Guidance document

Drug screens/urinalysis testing in outpatient and opioid treatment program settings

The state plan currently limits testing for drugs of abuse to pregnant persons receiving care in chemical dependency treatment settings or to people receiving care in opioid treatment programs. These limits do not apply to testing in medical offices or mental health treatment settings. All testing must be medically necessary and ordered by a physician (provider) as part of a medical assessment.

These limits do not apply to people enrolled in a therapeutic court and ordered to participate in chemical dependency treatment. Tests for these individuals are ordered by and are paid for by the criminal court system. This guidance is also not meant to cover workplace drug testing.

Please refer to the table below for limits and restrictions related to drug screen/urinalysis testing:

Clinics, mental health treatment agencies or chemical dependency treatment agencies prescribing medication for opioid and other substance use disorders and Opioid Treatment Program Settings			
Test type	**Non-pregnant**	**Pregnant**	**Comments**
Immunoassay			
Presumptive, point of care, urine drug tests for drugs of abuse	Up to 24 per 12 months	Up to 18 during pregnancy	Count resets when the individual changes practices or delivers
Confirmatory urine drug test by GCMS or LCMS			
1-15 drug classes	Up to 16 per 12 months	Up to 12 during pregnancy	Count resets when the individual changes practices
16-21 drug classes	Not covered	Not covered	
>21 drug classes	Not covered	Not covered	
Ethyl glucuronide	Not covered	Not covered	
Serial quantitative drug level testing	Not covered	Not covered	
Quantitative norbuprenorphine to buprenorphine levels	Not covered	Not covered	
THC/creatinine ratios	Not covered	Not covered	
Chemical Dependency Treatment Agencies that do not prescribe medications for SUD*			
Withdrawal management (Detoxification) Programs	One at admission	One at admission	
Residential (Inpatient) Treatment	One per month	One per month if indicated by results of presumptive test or the clinical encounter	
Intensive outpatient treatment programs	Four the 1st month then 2 per month	One per month if indicated by results of presumptive test or the clinical encounter	
Outpatient treatment programs	2 per month	One per month if indicated by results of presumptive test or the clinical encounter	

The rationale for not covering the tests listed above, or covering them more frequently than outlined, is as follows:

- It is expected that the frequency and utilization of both point of care and confirmatory tests will be higher in the initial stages of treatment and taper off over time. Given statewide prescription monitoring program reports and DEA seizure information there is not support for immunoassay or mass spectrometry testing more than 15 individual drug classes at any one time.

- Ethyl glucuronide levels when high are reflective of recent alcohol use, low cut off levels may be falsely negative for lower levels of alcohol use. There are also a number of substances that can lead to false positive ethyl glucuronide tests. This limits the ability to consistently draw reliable and accurate conclusions from the results to be applied towards patient care. If persistent evidence of alcohol use exists despite the person being treated for an alcohol use disorder, an increase in treatment intensity should be considered.

- Because hydration status, diurnal variability, a person's metabolic rate, and time since last ingestion can all effect drug levels and those of their metabolites, quantitative testing is not reliably predictive in reflecting patterns of use.

- Similarly there is not an agreed upon threshold, validated across large sample sizes or diverse populations, for what an appropriate norbuprenorphine to buprenorphine ratio should be to rule out diversion. The Medicaid program is by law required to use medical necessity to guide coverage decisions. Testing for the presence or absence of a drug or its metabolite to assure compliance with a therapeutic intervention may at times be considered medically necessary. Testing drug levels to determine whether or not 'diversion' or urine adulteration is occurring are not medical interventions and are not considered medically necessary.

- It is recognized that people often experience multiple concurrent substance use disorders. Urine drug testing is reflective of a moment in time and by itself is not diagnostic of a substance use disorder. If during treatment, urine drug testing suggests continued use and the individual's functional status is not improving, a higher level of care or the delivery of higher intensity services may be necessary.

- Confirmatory tests done in response to a negative presumptive screen require documentation of clinical signs or symptoms suggesting active use to document medical necessity.

- Confirmatory tests done to confirm an individual's self-reported use require chart documentation in support of medical necessity. Follow up visits must document the intervention that occurred as a result of a confirmatory test.

References:

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McDonell MG, Jordan Skalisky J, Leickly E, et.al. Using Ethyl Glucuronide in Urine to Detect Light and Heavy Drinking in Alcohol Dependent Outpatients *Drug Alcohol Depend*. 2015 December 1; 157: 184–187.

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