529.2 DRUG SCREENINGS

TABLES OF CONTENTS

Effective July 1, 2018

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

529.2 DRUG SCREENINGS

BACKGROUND

Drug screenings are considered for reimbursement when the screening results will alter patient management decisions and are deemed medically necessary and reasonable within commonly accepted standards of practice. Please refer to *Chapter 529, § 529.1, Laboratory and Pathology Services*, Chapter 503, Licensed Behavioral Health Center (LBHC) Services, Chapter 504 Substance Use Disorder Services, Chapter 521 Behavioral Health Outpatient Services, for program specific information.

POLICY

529.2.1 COVERED SERVICES

Drug screenings, as with all laboratory tests, must be ordered by the treating practitioner, operating within their scope of practice, who treats the member for a specific medical diagnosis, operating within their scope of practice. The order must include the ordering practitioner's name and identification number, and if applicable, the requesting substance abuse treatment facility name and identification number, and list:

1. Specific drugs that are being screened for;
2. Diagnosis (Use of a non-specific diagnosis code does not satisfy this requirement);
3. Symptomatology; and
4. Suspected condition or reason for the encounter, either by appropriate diagnosis code or a narrative description.

Coverage requirements are:

- Documentation must include how the test results will impact the treatment plan, and the rationale for the requested frequency of testing.
- Standing orders may be utilized but must be individualized for each member; signed and dated by the treating practitioner; and updated every 30 days.
- West Virginia Medicaid covers up to 24 presumptive drug screens and 12 definitive drug tests (testing under 22 drug classes) per calendar year without a medical necessity authorization from the Bureau for Medical Services' Utilization Management Contractor (UMC). To exceed this benefit limit, providers must contact the UMC for a medical necessity authorization prior to payment. **Note:** All definitive drug testing for over 22 drug classes requires medical necessity authorization prior to payment unless it is the result of an emergency room visit.
- Procedure codes must be reported with a quantity of one per episode of care, regardless of the number of collection/testing items used, the number of procedures, and/or the drug classes screened.
- Testing for more analytes than medically justified will be subject to audit.
- Substance Use Disorder in pregnancy is recognized as a special population. Frequency of drug screening must be defined as part of a comprehensive treatment plan.

529.2.2 NON-COVERED SERVICES

The following are non-covered services:

- Testing for the same drug with a blood and urine specimen simultaneously is not covered.

Effective July 1, 2018

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

529.2 DRUG SCREENINGS

- Specimen validity testing and urine alcohol testing when performed on the same day of service as a standard drug test, are not covered.
- Drug screening for pre-employment or employment purposes, medicolegal and/or court ordered drug screenings that do not meet medical necessity, and/or drug screenings for participation in school or military are not covered.
- "Routine" drug testing (drug testing done at specific intervals on asymptomatic members) is non-covered unless used in connection with treatment for Substance Use Disorders. Specific intervals at which each member test should be performed, based on their individual needs, must be documented in the members' medical record with their treatment plan as well as the relation of the specific tests to the member's treatment.
- Reflex testing is non-covered. Additional tests are covered only when specifically ordered and reviewed by the treating practitioner as medically necessary.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

Analyte: A substance whose chemical constituents are being identified and measured.

Drug Screening/Testing: Process of chemical analysis designed to determine the presence of a drug or class(es) of drugs in the body. Categories of drug screening/testing include:

1. **Presumptive Testing:** Presumptive testing determines if a drug or class of drug is present in the specimen.
2. **Definitive Testing:** Definitive testing determines the specific drug(s) present in the specimen.

Reflex testing: Occurs when an initial result meets pre-determined criteria and an additional test is done automatically, based on the criteria, without an order or review from the treating practitioner.

REFERENCES

West Virginia State Plan references laboratory services at sections 3.1-A (3) and 3.1-B (3).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter 529 Laboratory Services	Policy 529.2 Drug Screenings	October 2, 2015
529.2.1 and 529.2.2	Covered and Non-Covered Services	January 1, 2017
Entire Section	Policy 529.2 Drug Screenings	July 1, 2018

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.