MEDICAL POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Drug Testing-MI MCD-MM-1551	06/01/2024
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 during an initial assessment, ongoing monitoring, and recovery phases for members with substance use disorder (SUD), those at risk for abuse/misuse or diversion of drugs, and for other medical conditions. Drug testing assists providers in diagnosing and planning member care when prescription medication or illegal drug use or abuse is of concern.

Drug testing is one component of a comprehensive clinical approach during the initial assessment, stabilization, maintenance, and recovery phase for members with SUD. The assessment process, including initial drug testing, aids the treatment provider in individualizing the drug testing plan for a member. Testing is also used for the periodic screening of members prescribed chronic opioid therapy (COT) for pain based on a risk score and helps determine if a member is adhering to prescription medication, reveals nonprescribed drugs or illicit drugs, and/or provides 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 with two main types, presumptive and confirmatory. Drug testing is sometimes referred to as toxicology testing.

C. Definitions
- **Aberrant Behavior** – Behaviors indicating medication or drug abuse or misuse (ie, losing prescriptions, early refill requests, multiple prescribers for controlled substances).
- **American Society of Addiction Medicine (ASAM)** – A professional medical society in the field of addiction medicine dedicated to increasing access and improving the quality of addiction treatment.
- **Chronic Opioid Therapy (COT)** – The use of opioids to treat chronic pain at intervals longer than three 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.
- **Confirmatory/Quantitative/Definitive Test** – A test determining the amount of substances per unit of volume or unit of weight.
- **Diversion** – Unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace.
- **Independent Laboratory** – A lab certified to perform diagnostic and/or clinical tests independent of an institution or a provider's office.
- **Induction** – A phase of opioid treatment during which maintenance medication dosage levels are adjusted until a patient attains stabilization.

- **Medication Assisted Treatment (MAT)** – The use of medication in combination with behavioral health (BH) services to provide an individualized approach to the treatment of SUD, including opioid use disorder (OUD).
- **Opioid Treatment Program (OTP)** – A program or qualified provider delivering treatment to members with an opioid agonist treatment medication.
- **Presumptive/Qualitative Test** – The testing of a substance or mixture to determine 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** – BH services that can include individual and group psychotherapy, family counseling, nursing services, and pharmacological therapy with 24-hour support.

D. Policy

I. General guidelines for CPT testing codes:

A. Presumptive and/or definitive drug testing must be medically necessary. CareSource will reimburse definitive drug testing at the following quantities per member per calendar year before a review of medical necessity is required:

CPT Code	Description	Authorization Information
G0480	drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (eg, to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (eg, to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed	after 12 tests, medical necessity review is required
G0481	drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (eg, to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (eg, to control for instrument variations and mass spectral drift); qualitative or	after 12 tests, medical necessity review is required

	quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed	
G0482	drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (eg, to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (eg, to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed	medical necessity review is required for all testing
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (eg, to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (eg, to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed	medical necessity review is required for all testing

B. Each CPT code is counted as one test. A review of medical records will be performed to determine the appropriateness of any initial drug tests ordered within a calendar year when determining medical necessity for additional tests. Presumptive testing should be the initial test considered. Higher number drug panels are rarely indicated for routine urine drug testing (UDT) as lower number panels are sufficient for modifying treatment plans in most cases.
C. Documentation required for medical necessity review
Copies of test results are not sufficient documentation of medical necessity to support a claim. Documentation must match the number, level and complexity of testing components performed and should include the following:
    1. A provider's order that includes, at a minimum, **ALL** the following:
        a. type of test to be performed (presumptive or definitive)
        b. all medications currently prescribed to the member
        c. drug and drug class to be tested
        d. clinical indication
        e. signature and date of qualified provider
    2. Provider documentation of member record, if requested by Caresource, that includes the following:

a. complete member name and identification on each page of record
b. identification of the provider responsible for providing member care
c. appropriate indication for UDT and how results will guide treatment
d. CPT code that accurately describes the service(s) performed
e. relevant clinical information related to diagnosis(-es), including:
    01. phase of treatment (eg, assessment, early recovery, induction, stabilization, maintenance) and current ASAM level of care
    02. drug(s) of choice and current active symptoms leading to request
    03. days since last drug test with unexpected results
    04. current prescribed drugs, including over-the-counter and illicit drugs with unexpected results in recent tests
    05. provider actions taken on recent unexpected test results and member response to that action, including challenges to unexpected presumptive result(s)
    06. results of pill counts performed by treatment team

II. Additional guidelines for confirmatory testing
Confirmatory testing should not routinely be utilized as the first choice for UDT. Medical necessity criteria for confirmatory testing is met when **ONE** of the following is in the medical documentation:
A. Presumptive testing was negative for prescription medications when provider was expecting a positive result. Member reports taking medication as prescribed.
B. Presumptive testing was positive for prescription drug(s) with abuse potential not prescribed by provider, and the member disputes the test result.
C. Presumptive testing was positive for an illegal drug, and the member disputes the test result.
D. A specific substance or metabolite needs identified that cannot be identified by a presumptive test (ie, semi- or synthetic opioids, specific benzodiazepines).
E. A panel of drugs may be performed as part of an initial assessment to develop a monitoring plan but should only be conducted if there is a need for testing with greater than 14 drug classes, rarely indicated for routine UDT.

III. A review of medical necessity is not required in an emergency department (ED) setting. Blood drug testing is considered medically necessary when an ED setting, but confirmatory testing is rarely needed in this setting. UDT utilization will be monitored by CareSource.

IV. Providers and laboratories will ensure specimen integrity appropriate for the stability of the drug being tested. If tampering is suspected, the sample should be discarded. When possible, the member will remain at the facility until a new specimen is obtained and can be tested. CareSource may request documentation of FDA-approved complexity levels for instrumented equipment and/or CLIA Certificates of Registration, compliance, or accreditation as a high complexity lab. Labs must maintain documentation of lab results with copies of orders for drug tests.

V. Other Testing Guidance

A. Clinical Indications

Testing should be individualized to the member, including analytes testing ordered based on the member's drug(s) of choice. Periodically, drugs commonly used or regionally prevalent may be rotated into a random testing schedule with rationale not meant to include all drugs all the time, but rather drugs most likely to be present in the member to assist specific treatment. The lowest level of testing should be used to advise the provider that an intervention is needed.

Providers should understand windows of detection time to determine frequency of testing and 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.

1. Drug testing in addiction treatment
    a. UDT frequency is expected more frequently early in treatment or when tapering and is expected to decrease as a member stabilizes.
    b. Prior to Initiation or in the Induction Phase (early recovery and including members who have relapsed):
        01. Obtain history, as well as a medical and psychological assessment.
        02. Review approximate time frame of drug detected in urine.
        03. Identify questions to answer, as well as treatment planning options based on potential UDT results.
        04. 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.
        05. Test at least weekly, citing ASAM consensus guidelines.
        06. Discuss results with the member.
        07. Agree on a plan of care, including treatment interventions and goals.
    c. Maintenance phase: test at least once per month.
    d. Intensive outpatient: test at least weekly.
    e. SUD residential treatment program: test at least monthly.
    f. Stable recovery: requires less frequent drug testing.
    g. Members taking long-acting naltrexone: test at least monthly.
2. Drug testing in an opioid treatment program (OTP) per member
    a. Maintenance treatment: federal regulations governing OTPs require initial toxicology plus 8 random UDT screens per year.
    b. Short-term detoxification treatment: one initial UDT.
    c. Long-term detoxification treatment: an initial and monthly random UDTs.
3. Drug testing by advanced practice registered nurse (APRN)
    a. Prescribing naltrexone to treat opioid use disorder (OUD): complete UDT or serum medication levels at least every 3 months for the first year and then at least every 6 months thereafter.
    b. 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.

4. Chronic pain management
    a. Prior to or upon initiation of treatment:
        01. Complete an assessment for risk of abuse using a validated risk assessment screening tool (ie, Screener and Opioid Assessment for Patient with Pain-Revisited [SOAPP-R], Opioid Risk Tool [ORT]).
        02. Review the MI Automated Prescription System (MAPS).
        03. Obtain baseline UDT screening and discuss results with the member.
        04. Agree on a plan of care, including treatment goals, and provide education on risks and benefits with strategies to mitigate risks.
        05. Combine evidence-based, non-pharmacologic and non-opioid pharmacologic therapy, as necessary.
    b. Ongoing monitoring of treatment determined by level of risk for SUD:
        01. Review PDMP data every 1-3 months.
        02. Evaluate benefits and risks of treatment at least every 3 months.
        03. Test at the following intervals:
            (1). Low risk: UDT once a year.
            (2). Moderate risk: UDT twice a year.
            (3). High risk: UDT up to 4 times a year.
            (4). Presence of aberrant drug-related behavior: UDT immediately.

B. Unexpected Results

Potential reasons for unexpected results should be considered (ie, member nonadherence, lab errors, member metabolic rates, diversion). Any possible aberrant behaviors should be identified and discussed by the responsible provider with the member. Potential interventions should be implemented and may include (not an all-inclusive list):

1. Evaluate and discuss factors contributing to relapse.
2. Minimize tampering opportunities during collection of sample.
3. Monitor pill counts and/or review MAPS.
4. Adjust dose and/or collaborate with or refer to a specialist.
5. Change the level of care, intensity of treatment, or plan of treatment (ie, add behavioral therapy, enhance community supports).
6. Examine a change in lifestyle (ie, housing, support system) and attend to psychosocial barriers, such as transportation or financial needs.
7. Address co-occurring medical or BH needs.
8. Obtain a confirmatory UDT.

VI. Testing considered not medically necessary, includes, but is not limited to, the following:

A. Testing that is not individualized, including, but not limited to:
    1. reflexive testing
    2. routine, standard, standing, nonspecific, and/or preprinted orders
    3. Requesting all tests a machine can do because a result may be positive.
    4. large, arbitrary panels and/or universal testing
    5. orders for "*Conduct additional testing as needed."*

B. Testing required by third parties, including, but not limited to:

1. court-ordered testing for other medico-legal purpose, such as child custody
2. pre-employment or random testing that is a requirement of employment
3. physician's health programs, including recovery programs for physicians, dentists, veterinarians, pharmacists, or others
4. athletics testing or testing for school entry or military service
5. forensic testing
6. testing in residential treatment 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. other administrative testing purposes, such as testing for a driver's license
9. testing for 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 use of confirmatory testing following a negative presumptive result that was expected
G. custom profiles or panels testing
H. confirmatory tests prior to discussing results of presumptive tests with members

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. Testing for validity of specimen is included in the payment for the test and will not be reimbursed separately.

F. Related Polices/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	2/28/2024	Approved at Committee.
Date Revised		
Date Effective	06/01/2024	
Date Archived		

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