MEDICAL POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Drug Testing-AR PASSE-MM-1332	10/01/2024
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.

Table of Contents

A. Subject
Drug Testing

B. Background
Drug testing is part of medical care during initial assessment, ongoing monitoring, and recovery phases for members with substance use disorder (SUD) or those at risk for abuse/misuse or diversion of drugs. The drug testing process assists providers in member care and serves a variety of purposes, including enhancing patient care, reducing health risk, justifying continued therapy, and providing rationale for changing or altering treatment. 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, presumptive and confirmatory testing, also referred to as toxicology testing.

Presumptive testing identifies the use or non-use of a drug or class of drugs and are more commonly routine due to speed of testing, accuracy, and accessibility in a wide variety of settings. Definitive tests are more specific, can refine test results, and allow for the detection of specific drugs or metabolites of interest. Definitive testing may be needed when presumptive results are not sufficient to guide clinical care, but definitive testing must be clinically meaningful with documentation that supports the specific necessity of each definitive assay performed. Ethical use of drug testing requires a testing panel and frequency that is justified by the member's clinical condition and the ordering provider's actual need for information.

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)*** – Standard language by which clinicians, researchers, and public health officials in the US 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.
- **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.

- **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)** – 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.
- **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.

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.

A. MAT providers are required to follow SAMHSA guidelines, at a minimum:

1. Initial evaluation and diagnosis of Opioid Use Disorder (OUD), including:
   a. drug screening tests to accompany proper medication prescribing for MAT (Buprenorphine monotherapy is typically reserved only for pregnant women and members with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone combinations.)
   b. lab screening tests for communicable diseases based on the member's history
   c. all necessary consent forms for treatment and HIPAA compliant communication
   d. execution of a treatment agreement or contract
   e. a Person-Centered Service Plan (PCSP) or individualized treatment plan
   f. referral for independent clinical counseling or documented plan for integrated follow-up visit, including counseling
   g. identification of a MAT team member to function as the case manager for support services
2. Continuing treatment (first year)
   a. regular outreach to the member to determine assistance needs to access resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners
   b. at least 1 follow-up MAT office visit per month for medication and treatment management
   c. drug testing in conjunction with each monthly visit
   d. at least 1 independent clinical counseling visit or documented plan for integrated follow-up visit, including counseling, per month
3. Maintenance treatment (subsequent years)

a. regular outreach to the member to determine assistance needs to access resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners
b. at least 1 follow-up MAT office visit quarterly (every 3 months) for medication and treatment management
c. drug testing in conjunction with each quarterly visit
d. at least 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

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. 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.
D. 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 a limit of $500 per calendar year for all laboratory services, unless codes are billed with appropriate modifiers to indicate MAT for opioid use disorder. Additional instructions regarding billing MAT services can be found in section II of the *Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual* on the Arkansas Dept of Human Services website.
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. Documentation Requirements
A. Physicians are required to maintain the following records for each member:
1. history and physical examinations
2. chief complain on each visit
3. tests and results, including review of results with member and any follow-up or recommendations based on results
4. service or treatment, including prescriptions and referrals for other services
5. copies of records pertinent to services delivered by or under the supervision of the physician and billed to Medicaid

6. service dates of any services billed, including service dates for all components of global services billed

B. Independent lab services required documentation must include the following:
   1. the physician's order for laboratory tests
   2. test results
   3. all records pertinent to billing

C. 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 (e.g., assessment, continuing, maintenance)
      b. current level of care (e.g., 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, including 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 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 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 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. 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.

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

	07/17/2024	Annual review. Updated background. Deleted modifiers from II.A. Updated references. Approved at Committee.
Date Effective	10/01/2024	
Date Archived		

H. References

1. Agnoli AL, Howe R, Magnan E, et al. Urine drug testing among patients prescribed long-term opioid therapy: patient and clinician factors. *J Am Board Fam Med*. 2023;36(4):537-541. doi:10.3122/jabfm.2022.220360R1
2. Andersson HW, Wenaas M, Nordfjærn T. Relapse after inpatient substance use treatment: a prospective cohort study among users of illicit substances. *Addict Behav*. 2019;90:222-228. doi:10.1016/j.addbeh.2018.11.008
3. Chang YP, Raynor T. Factors associated with relapse in individuals with Opioid Use Disorder receiving suboxone in rural areas. *J Addict Nurs*. 2021;32(1):20-26. doi:10.1097/JAN.0000000000000381
4. CLIA program and Medicare laboratory services. Centers for Medicare and Medicaid Services. Updated May, 2023. Accessed June 12, 2024. www.cms.gov
5. *Clinical Drug Testing in Primary Care*. Technical Assistance Publication 32. HHS Publication No. 12-4668. Substance Abuse and Mental Health Services Administration; 2012. Accessed June 12, 2024. www.samhsa.gov
6. *Federal Guidelines for Opioid Treatment Programs*. Substance Abuse and Mental Health Services Administration. Updated December 12, 2023. Accessed June 12, 2024. www.samhsa.gov
7. Information about medications for Opioid Use Disorder (MOUD). US Food and Drug Administration. Updated May 22, 2024. Accessed June 12, 2024. www.fda.gov
8. Jaffe A, Molnar S, Williams N, et al. Review and recommendations for drug testing in substance use treatment contexts. *J Reward Defic Syndr Addict Sci*. 2016;2(1):28-45. doi:10.17756/jrdsas.2016-0
9. Jarvis M, Williams J, Hurford M, et al. Appropriate use of drug testing in clinical addiction medicine. *J Addict Med*. 2017;11(3):163-173. doi:10.1097/ADM.0000000000000323
10. Lu T, Fox A, Stein M. Primary care management of adults with Opioid Use Disorder. UpToDate. Updated February 29, 2024. Accessed June 12, 2024. www.uptodate.com
11. Medication Assisted Treatment for Opioid Addiction, ARK. CODE ANN. § 23-99-1119 (2023).
12. Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. §§ 8.1-.655 (2024).
13. *Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II.* Arkansas Dept of Human Services. Accessed June 12, 2024. www.humanservices.ar.gov
14. Public policy statement on drug testing as a component of addiction treatment and monitoring programs and in other clinical settings. American Society of Addiction Medicine. Updated October, 2010. Accessed June 12, 2024. www.asam.org

15. Rosano TG, Wood M, Hooten WM, et al. Application and clinical value of definitive drug monitoring in pain management and addiction medicine. *Pain Med*. 20228;23(4):821-833. doi:10.1093/pm/pnab303
16. Warrington JS, Warrington GS, Francis-Fath S, et al. Urinary Buprenorphine, Norbuprenorphine and Naloxone concentrations and ratios: review and potential clinical implications. *J Addict Med*. 2020;14(6):e344-e349. doi:10.1097/ADM.0000000000000676