IDP Name: Requirements for Urine Drug Screen Requests

Purpose

An overview of the minimum requirements to complete a urine drug screen (UDS) prior authorization (PA) request for Medicare, Medicaid, and BadgerCare Plus members. Furthermore, the policy will

- Optimize the care of members being treated with chronic opioids
- Foster collaboration between iCare and servicing providers
- Improve efficiency and clarity for our providers on the utilization and authorization of urine drug screens for iCare members
- Improve payment workflow related to the UDS policy
- Improve tracking and data on clinical and financial impact of urine drugs screens.

As a standard benefit, all iCare members will receive 6 urine drug screens per year without need for Prior Authorization. Providers will need to submit a prior authorization form to activate this benefit annually, no clinicals or order is required. These requests will need to be submitted for authorization within 14 days of the first UDS to be considered timely submissions.

If a provider anticipates they will need more than 6 UDS's in a year (for example for members with chronic opioid therapy) the provider must submit an annual authorization with the amount of screens being requested and supporting clinical documentation which includes the order and doctors note. This will be reviewed and authorized through the standard PA process, see *PA-001 Outpatient Skilled Services, Home Health Services, Durable Medical Equipment, and Procedures Prior Authorization Process*. All requests for over the standard benefit of 6 UDS's will need to be submitted within 14 days of the first UDS to be considered timely submissions.

Authorizations for Presumptive Urine Drug Screening Testing

A. Chronic Opioid Therapy (COT)

1. Can be submitted prospectively and annually
2. Electronic signature on order is acceptable
3. Definitive testing will only be covered as described in section below and tracked for trends. Additional documentation may be requested related to trends or quality initiatives.
4. Low to moderate risk
   - Members with low risk for abuse may be administered definitive tests up to one to two times per year (total of 2 max per 1 year auth). These requests may be authorized annually. Overages must be reviewed for medical necessity.
   - Members with moderate risk for abuse may be administered definitive tests up to one to two times every six months (total of 4 max per 1 year auth). These requests may be authorized annually. Overages must be reviewed for medical necessity.

- All low to moderate risk members may request an additional 6 presumptive screens /year with doctors notes supporting medical necessity and a signed MD order (low to moderate COT screening).
- The COT screening is required to be completed and stored in chart, but not necessary for submission. It may be requested for quality assurance and QI activities, as necessary.

5. High risk COT
   - Members with high risk for abuse may be administered definitive tests up to one to three times for every three month period screens /year with doctors notes supporting medical necessity and a signed MD order (high COT screening). These requests may be submitted annually for a total of 12 definitive tests.

     - Members that screen high, provider may submit for 12 definitive tests at once on an annual basis with an additional, these members will also be eligible for the 6 benefit level presumptive tests annually
     - If UDS screens exceed 6, they will deny until an appropriate COT screening tool, and PA is submitted with documentation including MD signed order and the notes proving medical necessity for overage.

B. AODA Treatment

1. All members will receive the benefit level of 6 UDS screens with the submission of a PA form (no further documentation necessary)

2. In addition to the benefit level of 6 UDS's, providers may request 50 presumptive and 25 confirmatory tests in the calendar year.

3. The request must be received within 14 days of member beginning AODA treatment

C. Medical Indications

1. Drugs of Abuse (DOA) screening is of extremely limited value in the acute clinical management of most patients. As a result, there is no indication for acute DOA testing.

2. Scenarios when the results of a DOA screen might alter acute management include:
   - Seizure/status epilepticus
   - Cardiovascular event (eg, ACS)
   - Psychiatric event (eg, acute psychosis)
   - Patient awaiting transplant
   - Pediatric patient with a positive DOA screen might undergo further evaluation for abuse (eg, skeletal survey), or their siblings might be screened
   - Coma

- Altered mental status in the absence of a clinically defined toxic syndrome or toxidrome
- Unexplained metabolic or respiratory acidosis in the absence of a clinically defined toxic syndrome or toxidrome
- To provide antagonist to specific drug

3. Appropriate diagnosis must be included on the request
4. Electronic signature on order is acceptable
5. Definitive testing will only be covered as described in section below and tracked for trends. Additional documentation may be requested related to trends or quality initiatives.
6. The benefit level of 6 UDS should cover the medical indications for a member
7. If a provider requires more than 6 UDS in a year for medical indications, the provider should submit a PA with requested UDS amount and dates of service

D. **Residential living requirements**

1. All members that live in Substance Abuse residential living facilities are eligible for the same testing as those that fall under the AODA treatment plan
2. If these members exceed the benefit allowable quantity they will need to receive a medical review by an RN.

Process

The initial 6 benefit level Urine Drug Screens will be processed as administrative approvals by the PA Assistant. iCare will accept up to 14 calendar days retroactive authorization for the initial request. These six (6) screens must be authorized on the same authorization and cannot be split up over different authorizations or submitted separately over time. When a Prior Authorization request for 6 UDS's is received, it will be processed as an administrative authorization without a need for nurse review.

Administrative Authorizations are processed by the PAA. The PAA will review the request, as part of the authorization entry process the PAA will do an audit of the authorizations that are in Trucare to ensure that the member has not received the benefit for the year. In the absence of any previous authorization the request can be entered and approved without need for records or order. The PAA will approve the authorization and send notification to the appropriate parties.

If a previous identified UDS auth has been entered in the last 12 months, the PA Assistant will forward the request to the PA RN for evaluation of records. If the PA RN finds that a provider has requested on behalf of a member that has already received the 6 benefit screens, she will review the information for appropriateness. If the request meets medical necessity for the indicated diagnosis, the PA RN will approve. If the request does not meet medical necessity it will then be forwarded for review by the Medical Director/ Chief Medical Officer.

The Medical Director/ Chief Medical Officer can choose to override the benefit and allow further screens without PA to be allowed if medically appropriate.

Drug Testing Panels or Profiles Definition

Presumptive UDS Panels

- Presumptive UDS testing typically involves testing for multiple analytes based on the beneficiary's clinical history and risk assessment and must be documented in the medical record.

Definitive UDS Panels

- Physician-directed definitive profile testing is reasonable and necessary when ordered for a particular patient based upon historical use and community trends. However, the same physician-defined profile is not reasonable and necessary for every patient in a physician's practice. Definitive UDS orders should be individualized based on clinical history and risk assessment and must be documented in the medical record.

Ordering of Definitive UDS

The member must meet one of the following criteria must be documented in the medical records to receive approval for overages or unusual circumstances.

1. Reflex Testing by reference laboratories – since reference laboratories do not have access to patient-specific data, reflex testing under the following circumstances is reasonable and necessary:

- To verify a presumptive positive UDS using definitive methods that include, but are not limited to GC-MS or LC-MS/MS, before reporting the presumptive finding to the ordering clinician and without an additional order from the clinician; or

- To confirm the absence of prescribed medications when a negative result is obtained by presumptive UDS in the laboratory for a prescribed medication listed by the ordering clinician.

2. Direct to definitive UDS without a presumptive UDS is reasonable and necessary, when individualized for a particular patient. This would particularly be with synthetic opioids (ie fentanyl) but must be individualized to patient history or risk

3. Definitive testing to confirm a negative presumptive UDS result, upon the order of the clinician, is reasonable and necessary in the following circumstances:

- The result is inconsistent with a patient's self-report, presentation, medical history, or current prescribed medication plan (should be present in the sample);

- Following a review of clinical findings, the clinician suspects use of a substance that is inadequately detected or not detected by a presumptive UDS; or

- To rule out an error as the cause of a negative presumptive UDS result.

4. Definitive testing to confirm a presumptive UDS positive result, upon the order of the clinician, is reasonable and necessary when the result is inconsistent with the expected result, a patient's self-report, presentation, medical history, or current prescribed medication plan.

5. Authorizations for definitive testing
    a. Must be patient specific and clinical documentation why ordered (drug not captured on presumptive (ie synthetic), positive presumptive
    b. Must be submitted within 14 days of testing to be covered
    c. Appropriate diagnosis must be included on the request

Non-Covered Services

1. Blanket Orders
2. Reflex definitive UDS is not reasonable and necessary when presumptive testing is performed at point of care because the clinician may have sufficient information to manage the patient. If the clinician is not satisfied, he/she must determine the clinical appropriateness of and order specific subsequent definitive testing (e.g. the patient admits to using a particular drug, or the IA cut-off is set at such a point that is sufficiently low that the physician is satisfied with the presumptive test result).
3. Routine standing orders for all patients in a physician's practice are not reasonable and necessary.

4. It is not reasonable and necessary for a physician to perform presumptive point of care testing and order presumptive IA testing from a reference laboratory. iCare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.

5. It is not reasonable and necessary for a reference laboratory to perform and bill IA presumptive UDS prior to definitive testing without a specific physician's order for the presumptive testing.

6. Drug testing of two different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.

7. UDS for medical-legal and/or employment purposes or to protect a physician from drug diversion charges.

8. Specimen validity testing including, but not limited to pH, specific gravity, oxidants, creatinine.

Monitoring Utilization

a. The Prior Authorization Department Manager will run a monthly report on UDS authorizations and utilization and watch for misuse.

b. The Prior Authorization Department Manager will monitor member level data on authorization requests from multiple providers and will indicate when a possible misuse is occurring. These situations will be managed on a case by case basis with involvement of the Chief Medical Officer/ Medical Director.

References

Applicable Codes: LCD L36037 page 16-30

1. UpToDate, Utilization of UDS in Clinical Practice
2. Local Coverage Determination (LCD): Urine Drug Testing (L36037)