent supplemental diagnoses supporting the need for the test(s)
 - c. all medications currently prescribed to the member
 - d. clinical indication
 - e. signature and date of qualified provider and the referring physician's individual provider identification number (PIN)
 - 01. If the member's Primary Care Physician (PCP) referred the member to the physician ordering the tests, the ordering physician must include with the order the PCP's individual PIN in addition to the ordering physician's individual PIN.
 - 02. The reference facility retains the ordering physician's provider information with the member's medical record for the medical necessity audit trail.
 - 2. 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:
 - a. phase of treatment (eg, assessment, continuing, maintenance)
 - b. current level of care (eg, use of ASAM levels)
 - c. member drug(s) of choice
 - d. days since last drug test with unexpected (i.e., not correlated with member history, positive when member indicates no substances used, etc.) results

- e. current prescribed drugs, 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, including how a test result will guide the plan of care
 - g. provider actions taken on recent unexpected test results and member response to that action
 - h. clinical documentation showing member contesting the unexpected result of a presumptive test
 - i. results of any pill counts performed by treatment team
- IV. 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. 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 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 management of clinical care for the member.
 - D. The provider billing for testing has the responsibility of ensuring that services are billed in accordance with these requirements.
- V. 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.
- 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 an individualized baseline UDT based on member's clinical presentation, prescribed medications, member's self-reported drugs of choice and regional drug trends.
 - b. Discuss results with member.
 - c. Agree on plan of care, including treatment interventions and goals.
 - 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. Blood drug testing is considered medically necessary when in an emergency department (ED) setting.
- VI. Testing considered not medically necessary for presumptive and/or definitive 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 (ie, 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 the 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. 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 and requested by CareSource. Laboratories must maintain hard copy documentation of lab results with copies of the order for the drug test and any required medical necessity review.

- F. Related Policies/Rules
 Medical Necessity Determinations
 Person-Centered Service Plans

G. Review/Revision History

DATE		ACTION
Date Issued	11/09/2022	
Date Revised	08/02/2023	Annual review. Updated references. Approved at Committee.
	07/17/2024	Annual review. Updated background. Deleted modifiers from II.A. Updated references. Approved at Committee.
	06/18/2025	Annual review. Updated references. Approved at Committee.
	03/11/2026	Annual review. Removed manual information and provided section number. Updated reference list. Approved at Committee.
Date Effective	06/01/2026	
Date Archived		

H. References

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

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