



SWOIPA

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SOUTHWEST OREGON IPA, INC. (SWOIPA) ADMINISTERS PHYSICAL AND BEHAVIORAL HEALTH BENEFITS FOR ADVANCED HEALTH MEMBERS.

Greetings SUD treatment partners!

Advanced Health became aware of some drug testing practices that fell outside of established best practices, an issue also recently discovered by providers/plans across the state.

To make navigating OHA's rules and statutes easier, we felt that developing an overarching policy, that guided OHP members substance use treatment, would be beneficial for all.

Please review this policy, evaluate your team's practices, and ensure alignment. We have configured our system to require an authorization after 24 presumptive tests and 12 definitive tests for non-dual eligible members within a rolling 12-month period beginning 10/1/26.

The policy will live on Advanced Health's website, under Providers, then under the tab for Policies and Procedures.

Don't hesitate to reach out to (541) 269-7400 with any questions or concerns.



Substance Use Disorder (SUD) Drug Testing Policy and Procedures

Company: Advanced Health	Approved by: Samyukta Vendrathi Title: Chief Operating Officer Current Revision Date: 10/8/2026 Current Review Date: 10/8/2026
Department: Behavioral Health Management	

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1. PURPOSE

- 1.1.** To establish standardized, evidence-based guidelines for urine drug testing (UDT) to ensure appropriate, medically necessary, and compliant use for members of Advanced Health CCO, in alignment with Oregon Health Authority (OHA) policies and Coordinated Care Organization (CCO) requirements.

2. SCOPE

- 2.1.** Advanced Health contracts with DOCS Management Services (DOCS) for most administrative and operational functions. Advanced Health, through a privileged provider agreement, delegates delivery of all physical health, behavioral health, and pharmacy services, including certain administrative functions, to Southwest Oregon IPA, Inc. (SWOIPA) as part of operational and compliance management. In addition, SWOIPA further subdelegates administrative and operational tasks to ensure effective benefit administration and program

operation under their privileged provider agreement to DOCS Management Services. These responsibilities include, but are not limited to, the development, review, approval, and ongoing maintenance of policies and procedures necessary to fulfill contractual and regulatory requirements. All contracted activities remain subject to oversight and accountability measures established by Advanced Health to ensure compliance with applicable laws, regulations, and organizational standards.

2.2. This policy applies to all providers delivering services to Advanced Health CCO members, including but not limited to:

- 2.2.1. Substance Use Disorder (SUD) treatment providers
- 2.2.2. Primary care and pain management providers
- 2.2.3. Behavioral health providers
- 2.2.4. Emergency department clinicians

3. ACRONYMS AND DEFINITIONS

3.1. Unless otherwise defined, all uppercase words will be defined the same as in the CCO Contract.

3.2. SUD - Substance use disorder

3.3. UDT - Urine drug testing

3.4. Presumptive Testing (Screening)

3.4.1. A presumptive drug test is a preliminary, qualitative screen that indicates the presence or absence of drugs or drug classes without confirming specific substances or concentrations.

3.4.2. Initial evaluation tool

3.5. Definitive Testing (Confirmatory) also called confirmatory testing, is a highly accurate laboratory method that identifies and measures the exact amount of specific drugs, illicit substances, and their chemical byproducts (metabolites) in a sample. It rules out false positives from initial rapid screens.

3.6. Drug Class

3.6.1. For purposes of this policy A drug class in this context refers to the specific category of substance causing the disorder.

3.7. “Per year” means rolling calendar year

4. POLICIES

4.1. Coverage Criteria

4.1.1. General Requirements | UDT is covered when:

4.1.1.1. Results impact treatment planning or clinical decision-making

4.1.1.2. Testing is consistent with evidence-based care to include Diagnostic Guideline D23, Urine Drug Testing

4.1.1.2.1. Presumptive Testing

4.1.1.2.1.1. Covered as the first-line test when clinically indicated, including:

4.1.1.2.1.1.1. Chronic opioid therapy monitoring

4.1.1.2.1.1.2. Substance use disorder treatment

4.1.1.2.1.1.3. Behavioral health assessment

4.1.1.2.1.1.4. Diagnostic clarification

4.1.1.2.2. Definitive Testing

4.1.1.2.2.1. Covered only when one of the following applies:

4.1.1.2.2.1.1. Inconsistent Results

4.1.1.2.2.1.2. Presumptive results are inconsistent with:

4.1.1.2.2.1.2.1. Patient history

4.1.1.2.2.1.2.2. Clinical presentation

4.1.1.2.2.1.2.3. Prescribed medications

4.1.1.2.2.2. Definitive testing is not allowed simply because it is more comprehensive, expensive or preferred method.

4.1.1.3. Clinical Impact

4.1.1.3.1. Results will change management

4.1.1.3.2. Detection Limitations

4.1.1.3.3. Suspected substances not reliably detected by screening (e.g., fentanyl)

4.1.1.4. Limitations:

4.1.1.4.1. Maximum 14 drug classes per date of service

4.1.1.4.2. Used only to confirm an unexpected or inadequately detected by presumptive result.

4.1.1.4.3. Not covered for routine or standing use without justification

4.1.1.4.3.1. For legal custodial purposes

4.1.1.4.3.2. Punitive reasons

4.1.1.4.3.3. Employment screening or workplace accidents

4.1.1.4.3.4. Admission into an educational or athletic program

4.1.1.4.3.5. It is sent to a non-certified, out-of-state facility

4.1.1.4.3.6. Convenience

4.1.1.4.3.7. If a drug test is requested solely to fulfill a court order, probation condition, or legal mandate without an attached treatment component, OHP explicitly excludes it

4.2. Frequency Guidelines for Substance Use Disorder (SUD) Treatment

4.2.1. In alignment with OHA and CCO policy:

4.2.2. Presumptive testing: Up to 24 dates of service annually

4.2.3. Definitive testing: Up to 12 dates of service annually

4.2.4. Prior Authorization Requirement:

4.2.4.1. Testing exceeding 24 presumptive or 12 definitive tests per year requires prior authorization with supporting clinical documentation.

4.3. Chronic Opioid Therapy (Chronic Pain)

4.3.1. Testing frequency must be based on a validated opioid risk assessment tool:

Risk Level	Presumptive Testing Frequency
Low Risk	Up to 2 times/year
Moderate Risk	Up to 4 times/year
High Risk	Up to 12 times/year

4.3.2. Definitive testing:

4.3.2.1. Only for confirmatory purposes

4.3.2.2. Maximum 12 dates of service per year

4.3.2.3. Prior Authorization Requirement:

4.3.2.3.1. Testing that exceeds risk-based limits or annual definitive testing limits requires prior authorization with clinical justification.

4.4. Exceptions to Frequency Limits

4.4.1. UDT may exceed standard limits when medically necessary:

- 4.4.1.1. Altered Mental Status
- 4.4.1.2. Example: Emergency department evaluations
- 4.4.2. Coverage includes:
 - 4.4.2.1. Presumptive testing
 - 4.4.2.2. Definitive testing (if clinically indicated)
- 4.4.3. Child Welfare Cases
 - 4.4.3.1. Testing conducted under DHS Office of Child Welfare Programs
 - 4.4.3.2. Covered beyond limits when medically necessary

4.5. Clinical Requirements| Providers must:

- 4.5.1. Document medical necessity
- 4.5.2. Justify:
 - 4.5.2.1. Frequency of testing
 - 4.5.2.2. Need for definitive testing
- 4.5.3. Demonstrate how results:
 - 4.5.3.1. Affect treatment decisions
 - 4.5.3.2. Influence safety or care planning
- 4.5.4. For testing exceeding policy limits:
 - 4.5.4.1. Submit prior authorization request
 - 4.5.4.2. Include clinical documentation and rationale demonstrating medical necessity
- 4.5.5. Documentation of presumptive testing results prior to definitive test ordering

4.6. Care Coordination & Access

- 4.6.1. Members have access to:
 - 4.6.1.1. SUD screening and treatment services
 - 4.6.1.2. Evidence-based UDT monitoring
- 4.6.2. Members may access services through:
 - 4.6.2.1. Substance Abuse Screening & Support tools
 - 4.6.2.2. Behavioral health referral systems

4.7. Prohibited Practices

- 4.7.1. The following are not covered:
 - 4.7.1.1. Routine definitive testing without clinical indication
 - 4.7.1.2. Testing that does not influence patient care
 - 4.7.1.3. Excessive panel testing beyond 14 drug classes
 - 4.7.1.4. Testing outside frequency limits without prior authorization and documented medical necessity

5. PROCEDURES

5.1. Determine Medical Necessity

- 5.1.1. Before ordering UDT, the provider must:
 - 5.1.1.1. Confirm the test will:
 - 5.1.1.1.1. Impact treatment planning or clinical decision-making
 - 5.1.1.1.2. Influence safety or care planning
 - 5.1.1.1.3. Ensure the test aligns with evidence-based care
 - 5.1.1.2. Document the clinical indication in the patient record

5.2. Select Appropriate Test Type

- 5.2.1. Presumptive Testing (First-Line)
 - 5.2.1.1. Use presumptive testing when UDT is clinically indicated, including:

- 5.2.1.1.1. Chronic opioid therapy monitoring
- 5.2.1.1.2. Substance use disorder treatment
- 5.2.1.1.3. Behavioral health assessment
- 5.2.1.1.4. Diagnostic clarification
- 5.2.1.2. Action:
 - 5.2.1.2.1. Order presumptive testing as the initial screening test
 - 5.2.1.2.2. Document rationale for ordering
 - 5.2.1.2.3. Use the appropriate billing codes:
 - 5.2.1.2.3.1. 80305-80307
 - 5.2.1.2.3.2. G0477-G0479
- 5.2.2. Definitive Testing (Confirmatory Only)
 - 5.2.2.1. Order definitive testing only when one of the following applies:
 - 5.2.2.1.1. Inconsistent results
 - 5.2.2.1.2. Presumptive results do not align with:
 - 5.2.2.1.2.1. Patient history
 - 5.2.2.1.2.2. Clinical presentation
 - 5.2.2.1.2.3. Prescribed medications
 - 5.2.2.1.2.4. Detection limitations
 - 5.2.2.1.2.5. Suspected substances not reliably identified by screening (e.g., fentanyl)
 - 5.2.2.1.2.6. Clinical necessity
 - 5.2.2.1.2.7. Results will change management
 - 5.2.2.2. Action:
 - 5.2.2.2.1. Clearly document the reason for definitive testing
 - 5.2.2.2.2. Do not use routine or standing definitive testing
 - 5.2.2.2.3. Use the appropriate billing codes:
 - 5.2.2.2.3.1. 80320-80377
 - 5.2.2.2.3.2. G0480-G0483

5.3. Apply Frequency Guidelines

- 5.3.1. Substance Use Disorder (SUD) Treatment
 - 5.3.1.1. Presumptive testing: Up to 24 dates of service per year
 - 5.3.1.2. Definitive testing: Up to 12 dates of service per year
- 5.3.2. If limits are exceeded:
 - 5.3.2.1. Submit prior authorization (PA)
 - 5.3.2.2. Include clinical justification and documentation

5.4. Chronic Opioid Therapy (Chronic Pain)

- 5.4.1. Determine risk level using a validated opioid risk assessment tool:
- 5.4.2. Risk Level Presumptive Testing Frequency
 - 5.4.2.1. Low Risk: Up to 2 times/year
 - 5.4.2.2. Moderate Risk: Up to 4 times/year
 - 5.4.2.3. High Risk: Up to 12 times/year
- 5.4.3. Definitive testing:
 - 5.4.3.1. Only for confirmatory purposes
 - 5.4.3.2. Maximum 12 dates of service per year
- 5.4.4. If limits are exceeded:
 - 5.4.4.1. Submit prior authorization with clinical justification

5.5. Apply Panel Limits

5.5.1. Do not order more than 14 drug classes per date of service

5.5.2. Avoid excessive panel testing

5.6. Use Exceptions When Medically Necessary

5.6.1. UDT may exceed standard limits only under documented medical necessity:

5.6.1.1.1. Altered Mental Status / Acute Care

5.6.1.1.2. Examples: emergency department evaluation

5.6.1.1.3. Both presumptive and definitive testing may be covered if clinically indicated

5.7. Child Welfare Cases

5.7.1. Testing ordered under DHS Office of Child Welfare Programs

5.7.2. May exceed limits when medically necessary

5.7.2.1. Action:

5.7.2.1.1. Document the clinical justification clearly in the medical record

5.7.2.1.2. Ensure the exception is supported by clinical findings

5.8. Documentation Requirements

5.8.1. Providers must:

5.8.1.1. Document medical necessity for every UDT

5.8.1.2. Justify:

5.8.1.2.1. Frequency of testing

5.8.1.2.2. Need for definitive testing

5.8.1.3. Document how the result will:

5.8.1.3.1. Change treatment

5.8.1.3.2. Affect safety or care planning

5.9. Prior Authorization (PA) Process

5.9.1. Required when:

5.9.1.1. Testing exceeds annual limits (SUD or chronic opioid therapy)

5.9.1.2. Testing exceeds risk-based frequency

5.9.1.3. Definitive testing exceeds allowed frequency

5.9.2. PA submission must include:

5.9.2.1. Clinical rationale

5.9.2.2. Relevant patient history

5.9.2.3. Evidence of medical necessity

5.9.2.4. Explanation of how results will influence care

5.9.3. Care Coordination and Access

5.9.3.1. Ensure members have access to:

5.9.3.1.1. SUD screening and treatment services

5.9.3.1.2. Evidence-based UDT monitoring

5.9.3.2. Providers should:

5.9.3.2.1. Use behavioral health referral pathways as needed

5.9.3.2.2. Leverage available screening and support tools

5.10. Prohibited Practices

5.10.1. Do not perform or bill for:

5.10.1.1. Routine definitive testing without clinical indication

5.10.1.2. Testing that does not influence patient care

5.10.1.3. Panels exceeding 14 drug classes per date of service

5.10.1.4. Testing beyond frequency limits without:

- 5.10.1.4.1. Prior authorization
- 5.10.1.4.2. Documented medical necessity

6. REFERENCE SOURCES

- 6.1. Oregon Health Authority (OHA) Diagnostic Guideline D23 – Urine Drug Testing
- 6.2. Health Evidence Review Commission (HERC) Coverage Guidance
- 6.3. Oregon Health Plan (OHP) CCO Requirements

7. RESPONSIBILITIES

- 7.1. **Director of Behavioral Health:** Will provide compliance & oversight and will oversee programs, financial, reporting and training matters, with the Compliance department's assistance in chart reviews and audits for the terms listed below.
 - 7.1.1. Advanced Health CCO will:
 - 7.1.1.1. Monitor utilization patterns
 - 7.1.1.2. Conduct audits for:
 - 7.1.1.2.1. Medical necessity
 - 7.1.1.2.2. Appropriate use of definitive testing
 - 7.1.2. Ensure compliance with:
 - 7.1.2.1. OHA guidelines
 - 7.1.2.2. CCO contract requirements
 - 7.1.2.3. Mental health parity laws
 - 7.1.3. Prior Authorization Enforcement:
 - 7.1.3.1. Prior authorization is required for all testing exceeding frequency limits
 - 7.1.4. Claims submitted without authorization may be:
 - 7.1.4.1. Denied
 - 7.1.4.2. Subject to retrospective review
 - 7.1.4.3. Flagged for audit
 - 7.1.5. Monitoring Activities Include:
 - 7.1.5.1. Tracking high-frequency testing
 - 7.1.5.2. Monitoring prior authorization requests and approvals
 - 7.1.5.3. Identifying outliers for corrective action

8. RELATED DOCUMENTS

- 8.1. *(Examples of internal documents: manuals, handbooks, process, instructions, related policies and procedures, etc.)*

9. ATTACHMENTS

- 9.1. *(Examples: forms, etc.)*

10. HEALTH EQUITY IMPACT ASSESSMENT TOOL

(If question does not apply, answer "Does Not Apply")

10.1. Does the policy advance equity and what are the intended outcomes? How? If not, does it have the potential to ignore or worsen existing disparities or produce other unintended	This policy is built upon inclusive, trauma informed and supportive treatment, care and communication for the best potential outcomes to be achieved.
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consequences, should this policy be enacted? If so, what mitigation should be planned?	
10.2. Was there equitable involvement in the drafting or revision process? How have you included those impacted in the process? Who else should be involved? Who is the focus and who may be being left out?	A BH team member sits on the Health Policy Equity team and are organizational SME's our policy has been reviewed for the inclusivity of all individuals and organizations included in this policy.
10.3. What are the potential equity-related disparate impacts of this policy, practice, or decision? How might this policy have a disproportionate impact, negatively or positively, on those historically underrepresented or excluded? How does this policy, practice or decision perpetuate or help to dismantle historical or other barriers to equity?	This should not have any negative equitable consequences for any participant in our Medicaid plan. We will continue to monitor and make any necessary changes as they arise.
10.4. What accountability, infrastructure and resources are required to implement the policy with the goal of advancing health equity?	We utilize internal meetings and processes to assure that all departments of AH learn from and support each other through the implementation of this policy.
10.5. What is the plan to evaluate and monitor the policy, practice, or decision to ensure equity in the short- and long-term?	Again, immediate review if a systems issue arises to the attention of the BH leaders as well as yearly review for process changes and policy content.

11. APPROVALS	
11.1 – Document Owner	Name and Title: Kera Hood, Director of Behavioral Health Department: Behavioral Health
11.2 – Approving Manager	Name and Title: Samyukta Vendrathi, Chief Operating Officer Department: Administration Signature: <u>Samyukta Vendrathi</u> Samyukta Vendrathi (Oct 14, 2026 06:42:52 PDT)
11.3 – Collaborators	Name(s) and Title(s): Wendy Haack, DO, Chief Medical Officer Chris Wilson, Director of Health Information Systems and Claims
11.4 – Approvals	Policy Review Committee Date Approved: 10/12/2026 OHA Approval (if needed) Date Approved:
11.5 – Original Effective Date	Date: 9/30/2026
11.6 – Review Period	How often PnP is reviewed: Annually
11.7 – Review Date(s)	Date: 9/30/2026
11.8 – Revision Date(s)	Date: 9/30/2026
11.9 – Add to Advanced Health Website	☒

BH-Substance Use Disorder Drug Testing Policy and Procedure 20260931

Final Audit Report

2026-10-14

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