NMNC 6.605.04 Substance Use Laboratory Testing for Drug and Alcohol Use

This clinical criterion relates to laboratory testing used in the initial assessment and ongoing monitoring of individuals at risk of *or* with substance use disorder who receive behavioral and/or addiction services.

The assessment of continued drug use should be based on treatment interactions, behavioral observations, as well as mental status and history and physical evaluation. Review of findings consistent with drug use in many cases results in self-disclosure of ongoing substance use. However, the validity of an individual's self-reported substance use is not always reliable.

Ambulatory laboratory testing for drugs of abuse is a medically necessary and useful component of addiction treatment. Drug tests results are of importance in treatment programs and in outpatient addiction treatment. General testing should be ongoing, random and more frequent earlier in treatment or when an individual is at risk of *or* has relapsed. The drug screen result can influence treatment and level-of-care decisions; point-of-care testing (POCT) is encouraged to aid in these decisions. It is important that ordered tests match treatment needs, the documented history and the most current version of the *DSM* diagnosis. Ordering providers should document drug-testing rationale indications, test results, and how results might impact treatment plan

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All* of the following criteria must be met:** 1) Member has been evaluated by a licensed clinician and demonstrates symptoms consistent with a *DSM* or corresponding ICD diagnosis 2) Tests ordered are within the scope of license of the ordering practitioner 3) Ordered tests must match treatment needs and clinical history, including documented rationale for order with intent for using test results	A screening immunoassay without confirmation or quantitative testing is typically sufficient for ongoing clinical monitoring. 1) Initial screening for substance use disorders, with rapid test immunoassay (5, 10 or 12 panel) and alcohol screening are recommended upon admission for the treatment of substance use disorder 2) Post-admission, screenings are expected and may be approved at a frequency not to exceed four every 30 days 3) Testing at a frequency greater than four times in 30 days requires rationale documented in medical record and must meet medical necessity Onsite Clinical Laboratory Improvement Act (CLIA)-waived testing is preferred as results can rapidly be integrated into treatment decisions and clinical assessment	Most positive screening results are confirmed by the patient's self-disclosed admission of substance use. All orders for quantitative (confirmatory) testing of drugs of abuse require a positive qualitative (screening) test or suspected false negative test and shall be performed only for the specific drug class identified or suspected in the case of false negative. Quantitative testing is indicated for a positive qualitative test when there is a need to refine the results, quantify levels, or when the patient is disputing results. Quantitative testing is indicated for a negative qualitative test when there is a concern that the negative result was an error (false negative). For example, the drug was prescribed and a positive test was anticipated; the patient appeared intoxicated or there is high suspicion of relapse; the timing of the specimen was beyond the half-life of the

		drug; the sensitivity of the test was insufficient to detect the drug of interest (e.g., synthetic or semi-synthetic opioids); or other laboratory abnormality suggested a false negative. Quantitative testing exceeding three procedure codes or drug classes every 30 days requires rationale documented in medical record and must meet medical necessity.

Exclusions

Any **one** of the following criteria is sufficient for exclusion:

1) Quantitative testing or drug confirmation testing is excluded from coverage if performed for forensic or legal purposes; or
2) Quantitative testing for negative screening results is excluded without written documentation of clinical concern regarding false negative; or.
3) Quantitative testing requires a positive screening test or suspected false negative test and shall be performed only for the specific drug class identified; or
4) Blood and urine screens ordered for the same drug panel on the same day will not be paid; or
5) Quantitative or qualitative drug testing is covered only for a member receiving active treatment or evaluation of symptoms consistent with a *DSM* or corresponding ICD diagnosis. Laboratory testing is expected to be conducted in the context of a therapeutic relationship, treatment plan or work-up; or
6) Routine use of test panels without discernment of clinical relevance for each member; or
7) Confirmation and quantification of all presumptive positive and negative test results; or
8) Frequent drug testing without consideration of the window of detection for substance(s) in question; or
9) No documentation of rationale for testing or test results in medical record

Reference Sources

Beacon's Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Addiction Psychiatry (AAAP); American Society of Addiction Medicine (ASAM); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon's Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)