Medical Affairs Policy

**Service:** Urine Drug/Alcohol Screening and Testing  
*PUM 250-0013*

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<th>Medical Policy Committee Approval</th>
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<tr>
<td>Prior Authorization Needed</td>
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Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

**Description:**

Urine/alcohol drug screening and testing (UDS) is used to detect alcohol, prescription medications, and illegal substances to improve medical treatment. This policy addresses UDS in the clinical setting, most commonly for Chronic Pain Management and Behavioral Health Abuse and Addiction Management programs. **Note: UDS for forensic or employment purposes is typically not a covered benefit of the health plan.**

There are two general laboratory methods of measuring the presence of drugs and alcohol and their metabolites (break down products) in urine. The first method, immunoassay, also referred to as **qualitative / presumptive testing,** measures the presence or absence of a drug or class of drug in the urine. The test result is reported as either positive or negative based on detection above a predetermined cut-off threshold concentration of the substance. In most cases of preliminary screening and monitoring, adequate information can be obtained via qualitative (immunoassay) testing.

The second method, **chromatography / mass spectrometry,** also referred to as **quantitative/ confirmatory / definitive testing,** measures the exact concentration of a specific drug or its metabolites in the urine and is more specific as to the individual compound present. The test result is expressed in numerical terms, not as a qualitative description such as “positive” or “negative.” This technique is used to verify the results of the initial drug screen or to provide screening data when other techniques are unable to validly and reliably detect the presence of a specific compound in urine. The decision of when, how, and what to test, depends upon the clinical medical and behavioral health history (including drugs of abuse), behaviors related to chronic pain, medications prescribed, risk potential for drug misuse, and the treatment plan.
Proper interpretation of a drug screen/test depends upon the clinical context, type of test being performed, and likelihood of false positive and false negative results. There is no uniformity across test labs as to what is included in extended drug assays or what the cutoff values for detection should be (except for drugs related to workplace testing laws). Consequently, screening and testing should focus on the detection of specific drugs and should be based on the medical necessity to identify the presence of a compound tested, and not routinely include a panel of drugs or a drug class.

In many cases, quantitative urine drug tests are not necessary since adequate information can be obtained via qualitative testing.

**Indications of Coverage:**

I. The following documentation is required for any indication listed in sections I.A through I.D:

1. Medical record documentation indicates the medical necessity of performing the preliminary or confirmatory urine drug test that has been ordered:
   a. Medical and behavioral health history. Include history of opioid use, and the history of the medical condition associated with the indication for opioid therapy
   b. Presence or absence of aberrant behaviors related to chronic pain management (e.g. self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other documented change in affect or behavioral pattern)
   c. Current treatment plan
   d. Medications prescribed
   e. Assessment of risk potential for drug misuse, diversion and addiction, including data from a query to the state prescription drug monitoring program
   f. Use of a validated risk assessment interview or questionnaire tool, with appropriate risk stratification and monitoring protocols which affirm the medical necessity for drug testing

2. When definitive tests are ordered, documentation must include an order for each compound being quantified

3. Documentation in the patient’s health record describing how the results will specifically impact the treatment plan.
4. Testing is appropriate in screening or in ‘for-cause’ situations where the clinical presentation calls for testing. These situations can include:

a. Altered mental status

b. Medical/Psychiatric condition in which drug/alcohol toxicity may be a contributing factor in the differential diagnosis

c. Pregnancy with documentation that there has been a history or reasonable suspicion of perinatal maternal drug use, or a history of recent delivery of infant diagnosed with Neonatal Abstinence/ Neonatal Withdrawal Syndrome.

d. Need to assess adherence to prescribed medications; note that screening / preliminary methodologies are sufficient for most adherence testing.

e. Need to assess abstinence vs presence of any non-medical use of alcohol, prescription drugs, or illicit drugs during a course of addiction treatment.

I.A. **Preliminary** urine/alcohol drug screening/testing is considered medically necessary using any of the following:

1. A panel of compounds (e.g., within a given pharmaceutical or drug class) tested using immunoassay or other qualitative methods

2. Definitive (quantitative) testing provided there is a documented medical necessity to test for the presence of a compound not reliably/validly detectable via qualitative / immunoassay methodologies. Drug testing for a panel of compounds using definitive testing methods is considered not medically necessary.

I.B. **Drug confirmation using definitive testing methods** is considered medically necessary for any of the following situations:

1. Qualitative screening result is positive and documentation supports the reason for further testing in light of the positive qualitative test, (e.g. positive for opiate but need to identify the specific drug). Definitive testing is considered medically necessary only for those compounds that could have contributed to the positive preliminary result.

   Note: If the patient reports use of the drug identified as positive in a qualitative screening, quantitative confirmation is considered not medically necessary

2. The results of the preliminary test do not align with the patient’s history or clinical presentation or if the results are otherwise unexpected or confusing.
Definitive testing is considered medically necessary only for agents that are incongruent with the history and qualitative results.

I.C. **New patient screening:** Drug testing is considered medically necessary when all documentation criteria is met. New patient screening typically involves the following drugs/drug classes, using preliminary testing methods (See Section A): Alcohol; amphetamines / methamphetamine; barbiturates; sedative / hypnotics; tetrahydrocannabinol; cocaine; opiates as a drug class (not including other opioids); oxycodone; and methadone.

Confirmatory testing in a scenario of new patient screening is considered medically necessary only for specific benzodiazepines or opioids not readily detectable by preliminary methods.

I.D. **On-going patient monitoring:**

Drug testing is performed to assess adherence to a treatment plan in which controlled substances are being prescribed, to assess abstinence, or to identify unauthorized substance use during addiction treatment. Testing during on-going patient monitoring is considered medically necessary when any of the following are met:

1. Testing via preliminary testing methods is considered medically necessary when criteria in Section I.A. are met.

2. Definitive (quantitative) testing is considered medically necessary when there is appropriate documentation per Section I.B.

3. Serial definitive (quantitative) testing for the same substance is considered medically necessary when there is documentation of the following:

   a. Quantitative assay with corrected creatinine ratios: The follow-up testing is ordered to determine whether a preliminary result indicates new substance use vs. slow metabolism/drug disposition from a previously confirmed instance of use of tetrahydrocannabinol (THC), oxazepam or temazepam. The date and result of the previous positive test must be provided.

   ➢ **Note:** Daily or scheduled testing is considered not medically necessary unless documentation supports the rationale for the schedule.

II. **Frequency of Qualitative Testing**

II.A. Frequency is based on a validated risk assessment:
1. Low Risk—randomly with maximum of one test every 3 months (depending on state licensing board requirements for treatment compliance (e.g. opioids) and commonly abused illicit drugs: amphetamines, cocaine, and THC.

2. Moderate Risk—randomly with maximum of one test every 2 months (depending on state licensing board requirements for treatment compliance (e.g. opioids) and commonly abused illicit drugs: amphetamines, cocaine, and THC and other prescribed drugs based on the individual patient’s case).

3. High Risk—randomly with maximum of one test every month. Such testing ideally will not be at each scheduled office visit.

OR

II.B. “For-cause” testing beyond the randomized periodic testing schedule (e.g. due to suspicious behaviors, self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other documented change in affect or behavioral pattern will be considered medically necessary only when there is documentation of the specific need for testing.

Limitations of Coverage:

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, deny as not medically necessary.

D. Testing ordered by third parties such as school, courts, employers, police or requested by a provider to meet the requirements of a third party is typically an exclusion of the member health plan (See certificate language).

E. Repeated preliminary or confirmatory testing prior to receiving the results of the initial preliminary test is considered not medically necessary.

F. Routine confirmatory testing (quantitative) of drug screens with negative qualitative results is not medically necessary unless there is documentation the negative finding is inconsistent with the patient’s medical history or current documented chronic pain medication list.
G. Quantitative urine testing to verify compliance with a prescribed dosage of medication is considered not medically necessary. There are no clinical instances in which urine drug levels are a valid measure to assess therapeutic drug levels.

H. The use of quantitative multi-test panels is considered not medically necessary unless documentation includes a statement of the reasons for each of the drugs/drug classes or alcohol to be quantified.

I. Use of quantitative methods for preliminary testing, or use of quantitative panels when there is a validated qualitative test available for the specific metabolites of concern available through standard laboratories, is considered not medically necessary.

J. Routine analysis for specimen integrity is considered not medically necessary.

K. Specimen validity testing including ToxProtect genomic cross verification to match urine specimen to the donor is considered experimental, investigational, unproven and not medically necessary.

**Documentation Required:**

- Office notes
- List of current medications
- Lab Reports

**References:**


4. University of Washington, Division of Pain Medicine, Urine Drug Testing Interpretive Algorithm for Monitoring Opioid Treatment (adapted from the Washington Agency Medical Directors Group Opioid Treatment Guidelines 2010), available online at: https://depts.washington.edu/anesth/education/forms/pain/UW-UDTinterpretationAlgorithm.pdf


7. MCG 21st ed ORG: B817-T Urine Toxicology Testing


10. Hayes GTE Overview ToxProtect (Genotox Laboratories). Published Mar 09, 2017

WPS/Arise Review History:

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Approved by the Medical Director