AHCCCS Arizona Health Care Cost Containment System NEWS

April 30, 2024

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

Effective with dates of services beginning May 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.

Definitive/Quantitative/Confirmation ("definitive" UDT)

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 and risk assessment and must be documented in the medical record.

To be considered medically necessary, drug testing shall be individualized to test only for substances specific to the individual member's 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:

- Routines 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);

- Simultaneous performance of presumptive and definitive tests for the same drugs or metabolites at the same time (Definitive testing should be guided by the results of presumptive testing);
- Presumptive Point of Care Testing (POCT) or IA testing and ordering presumptive IA UDT from a lab on the same day.
- 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.
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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 a rolling 7 days. More than 3 presumptive UDTs in a rolling 7 days will be denied.
2. For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in a rolling 7 days. More than 3 presumptive UDTs in a rolling 7 days will be denied.
3. For patients with > 90 consecutive days of abstinence, presumptive UDT is not to exceed 3

presumptive UDTs in a rolling 30 days. More than 3 presumptive UDTs in a rolling 30 days will be denied.

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 a rolling 7 days. More than 1 definitive UDT in a rolling 7 days will be denied.
2. For patients with 31 to 90 consecutive days of abstinence, definitive UDT is not to exceed 3 definitive UDTs in a rolling 30 days. More than 3 definitive UDTs in a rolling 30 days will be denied.
3. For patients with > 90 days of consecutive abstinence, definitive UDT is not to exceed 3 definitive UDTs in a rolling 90 days. More than 3 definitive UDTs in a rolling 90 days will be denied.

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 physician or non-physician practitioner 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 physician/treating physician must indicate the medical necessity for performing a qualitative drug test. All tests must be ordered in writing by the treating provider and all drugs/drug classes to be tested must be indicated in the order.
- When a definitive/quantitative test is performed, the record must show that an inconsistent positive finding was noted on the presumptive testing or that there was no available, commercially or otherwise, presumptive test except when not medically necessary to perform presumptive testing in the Court Ordered Treatment (COT) patient subset.
- If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the test. The physician must include the clinical indication/medical necessity in the order for the test.