



October 18, 2018

Announcement 1713

Drug Screening and Testing Policy Changes

Effective August 1, 2018, presumptive drug screens are limited to one per day with a maximum of 20 tests per 12-rolling months. Only three definitive drug screens are permitted per recipient per 12-rolling months. Should more than 20 presumptive screens or more than three definitive screens be needed in 12-rolling months, a prior authorization is required. Claims paid in excess of these limits, without an approved prior authorization, are subject to recoupment.

The impacted provider types (PTs) are: 12 (Hospital, Outpatient), 17 (Special Clinics), 20 (Physician, M.D., Osteopath, D.O.), 24 (Advanced Practice Registered Nurse), 43 (Laboratory, Pathology), 60 (School Based), 74 (Nurse Midwife) and 77 (Physician's Assistant).

[Medicaid Services Manual \(MSM\) Chapter 800 Laboratory Services](#) has been updated with the following information:

Section 803.1A Coverage and Limitations

1. Covered Services

p. Drug Screening and Testing

1. Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the recipient's medical history, current clinical presentation or risk potential for abuse and diversion.
2. Each drug or drug class being tested for must be indicated by the referring physician in a written order and reflected in the patient's medical record.

This information must be patient-specific and accurately reflect the need for each test and must include the specific drugs being screened including recipient diagnosis.

3. Current coding for testing of drugs relies on a structure of screening (known as presumptive screening) and may be followed by quantitative measurements (known as definitive testing) that identifies the specific drug or drugs and quantity in the recipient.
 - a. Only one presumptive test performed by direct observation or instrument assisted direct observation or instrument chemistry analyzers may be billed per recipient per day within a maximum of 20 presumptive test per 12-rolling months.
 1. If the recipient should require more than 20 presumptive tests per 12-rolling month, a prior authorization is required.
 - b. Only three definitive drug tests are permitted per recipient per 12-rolling months.
 1. If the recipient requires more than three definitive tests per 12-rolling month, a prior authorization is required, meeting medical necessity.
 2. Definitive testing is only covered to confirm an unexpected result or identify drugs or metabolites that cannot be detected on a presumptive drug screen.
 3. Definitive testing should be based on the recipient's presentation and history and only include what is needed for safe pain management.
4. Standing orders for presumptive drug screens may be utilized, but must be individualized for each member, signed and dated by the treating practitioner and updated every 30 days. Standing orders are not permitted for definitive drug screens.

5. Procedure codes should 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.
6. Testing for the same drug with a blood and urine specimen simultaneously is not covered.
7. Drug screening for pre-employment or employment purposes, medicolegal and/or court ordered that do not meet medical necessity and/or drug screenings for participation in school or military are not covered.
8. Routine drug screening is not covered unless used in conjunction with an extended course of treatment for substance use disorders. Specific intervals, at which recipient test should be performed, based on their individual needs, must be documented in the member's medical record with their treatment plan.
9. Drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.