AHCCCS
Arizona Health Care Cost Containment System

Division of Fee for Service Management

July 30, 2024

Subject: Urine Drug Testing for Substance Use Disorder Medical Necessity and Billing Guidelines

Effective with dates of services beginning August 1, 2024, The Arizona Health Care Cost Containment System (AHCCCS) will implement the following guidelines for urine drug testing (UDT) and billing for presumptive and definitive UDT relative to substance use disorders.

All providers who bill for Medicaid services in Arizona must fully understand and follow all existing laws, regulations and rules for Medicaid payment for drug testing and must properly submit only valid claims.

This update is to clarify the following:
The appropriate indications and expected frequency of testing for drugs/substances present in urine in identifying and treating substance use disorders. Documentation requirements, by the clinician in the patient's medical record, to support the medical necessity for drug testing on an individual patient basis.

Urine drug testing (UDT) provides objective information to assist clinicians in identifying the presence or absence of drugs or drug classes in the body and making treatment decisions.

Presumptive/Qualitative UDT ("presumptive" UDT):

Presumptive UDT may be ordered by the clinician when it is medically necessary to rapidly obtain and/or integrate results into clinical assessment and treatment decisions. Presumptive UDT typically involves testing for multiple analytes based on the specific member's clinical history and risk assessment and must be documented in the medical record.

A presumptive UDT consists of various platforms including cards, dipsticks, cassettes, and cups based on qualitative competitive immunoassay (IA) methodology with one or more analytes in the test. A presumptive IA test detects the presence of the amount of drug/substance present in urine above a predetermined "cut-off" value and may be read by direct optical observation or by instrument assisted direct optical observation. Thin layer chromatography is also a method of presumptive UDT.

Chemistry analyzers with IA UDT technology can be used in an office or clinical laboratory setting. This test provides less immediate test results. At no time is IA technology by chemistry analyzer analysis considered confirmatory (definitive) testing.

When presumptive UDT is insufficient for certain clinical needs, it may be medically necessary for clinicians to utilize definitive UDT. The clinical information supplied must support the medical necessity for definitive UDT, as described in the following section on definitive UDT.

Definitive/Quantitative/Confirmation ("definitive" UDT):

Definitive methods typically include GC-MS and LC-MS/MS testing methods. Gas Chromatography coupled with Mass Spectrometry (GC-MS) and Liquid Chromatography coupled with Mass Spectrometry (LC-MS/MS) are complex technologies that use the separation capabilities of gaseous or liquid chromatography with the analytical capabilities of mass spectrometry. These methodologies require the competency of on-site highly trained experts in this technology and interpretation of results. While these tests require different sample preparation and analytical runs, they identify specific drugs, metabolites, and most illicit substances and report the results as absent or present typically in concentrations of ng/mL.

Definitive UDT is considered medically necessary when the clinical information supplied supports the definitive testing as in:

- Identify a specific substance or metabolite that is inadequately detected by a presumptive UDT Screen;
- Definitively identify specific drugs in a large family of drugs;
- Identify a specific substance or metabolite that is not detected by presumptive UDT such as fentanyl, meperidine, synthetic cannabinoids, and other synthetic/analog drugs;
- Identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of THC use according to a treatment plan);
- Identify a negative, or confirm a positive, presumptive UDT result that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan;
- Rule out an error as the cause of a presumptive UDT result;
- Identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances; and
- Use in a differential assessment of medication efficacy, side effects, or drug-drug interactions.

Definitive UDT orders should be individualized based on clinical history, risk assessment, substance use patterns, results of presumptive testing, and must be documented in the medical record. Definitive testing for more than 7 classes of drugs (including metabolites) may be subject to prepayment review.

It is not considered medically necessary to order definitive testing for all analytes in every drug test conducted on a patient and to do so repeatedly, without regard to the results from previous tests or the patient's overall response to addiction treatment interventions. To be considered medically necessary, drug testing requires that the scope of the analyte panel and the frequency of testing be justified by the patient's clinical status and the ordering clinician's need for information.

For both presumptive and definitive UDT to be considered medically necessary, drug testing shall be individualized to test only for substances specific to the individual member's clinical history and plan of treatment. Clinical documentation must specify how the test results will be used to guide clinical decision making. The medically necessary frequency of drug testing for any indication should be individualized and included in the treatment plan.

The following drug tests are not considered medically necessary:

- Routine standing or blanket orders of drug tests (i.e., routine/same orders for all patients in a provider's practice that are not individualized to the member's history and clinical presentation);
- Reflex definitive UDT not based on a specific clinician's order.
- IA testing, regardless of whether it is qualitative or semi-quantitative (numerical), may not be used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes, or other IA testing methods. Definitive UDT provides specific identification and/or quantification typically by GC-MS or LC-MS/MS.
- Simultaneous performance of presumptive and definitive tests for the same drugs or metabolites at the same time;
- Presumptive Point of Care Testing (POCT) or IA testing and ordering presumptive IA UDT from a lab on the same day.
- Reference laboratory performing and billing IA presumptive UDT prior to definitive

testing without a specific physician's order for the presumptive testing.
- Drug testing of 2 different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.
- UDT for medico-legal and/or employment purposes or to protect a physician from drug diversion charges.
- Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.

Diagnosis and treatment for substance abuse or dependence

The UDT result should guide clinical decision making, treatment planning and level of care decisions. Ordered tests and testing methods (presumptive and/or definitive) must match the stage of screening, treatment, or recovery; the documented history; and diagnosis.

For patients with known indicators of risk for SUD, the clinician may screen for a broad range of commonly abused drugs using presumptive UDT, or using definitive UDT if medically necessary as described above.

For patients with a diagnosed SUD, the clinician should perform random UDT at random intervals to properly monitor the patient. Testing profiles must be determined by the clinician based on the following medical necessity guidance criteria:

- Patient history, physical examination, and previous laboratory findings;
- Stage of treatment or recovery;
- Suspected abused substance;
- Substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The patient's medical record must include an appropriate number of UDTs billed over time based on the stage of screening, treatment, or recovery; and the rationale for the drugs/drug classes ordered; the results must be documented in the medical record and used to direct care.

Note on UDT for alcohol metabolites: these guidelines also apply to UDT for ethyl alcohol/ethanol metabolites, such as ethyl glucuronide (EtG). EtG tests can be conducted in reference laboratories, in clinical settings using a desktop analyzer, or by using a point-of-care dipcard.

1. Maximum Number of Allowed Presumptive UDTs for SUD

The number of UDTs billed over time must meet medical necessity and be documented in the patient's medical record.

1. For patients with 0 to 30 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 7 days. More than 3 presumptive UDTs in 7 days is not considered medically necessary and is not covered.
2. For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 7 days. More than 3 presumptive UDTs in 7 days is not considered medically necessary and is not covered.
3. For patients with > 90 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 30 days. More than 3 presumptive UDTs in 30 days is not considered medically necessary and is not covered.

2. Maximum Number of Allowed Definitive UDTs for SUD

Depending on the patient's specific substance use history, definitive UDT to accurately determine the specific drugs in the patient's system may be necessary. Definitive testing may be ordered when accurate and reliable results are necessary to integrate treatment decisions and clinical assessment. The number of UDTs billed over time and the rationale for definitive UDT must be documented in the patient's medical record.

1. For patients with 0 to 30 consecutive days of abstinence, definitive UDT is not to exceed 1 definitive UDT in 7 days. More than 1 definitive UDT in 7 days is not considered medically necessary and is not covered.

2. For patients with 31 to 90 consecutive days of abstinence, definitive UDT is not to exceed 3 definitive UDTs in 30 days. More than 3 definitive UDTs in 30 days is not considered medically necessary and is not covered.
3. For patients with > 90 days of consecutive abstinence, definitive UDT is not to exceed 3 definitive UDTs in 90 days. More than 3 definitive UDTs in 90 days is not considered medically necessary and is not covered.

Documentation Requirements

All documentation must be maintained in the patient's medical record and made available to the AHCCCS upon request.

The patient's medical record must include an appropriate number of UDTs billed over time based on the stage of screening, treatment, or recovery; and the rationale for the drugs/drug classes ordered; the results must be documented in the medical record and used to direct care.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the clinician responsible for and providing the care to the patient.

The medical record documentation must support the medical necessity of the services as stated in this policy.

Medical record documentation (e.g., history and physical as well as, progress notes) maintained by the ordering/treating clinician must indicate the medical necessity for performing a presumptive/qualitative drug test. All tests must be ordered in writing by the treating clinician and all drugs/drug classes to be tested must be indicated in the order.

When a definitive/quantitative test is performed, the medical record documentation must show the ordering clinician's rationale for the definitive UDT and the tests including drugs ordered must be documented in the patient's medical record..

If the provider of the service is other than the ordering/referring clinician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring clinician's order for the test. The clinician must include the clinical indication/medical necessity in the order for the test.

Thank you,