Comments for Chapter 529.2- Drug Screenings
Effective Date July 1, 2018

Comment Number	Date Comment Received	Comment	Result
1.a.	06/01/18	"...Placing arbitrary limits on the number, frequency, specific analytes screened for and/or the type or purpose of a drug screen gives us concern. We commend the Bureau for providing a waiver of some of the proposed service limits if subject to medical necessity review yet readily acknowledge experiences that demonstrate such reviews can without BMS establishing clear expectations become barriers to treatment."	No Change: • Limits are consistent with other state Medicaid programs and private insurers. • The Utilization Management Contractor (UMC) will provide medical necessity authorization training via webinar.
1.b.	06/01/18	"...if BMS will require its consistent application across all payers of Medicaid services, the limits concern us. With that in mind we encourage the Bureau to keep this part of the Manual open while the input it gathers through the public comment process can be circulated and additional insight gained."	No Change: • A formal comment period has been offered and completed for this manual. • Under the ongoing data collection related to our 1115 SUD Waiver, the impact of our policy changes will be re-evaluated intermittently.
2.a.	06/01/18	"Would this only apply to FFS or would this apply to MCOs as well?"	This manual applies to Fee-for-Service members and MCO members.
2.b.	06/01/18	"...The rationale for test frequency is self-evident – or should be (they have a SUD and they recently stopped, and they are in a treatment program, and, most importantly, we need to confirm on an on-going basis that the client is still in the correct level of care, is drug-free or only testing positive for what is prescribed at reasonable levels given the prescription). Seems like more unnecessary redundant documentation requirements to me."	No Change: Documentation must justify medical necessity based on the individual's treatment plan.
2.c.	06/01/18	"So, I assume that "definitive" tests are "confirmation" tests, and only 12 of those a year?"	No Change:

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			• Previous HCPC definitions referred to confirmation tests as the method to identify individual drugs. Current HCPC definitions refer to definitive drug tests as the method to identify individual drugs. • There will be a limit of 12 definitive tests per calendar year. Once this limit is met, a medical necessity authorization is available to exceed the limit.
2.d.	06/01/18	"With substance use disorders, people may need more than 12 confirmation drug screening tests in a year..."	No Change: This limit can be exceeded with a medical necessity authorization.
2.e.	06/01/18	"What's the difference between and the definition of "presumptive", "definitive" and "routine reflex" testing (routine reflex testing mentioned at the end of the non-covered services section in the new draft)?"	No Change: Definitions are provided in the policy. Categories of drug screening/testing include: Presumptive Testing**:** Presumptive testing determines if a drug or class of drug is present in the specimen. Definitive Testing**:** Definitive testing determines the specific drug(s) present in the specimen Change: The definition for Reflex Testing was added to the Glossary. "Reflex testing occurs when an initial result meets pre-determined criteria and an additional test is done

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			automatically, based on the criteria, without an order or review from the treating practitioner.”
2.f.	06/01/18	"What about MAT program clients? The MAT regs require weekly drug testing for buprenorphine? So, Medicaid won’t pay for more than 24 presumptive drug screens and no more than 12 definitive drug tests for either MAT clients or pregnant clients?"	No Change: • In 69CSR12 31.2.d.1 of the West Virginia State code, “A patient receiving medication assisted treatment medication maintenance services must have at least one random drug screen quarterly during treatment.” In Chapter 503, 504, and 521 of the Medicaid policy, Phase 1 for MAT requires two random drug screens per month, and Phase 2 requires one random drug screen per month. Proposed limits are within reasonable ranges of the Medicaid policies and state regulations. Change: • There are provisions to exceed the limit: "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

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			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."
2.g.	06/01/18	"Earlier in the sentence, the documentation requirements are discussed and are in the current language, saying "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…." Then adding …as well as the relation of the specific tests to the member's treatment. Are they asking what is the relation to the specific tests to a person's treatment?"	No Change: This is intended to remind providers of the necessity to capture the logic of their drug testing strategy in the documentation for the individual members.
2.h.	06/01/18	"So, I've never in my career heard of "reflex testing". What is that? They have definitions for analyte, presumptive testing (that you still get 24 of a year), and now adding "definitive testing" which determines the specific drugs present (which you now only get 12 of), but is "reflex testing" the confirmation testing where we again get a positive or negative result plus confirmation of levels of drugs in the specimen?"	Change: Added Definition to the Glossary: 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.
2.i.	06/01/18	"The confirmation testing is the only way to truly know a clients' status."	No Change: Drug screening is a tool utilized by clinicians and practitioners to help guide

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			treatment planning and treatment interventions. Definitive testing is a covered benefit by West Virginia Medicaid: "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."
2.j.	06/01/18	"While "routine" testing is not covered "unless used in connection with an extended course of treatment for SUD" – does that mean short-term residential treatment programs do not qualify or outpatient services do not qualify..."	Change: Policy has been updated to read: "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."

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			Refer to Chapters 503 and 504 for more information.
2.k.	06/01/18	"What's considered an "extended course of treatment?"	Change: Policy has been updated to read: "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.
3.	05/31/18	"...your wanting to take away a useful tool that makes addicts accountable for being in programs and trying to get the help they need."	No Change: No drug testing services are being eliminated with this manual change, and there are provisions for any drug testing service to be provided beyond limits with a medical necessity authorization.
4.a.	05/29/18	"Our experience is that most people suffering from a SUD are using multiple substances, depending on what is available and what they can afford at the time."	No Change: Drug testing services for multiple substances are covered by West Virginia Medicaid.
4.b.	05/29/18	"Routine, random drug testing is an intricate component of a high quality treatment and recovery service. The draft revisions would exclude routine, random drug testing and would allow drug screening only after a person is demonstrating symptoms of impairment or signs of drug use."	No Change: Drug testing is covered for Substance Use Disorders when medically necessary. "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

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			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."
4.c.	05/29/18	"Limiting provider's discretion for how often, how many and under what circumstances a drug test will be paid for will compromise the integrity of programs and services in West Virginia. Limiting the number of drugs that can be tested based on a person's prior use will also compromise the integrity of programs and services as we all know that by far, most people with SUDs are using multiple drugs of abuse."	No Change: Providing medical necessity documentation for drug testing services ensures that West Virginia Medicaid members are getting medically appropriate care.
4.d.	05/29/18	"Requiring standing orders to be re-authorized every 30 days is another burdensome documentation requirement that is unnecessary when most standing orders are good until they are replaced or repealed."	No Change: The thirty-day rule ensures that each order is individualized and up to date with the member's current medical need.
5.a.	06/01/18	"What really worries me, though, is the change from definitive to presumptive screenings. Patients in MAT programs shouldn't have to worry about getting kicked out of programs and ending up back on the streets because of faulty tests showing up positive for things they never took."	No Change: No drug testing services are being eliminated with this manual change. 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.

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			Refer to Chapter 503 and 504.
6.a.	05/31/18	"Definitive testing for G0481-G0483 should always require a prior authorization. Other states such as Maryland do not cover the two codes G0482 and G0483. There are very rare reasons why definitive testing would be need. The vast majority of patients do not fail a preliminary drug test with the need to confirm more than 8 analytes. Furthermore, providers should be reviewing presumptive results with the patient prior to ordering definitive tests. If a patient confirms the unexpected finding then there is no further need for definitive testing. These could be allowed via prior authorization if a Medicaid member is having an annual test or if the number of disputed unexpected positives/negatives on a presumptive test were at the amount of the requested definitive test. Based on prior dealings with certain providers, there is a concern that codes G0482 & G0483 may be abused."	No Change: The proposed limits are consistent with other state Medicaid programs and private insurers. All West Virginia Medicaid services must be medically necessary. Change: Policy was updated to read: "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."
6.b.	05/31/18	"The policy states that West Virginia Medicaid covers up to 24 presumptive drug screens and 12 definitive drug tests per calendar year without medical review; however, all testing is subject to post payment review and recovery. Is the intent and/or purpose of this provision to allow providers to bill	Change: The intent is to only require a medical necessity authorization once the limits are met. Policy was updated to read: "West Virginia Medicaid covers up to 24 presumptive drug

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		that number of tests with no pre or post payment review for any medical necessity? If so, that appears to contradict the provision in the policy that states 'testing for more analytes than medically justified will be subject to audit.'"	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."
6.c.	05/31/18	"The policy that states 'Testing for more analytes than medically justified will be subject to audit.' Routine use of 80307 would then also justify an audit. Furthermore, 80307 should be considered as requiring prior authorization."	No Change: All medical services are subject to audit. Prior authorization of 80307 was considered, however, it will not be required at this time.
6.d.	05/31/18	"Will BMS provide the presumptive codes that may be billed up to 24 times per calendar year? 80305 and 80306 should be the presumptive codes that do not require preauthorization."	No Change: CPT codes 80305, 80306, and 80307 require a medical necessity authorization once the accumulative limit of 24 has been reached.
6.f.	05/31/18	"Since the policy allows tests 'per calendar year' language needs to be added to pro rate the number of tests members may have if they start treatment at times other than January. If not, and the policy allows twenty-four (24) presumptive and twelve (12) 'without medical review' then it appears providers can bill the total number	No Change: Policy allows for 24 presumptive and 12 definitive tests without a medical necessity authorization, regardless of when a member started treatment.

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		of tests regardless of when a member started treatment. Instead, should the policy state 'per rolling year' and not "per calendar year.'"	Policy was updated to read: "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."
6.g.	05/31/18	"If thirty-six (36) tests are allowed "without medical necessity" then why is the requirement for 'documentation must include how the test results will impact the treatment plan, and the rationale for the requested frequency of testing.' Or, is this requirement necessary to request more than the thirty-six (36) tests?"	No Change: All services for West Virginia Medicaid are required to be medically necessary. The 24 presumptive and 12 definitive test limit allows for medically necessary testing up to that limit without a medical necessity authorization prior to payment.
6.h.	05/31/18	"May providers bill more presumptive tests and less definitive tests? For example, bill thirty (30) presumptive and six (6) definitive tests. If so, the policy needs to be revised to reflect this."	Change: Policy was updated to read: "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

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			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."
6.i.	05/31/18	"Presumably, this policy is member specific. Meaning members may have twenty-four (24) presumptive tests and twelve (12) definitive tests per calendar year without any medical necessity determination. It is not unreasonable to conclude that certain providers will encourage members to switch plans once they have maximized the twenty-four (24) presumptive and twelve (12) definitive tests with no medical necessity review. Language needs added to specifically address this issue and prevent it from occurring. If in fact that is the case, how will BMS account for members who switch MCOs throughout the year?"	No change. Under the ongoing data collection related to our 1115 SUD Waiver, the impact of our policy changes will be re-evaluated intermittently.
6.j.	05/31/18	"How will the policy take into account all testing that was completed for members prior to the effective date of the policy?"	No Change: If the member has already met or exceeded the calendar year limit prior to July 1, 2018, the provider will need to contact the UMC for a medical necessity authorization prior to payment to exceed this benefit limit.
6.k.	05/31/18	"The phases of treatment need to be better defined. Initiation phase, stabilization phase,	No Change: The phases of treatment are not contained within this manual. For more

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		and maintenance phase are the current terms used in addiction medicine. The state's use of phase I and phase II do not align with the terms or the duration of the stages."	information regarding stages of treatment, refer to Chapter 503 Licensed Behavioral Health Center (LBHC) Services, Chapter 504 Substance Use Disorder Services, and Chapter 521 Behavioral Health Outpatient Services.
6.l.	05/31/18	"Members who are in Phase I of the Non-Methadone Medication Assisted Treatment Program are mandated to have a minimum of two random drug screens per month. If a provider utilizes all of the 36 total drug tests prior to the member exiting Phase I in a calendar year will that fact alone be enough for medical necessity for additional drug tests. For example, the 36 total tests are utilized during the first six (6) calendar months (January –June). Would the member then be allowed to remain in Phase I of the program even though the provider has utilized the maximum allowed drug tests?"	No Change: If the member has already met or exceeded the calendar year limit, the provider will need to contact the UMC for a medical necessity authorization prior to payment to exceed this benefit limit. All of this information would be taken into account when determining the members' medical necessity authorization.
7.a.	05/29/18	We are concerned that some providers will reach the limits quickly, and we respectfully request that BMS consider a policy that spreads the benefit limits over the course of the year. For instance, rather than covering up to 24 presumptive drug screens and 12 definitive drug tests per calendar year without medical review, consider one of the following alternatives. -Covering up to 12 presumptive drug screens and 6 definitive drug tests per 6 months without medical review; or -Covering up to 6 presumptive drug screens and 3 definitive drug tests per 3 months without medical review."	No Change: BMS will stay with current calendar year timeframe. This is in keeping with concerns from providers that more testing is needed in the beginning of treatment and allows more provider flexibility to meet the needs of the member.

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7.b.	05/29/18	"The MCOs would prefer to be allowed to medically manage presumptive and definitive drug tests using our own criteria. It was stated by BMS early in these discussions that we would be allowed to follow our own criteria and the BMS criteria would simply be a guide. It is also a concern that the level of testing is not called out by BMS. If the MCOs are not allowed to utilize their own criteria in determining what level of definitive testing is warranted this area will be ripe for abuse with providers potentially billing a higher number of level 2 & 3s with inordinately higher costs."	No Change: Under the ongoing data collection related to our 1115 SUD Waiver, the impact of our policy changes will be re-evaluated intermittently.