Drug Testing in Pain Management and Substance Use Disorder Treatment

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Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Intravenous Anesthetics for the Treatment of Chronic Pain is addressed separately in medical policy 00463.

This policy does not address the use of drug testing in the following circumstances:

A. State, Federally regulated and legally mandated drug testing (i.e., court ordered drug screening, forensic examinations).
B. Non-forensic testing for commercial driver's licensing or any other job-related testing (i.e., as a prerequisite for employment or as a means for continuation of employment).
C. As a component of routine physical/medical examination.
D. As a component of care rendered in an urgent/emergency situation.
E. As a routine component of a behavioral health assessment

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Presumptive drug screening using urine samples
Based on review of available data, the Company may consider presumptive drug screening using urine samples (qualitative, semi-quantitative or quantitative) in outpatient drug testing to be **eligible for coverage.****

Patient Selection Criteria
Coverage eligibility will be considered for presumptive drug screening using urine samples (qualitative, semi-quantitative or quantitative) in outpatient drug testing in **ANY** of the following situations:

- To assess an individual being treated for chronic, non-cancer pain or substance abuse or dependence when clinical evaluation of the individual (history/signs/symptoms) suggests the use of non-prescribed medications or illegal substances at the following frequency:
    - Prior to initiating chronic opioid pain therapy in chronic non-cancer pain to determine if the individual has been exposed to controlled substances or potentially confounding illicit drugs; **OR**
    - To verify an individual's compliance with treatment or identify undisclosed drug abuse as part of routine monitoring for individuals who are receiving treatment for non-cancer chronic pain with prescription opioid pain medication. The random testing interval and drugs selected for testing should be based on the individual's history, condition and treatment, as documented in the medical record:
        - Monitoring of low risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to one (1) time per year after initiation of therapy; **OR**
        - Monitoring of moderate risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to two (2) times per year after initiation of therapy; **OR**
        - Monitoring of high risk (as defined by a risk assessment tool) individuals on chronic opioid therapy, up to four (4) times per year after initiation of therapy; **OR**
        - For individuals with aberrant behavior (lost prescriptions, multiple requests for early refills, and opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.) testing at the time of visit meets coverage criteria;

OR

- In pregnant individuals at high-risk for substance abuse in whom suspicion of drug use exists as a result of the answers to substance abuse screening questions or indicated by information from the prescription drug monitoring program (PDMP), as documented in the medical record; **OR**
- In newborns when there is a history of maternal substance abuse or agitated/altered mental status in the birthing parent; **OR**

- In candidates for organ transplant who have a history of substance abuse to demonstrate abstinence prior to transplant; **OR**
- In individuals with a suspicion of or a diagnosis of mental illness, including but not limited to the following:
    - Anxiety disorders; **OR**
    - Schizophrenia; **OR**
    - Major depressive disorder; **OR**
    - Mood disorders; **OR**
    - Suicidal ideations; **OR**
    - Substance abuse disorder;

OR

- In individuals with attention-deficit hyperactivity and disruptive behavior disorders; **OR**
- In cancer patients on opioid pain medication; **OR**
- In individuals with epilepsy; **OR**
- For the management and compliance monitoring of an individual under treatment for substance abuse or dependence at the following frequency after baseline at initial evaluation and must be documented in the patient's medical record:
    - For patients with 0 to 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 2 per week; **OR**
    - For patients with > 90 consecutive days of abstinence, qualitative drug testing at a frequency of 1 to 3 in one month;

OR

- In individuals where substance abuse is in the differential diagnosis of the presenting conditions.

Definitive Drug Testing
Based on review of available data, the Company may consider confirmatory/definitive qualitative or quantitative drug testing of up to seven drug classes when laboratory-based definitive drug testing is specifically requested, and the rationale is documented by treating physician to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility will be considered for confirmatory/definitive qualitative or quantitative drug testing of up to seven drug classes when laboratory-based definitive drug testing is specifically requested, and the rationale is documented by treating physician in **ANY** of the following situations:

- The result of the presumptive drug screen is different than that suggested by the patient's medical history, clinical presentation or patient's own statement. For example:
  - The test was negative for prescribed medications; **OR**
  - Positive for a prescription drug with abuse potential which was not prescribed; **OR**
  - Positive for an illegal drug;

OR

- For diagnosing and monitoring individuals with substance use disorder or dependence, when accurate and reliable results are necessary for treatment decisions:
  - For patients with 0 to 30 consecutive days of abstinence, random definitive drug testing at a frequency of not to exceed 1 per week; **OR**
  - For patients with 31 to 90 consecutive days of abstinence, random definitive drug testing at a frequency of 1 to 3 per month. No more than 3 definitive drug tests in one month will be allowed; **OR**
  - For patients with > 90 consecutive days of abstinence, definitive drug testing at a frequency of 1 to 3 every three months meets coverage criteria. No more than 3 definitive drug tests in a 3-month period will be allowed;

OR

- For monitoring of individuals on opioid therapy, to ensure adherence to the therapeutic plan, for treatment planning, and for detection of other, non-prescribed opioids; **OR**
- A presumptive test does not exist or does not adequately detect the specific drug or metabolite to be tested (for example, specific drugs within the amphetamine, barbiturate, benzodiazepine, tricyclic antidepressants, and opiate/opioid drug classes as well as synthetic/analog or "designer" drugs); **OR**
- To definitively identify specific drugs in a large family of drugs; **OR**
- To identify drugs when a definitive concentration of a drug is needed to guide management.

When Services Are Considered Not Medically Necessary

The use of confirmatory/definitive qualitative or quantitative or presumptive (qualitative, semiquantitative or quantitative) drug testing using proprietary tests such as CareView360 **does not meet coverage criteria** and is considered to be **not medically necessary****.

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for drug testing. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

The use of drug testing in outpatient pain management and outpatient substance use disorder treatment is considered to be **investigational*** when the above criteria are not met, including but not limited to routine presumptive or definitive drug testing (e.g., testing at every visit, without consideration for specific patient risk factors or without consideration for whether definitive testing is required for clinical decision making) and validity testing when used as a separate evaluation (e.g. pH, specific gravity, nitrates, chromates, and creatinine).

Policy Guidelines

Notes:

This policy does not apply to testing required by third parties such as but not limited to: testing for a medico-legal purpose such as child custody; testing for pre-employment or random testing for employment; or testing for athletics.

Validity testing includes pH, specific gravity, nitrates, chromates, and creatinine, which are performed on the same specimen that is being drug tested. Validity testing is an internal process to affirm that the reported results are accurate and valid.

Pain Management
The risk level for an individual patient should include both a global assessment of risk factors and monitoring for the presence of aberrant behavior. Standardized risk-assessment tools are available, such as the 5-item Opioid Risk Tool (ORT). Another screening instrument is the Screener and Opioid Assessment for Patients in Pain, a 24-item tool.

Aberrant behavior is defined by 1 or more of the following:

- multiple lost prescriptions,
- multiple requests for early refill,
- obtained opioids from multiple providers,
- unauthorized dose escalation, and
- apparent intoxication during previous visits.

Note that the ORT is a copyrighted instrument. The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain does not include specific screening frequencies but states that an individual patient's risk for opioid misuse and addiction should be considered when deciding when to order a urine drug screen.

Substance Use Disorder
The 2017 consensus statement from the American Society of Addiction Medicine provides guidance on appropriate use of drug testing in substance use disorder.

Medical records should support the need for testing for the specific substance(s) of interest by documentation regarding the diagnosis, history and physical examination, and/or behavior of the patient. Medical records should also justify the test that is being used and describe how results of testing will guide medical decision-making.

Presumptive Testing

Selecting an Appropriate Test
A medical and psychosocial assessment should guide the process of choosing a drug test that is individualized based on the patient's needs, appropriate for the substance(s) targeted, and the particular window of time of suspected use.

If a panel that includes testing for several substances is being ordered, justification for the use of a panel instead of individual testing is needed.

Selecting an Appropriate Matrix
Urine, blood, exhaled breath, oral fluid, sweat, and hair are matrices used in drug testing. Urine is the preferred matrix but all matrices have advantages and disadvantages with respect to sensitivity and specificity over different time windows, time to obtain results, different susceptibility to sample tampering, and ease of collection.

Matrices other than urine may also be appropriate when urine cannot be collected (eg, patients on dialysis or with shy bladder) or when a sample collection technique is too invasive. Justification of matrix other than urine should be included in the medical record.

Selecting an Appropriate Frequency of Testing
Plans may wish to set a threshold for the number of tests that are approved without review with subsequent tests requiring medical review. Patients who have unusually high numbers of tests ordered need medical review to confirm that the tests meet medical necessity.

Appropriate frequency of testing depends on many factors:

- Tests' detection capabilities and windows of detection
- Patient factors such as severity and chronicity of addiction
- Substance(s) used
- Phase of treatment
    - During the stabilization phase, drug testing may be scheduled more frequently
    - During the maintenance phase, drug testing may be scheduled less frequently

Presumptive Test Availability
There may not be commercially available tests for certain synthetic or semisynthetic opioids. Table PG1 describes limitations on availability of presumptive tests.

Table PG1. Limitations in Availability of Presumptive Immunoassays

Drug Type	Potential limitations in availability of or sensitivity of presumptive immunoassays for certain drugs in urine
Benzodiazepines	• Clonazepam and lorazepam are detected with varying sensitivity by different assays. • Therapeutic doses of benzodiazepines are generally not detected.
Semisynthetic Opioids	• Oxycodone and oxymorphone (a metabolite of oxycodone) are detected in a few but not most standard opiate immunoassays depending on the antibodies used by the manufacturer. • Hydrocodone and hydromorphone (a metabolite of hydrocodone) are also detected in most standard opiate immunoassays.
Synthetic opiates	• Meperidine, methadone, buprenorphine, and fentanyl will not be detected in a standard opiate immunoassay and require their own definitive test for detection.
Natural opioids	• Morphine and codeine (which is metabolized to morphine) are detected by standard immunoassays for opiates but presumptive testing does not distinguish specific drug present. • Heroin is unable to be specifically detected by presumptive tests due to rapid metabolism to 6-MAM and subsequently to morphine.

Sources: Based on information included in ASAM 2017 guideline and Washington State interagency guideline (Washington State Agency Medical Directors' Group, 2015)

Guidance on Definitive (Confirmatory) Testing

Specific situations for definitive drug testing may include, but are not limited to the following:

- Need to detect a specific substance not adequately identified by presumptive methods (see Presumptive Test Availability, above)

- Unexpected positive test inadequately explained by the patient (e.g., a positive result on a presumptive test is inconsistent with the history and physical exam)
- Unexpected negative test (suspected medication diversion)
- Need for quantitative levels to compare with established benchmarks for clinical decision making such as treatment transition or changes in medication therapies.

Table PG2, on interpreting unexpected results of urine drug tests, is adapted from a table developed by the Canadian National Opioid Use Guideline Group that was cited by the American Society of Interventional Pain Physicians in its guideline on prescribing opioids for chronic non-cancer pain.

Table PG2. Interpreting Unexpected Urine Drug Tests Results

Unexpected Result	Possible Explanations	Possible Actions for the Physician
Test is negative for prescribed opioid	• False-negative • Noncompliance • Diversion	• Conduct confirmatory testing, specifying the drug of interest (eg, oxycodone often missed by immunoassay) • Take a detailed history of individual's medication use for the preceding 7 days (eg, could learn that individual ran out several days before test) • Ask patients if they've given the drug to others • Monitor compliance with pill counts
Test is positive for nonprescribed opioid or benzodiazepines	• False-positive • Individual acquired opioids from other sources (double-doctoring, "street")	• Repeat urine drug testing regularly • Ask patients if they accessed opioids from other sources • Assess for opioid misuse/addiction • Review/revise treatment agreement
UDS positive for illicit drugs (eg, cocaine, cannabis)	• False-positive • Individual is occasional user or	• Repeat urine drug test regularly • Assess for abuse/addiction and refer for addiction treatment as appropriate

Unexpected Result	Possible Explanations	Possible Actions for the Physician
	addicted to the illicit drug • Cannabis is positive for individuals taking certain medications (eg, dronabinol)	

UDS: urine drug screen.

Background/Overview

Pain Management

According to a 2012 evidence assessment by the American Society of Interventional Pain Physicians, approximately one-third of chronic pain patients do not use opioids as prescribed or may abuse them. In 2016, the International Narcotics Control Board (INCB) reported that between 1999 and 2010, the number of deaths related to the use of prescription opioid painkillers increased 5-fold among U.S. women and increased by a factor of 3.6 among U.S. men. As far as age groups, the INCB reported the rates of drug overdose deaths increased over the period from 1999 to 2017 for all age groups, however in 2017, rates were significantly higher for those 25 to 64 years of age (31.4 per 100,000) than for those age 65 and over (6.9 per 100,000). In the United States, drug overdose deaths increased approximately 15% from 2020 to 2021. Additionally, studies have found that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and the use of illicit drugs.

Substance Use Disorder

Substance use, abuse, and addiction involving numerous prescription and illicit drugs is also a serious social and medical problem. Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry and is manifested by the individual pathologic pursuit of reward and/or relief by substance use and other behaviors.

Monitoring Strategies

Various strategies are available to monitor pain management and substance use disorder treatment patients, and multicomponent interventions are often used. Many settings require patients to sign a

contract before they are given a prescription for opioids. The contracts generally involve obtaining patients' agreement on behaviors they will engage in during the treatment period (eg, taking medication as prescribed) and not engage in (eg, selling prescribed medication and/or obtaining additional prescriptions from other physicians).

Confirming whether patients follow these behavioral guidelines can be a challenge. Risk-assessment screening instruments, such as the Screener and Opioid Assessment for Patients with Pain, and the Opioid Risk Tool, can aid in the assessment of patients' risk for inappropriate drug use. In addition, the presence of "aberrant behaviors" can be used as a marker for patients who are at high-risk for deviating from treatment protocols. Aberrant behaviors include multiple lost prescriptions, obtaining prescriptions from other practitioners, and displaying evidence of acute intoxication during office visits.

Testing Matrices
Another strategy for monitoring patients is testing of biologic specimens for the presence or absence of drugs. Currently, urine is the most commonly used biologic substance. Advantages of urine drug testing (UDT) are that it is readily available and standardized techniques for detecting drugs in urine exist. Other biologic specimens (eg, blood, oral fluids, hair, sweat) can also be tested. All matrices have advantages and disadvantages with respect to sensitivity and specificity over different time windows, time to obtain results, different susceptibility to sample tampering, and ease of collection.

Urine Drug Testing
There are 2 primary categories of UDT: presumptive testing (immunoassay) and confirmatory testing (specific drug identification).

Presumptive (Immunoassay) Testing
Immunoassay testing (also called presumptive testing or qualitative testing or screening) can be performed in a laboratory or at point-of-service. Immunoassay tests are based on the principle of competitive binding and use antibodies to detect a particular drug or drug metabolite in a urine sample. With competitive binding, a fixed amount of a labeled drug is added to the urine sample, and the drug or metabolite in the sample competes with the labeled drug for binding sites on the antibody. The amount of labeled antigen that binds with the antibody is inversely proportional to the amount of the drug or metabolite in the sample.

Immunoassay tests vary in the type of compounds they can detect. Some detect specific drugs and may fail to recognize similarly structured drugs within the same class. Other immunoassays identify only classes of drugs and thus results cannot be used to determine which drug a patient is taking. For example, a positive result of an opiate immunoassay can be due to morphine or hydromorphone. The degree of cross-reactivity (i.e. an antibody's reactivity with a compound other than the target of the test) varies widely among immunoassays.

Immunoassay findings are generally reported qualitatively as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). Raising or lowering the threshold thus changes the proportion of positive tests. A negative test is interpreted as a level below the threshold and does not necessarily mean that the drug or metabolite is absent.

Immunoassays generally have a rapid turnaround time, to within minutes for on-site tests, and 1 to 4 hours for laboratory-based tests.

Confirmatory (Specific Drug Identification)
Confirmatory tests are always performed in a laboratory. Gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/mass spectrometry (LC/MS) are considered to be the criterion standard for confirmatory testing. These techniques involve using GC or LC to separate the analytes in a specimen and for MS to identify the specific molecular structures of the drug and its metabolites. The tests are able to quantify the amount of drug or metabolite present in the urine sample. Definitive quantitative tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS and LC/MS generally require the specification of the drug or drugs to be identified. Alternatively, "broad-spectrum screens" can be conducted. There is a several-day turnaround time for GC/MS and LC/MS testing.

An issue with both types of UDT is the possibility of sample tampering to mask the presence of illegal drugs. A variety of products and techniques are available to patients and can be as simple as drinking a large amount of water to dilute the sample. There are also commercial dilution and cleaning products, additives, and urine substitutes. Some of these techniques can be detected by visual inspection of the sample (eg, color) or by on-site testing of sample characteristics including urine temperature, creatinine concentration, and specific gravity.

The correct interpretation of UDT results is very important. Knowledge of drug metabolites is essential for accurate interpretation. Accurate interpretation of test results also requires knowledge of the drug manufacturing process. For example, due to manufacturing impurities, a small amount of hydrocodone may be present in urine samples from patients prescribed oxycodone. Thus, it would be acceptable to detect a small amount of hydrocodone if high amounts of oxycodone were also present.

There are various approaches to incorporating UDT into pain management and substance use disorder treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use. Some clinicians believe that UDT should be routinely used to establish baseline information about substance use, but the optimal frequency and interval of testing remains uncertain. A universal approach to screening may uncover more inappropriate use and may reduce patients' sense that testing is being performed due to a lack of trust. However, routine universal screening may place an unnecessary burden on the health care system and on the doctor-patient relationship. An alternative approach is selective testing of patients who are judged to be at increased risk for drug misuse.

Existing protocols vary for the use of presumptive versus definitive tests. Some involve conducting routine confirmation of positive presumptive tests with definitive quantitative testing. Others use selective confirmation of positive presumptive tests, such as when an unexpected immunoassay result is not adequately explained by the patient. There is also a mixed approach, with routine confirmation of presumptive tests only for drugs with poor-performing immunoassays.

Full informed consent is a requirement before UDT. Patients should be informed of the specific drug testing protocol before treatment and should provide written agreement with the plan for monitoring. As stated in a joint U.S. Veterans Affairs/Department of Defense guideline, patients' refusal to consent to urine testing should be considered a factor in the overall assessment of patients' ability to adhere to treatment.

Oral Fluid Drug Testing

Oral fluid (liquid samples obtained from the oral cavity) can potentially be used to test for drug use. Oral fluid contains secretions from several different sources, including secretions from the 3 pairs of major salivary glands (parotid, sublingual, and submandibular), secretions from the minor salivary glands, oro-nasopharyngeal secretions, and cellular debris. The mixture of fluids obtained varies

depending on the collection method used (eg, spitting, suctioning, draining, or collection on some type of absorbent material). Drug concentrations can be affected by the collection method and by the use of saliva stimulation methods. Several collection devices are commercially available in the U.S., and they generally involve collection on an absorbent material, such as foam pads; pads are then placed in a container with a stabilizing buffer solution. Drug concentrations may also depend on how the oral fluid is recovered from the collection device (eg, by centrifugation or by applying pressure). Drug concentrations may not reflect blood levels because of residual amounts of a drug (specifically those ingested or smoked) remaining in the oral cavity after recent use.

Analysis techniques must be able to detect drugs present in low concentration and in a small volume of fluid (often <1 mL). Immunoassay techniques are available to detect drugs in oral fluid; they require a small sample volume (»25 µL). Immunoassays tend to be relatively sensitive techniques, but they have low specificity. Confirmation analysis is generally performed using MS-based methods. In recent years, advancements have been made in MS analysis techniques, including the development of multianalyte LC/MS methods.

A practical advantage of oral fluid collection compared with urine collection is that samples can be obtained under direct supervision and without loss of privacy. It has been used in situations where urine sampling is impractical, such as testing drivers during traffic stops. Oral fluid sampling also has the potential to be useful in pain management or substance use disorder treatment settings, particularly when substitution or tampering with urine drug samples is suspected.

Hair Testing

Hair is composed of protein that traps chemicals in the blood at the time the hair develops in the follicle. Hair on the human head grows at approximately 0.5 inches per month. Thus, a 1.5-inch hair sample could be used to detect drug use during the previous 90 days. Potential advantages of hair as a drug testing source include noninvasive collection; ease of collection, storage, and shipping; availability of samples for testing and retesting; and difficulty in tampering. Potential disadvantages include: recent drug use (ie, within the past 7 days) cannot be detected; difficulty in detecting very light drug use (eg, a single episode); and drug levels can be affected by environmental exposure. In addition, variation in hair texture as well as cosmetic hair treatments can affect drug incorporation into hair and the accuracy of drug tests on hair samples. As with other types of samples, hair can be initially tested using immunoassay techniques, with confirmation by MS-based methods. Hair testing has been used in a variety of situations where detection of drug use during the previous

several months is desired (eg, pre-employment screening, post-drug-treatment verification of relapse).

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

The U.S. Food and Drug Administration (FDA) regulates drugs of abuse tests that are sold to consumers or health care professionals in the U.S. The FDA reviews many of these tests before they are sold for use. In its review, the FDA evaluates the design and performance of tests and sample collection systems to help ensure that they produce accurate results. The FDA does not review drugs of abuse tests intended for employment and insurance testing provided they include a statement in their labeling that the device is intended solely for use in employment and insurance testing. The FDA review does not include test systems intended for federal drug testing programs (eg, programs run by the Substance Abuse and Mental Health Services Administration, the Department of Transportation, and the U.S. military.)

The FDA has cleared assays for urine testing of drugs of abuse as well as oral fluid specimen collection devices and assays for analysis of oral fluid for drugs of abuse through the 510(k) regulatory pathways. Several collection devices are commercially available in the U.S., and they generally involve collection on an absorbent material, such as foam pads; pads are then placed in a container with a stabilizing buffer solution. Immunoassays of urine specimens have previously been cleared by the FDA and are used as the predicates for the oral fluid immunoassays.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). Testing with GC/MS and some immunoassays are performed in laboratory settings. Laboratories that offer laboratory-developed tests must be licensed by the CLIA for high-complexity testing.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical

practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Description
Patients in pain management programs and substance use disorder treatment may misuse prescribed opioids and/or may use nonprescribed drugs. Thus, these patients are often assessed before treatment and monitored while receiving treatment. Drug testing can be part of this monitoring strategy; it is most often used as part of a multifaceted intervention that includes other components, such as patient contracts.

Summary of Evidence
For individuals who have chronic pain treated with opioids who receive drug testing, there is limited peer-reviewed scientific literature to guide drug testing strategies; however, guidelines indicate that drug testing is standard of care. Guidelines from the Centers for Disease Control and Prevention, American Society of Interventional Pain Physicians, American Pain Society and American Academy of Pain Medicine, American College of Occupational and Environmental Medicine, Department of Veterans Affairs, and Department of Defense have recommended drug testing and consider the frequency of testing to be at the discretion of the health care provider, based on an assessment of the patient's risk for misuse or addiction.

For individuals who have a drug addiction who are in substance use disorder treatment who receive drug testing, there is limited peer-reviewed scientific literature to guide drug testing strategies; however, guidelines indicate that drug testing is standard of care. Guidelines from the American Society of Addiction Medicine have recommended drug testing and consider the frequency of testing to be at the discretion of the health care provider, based on an assessment of the patient's risk and substance(s) used.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 5 physician specialty societies and 8 academic medical centers while this policy was under review in 2014. There was near-consensus among reviewers that, in outpatient pain management, presumptive (i.e. qualitative) urine drug testing may be considered medically necessary for patients who meet the stated criteria and that the frequency of repeat drug testing should depend on the risk level of the individual. There was also near-consensus among reviewers that, in substance abuse treatment, baseline presumptive drug testing may be considered medically necessary for patients who meet the stated criteria and that targeted weekly qualitative screening for a maximum of 4 weeks may be considered medically necessary during the stabilization phase. There was mixed input on the frequency of presumptive drug testing that may be considered medically necessary during the maintenance phase of substance abuse treatment. In addition, clinical input was mixed on confirmatory definitive (i.e. quantitative) drug testing and particularly on whether definitive drug testing should only be performed on a drug-specific basis.

Practice Guidelines and Position Statements
Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Pain Management
Nuckols et al (2014) published a systematic review of guidelines that addressed the management of opioid use for chronic pain. Reviewers included guidelines from national organizations and specialty societies, as well as guidelines from state agencies and specific health systems. Moreover, reviewers identified 9 guidelines with recommendations on urine drug testing (UDT). Recommendations varied widely; 2 recommended mandatory testing for all patients, another recommended testing only patients at increased risk of a medication use disorder, and 2 stated that testing patients at low-risk of abuse is not cost-effective. If UDT is used, the recommended frequency of follow-up testing was at least quarterly in 1 guideline, at least yearly in another, and randomly in 2.

American Academy of Pain Medicine
In 2018, the American Academy of Pain Medicine (AAPM) published consensus recommendations on urine drug monitoring in patients receiving opioids for chronic pain. The AAPM recommended

definitive testing at baseline for patients prescribed opioids for chronic pain unless presumptive testing is required by institutional or payer policy. The AAPM also recommended that the choice of substances to be analyzed should be based on considerations that are specific to each patient and related to illicit drug availability. Baseline risk assessment for aberrant medication-taking behavior, misuse, and opioid use disorder should be conducted using patient history, validated risk assessment tools, prescription drug monitoring program data, previous urine drug monitoring results, and evaluation of behaviors indicative of risk. The recommended frequency of urine drug monitoring was based on risk assessment: at least annually for patients at low risk, 2 or more times per year for those at moderate risk, and 3 or more times per year for those at high risk.

American Society of Interventional Pain Physicians

In 2017, the American Society of Interventional Pain Physicians issued guidelines for responsible, safe, and effective opioid prescribing for chronic non-cancer pain. The guidelines included the following recommendations on UDT (see Table 1).

Table 1. Recommendations on Urine Drug Testing for Chronic Non-Cancer Pain

Recommendation	LOE	SOE
"Comprehensive assessment and documentation is recommended before initiating opioid therapy, with documentation of comprehensive history, general medical condition, psychosocial history, psychiatric status, and substance use history."	I	Strong
"Screening for opioid abuse is recommended, as it will potentially identify opioid abusers and reduce opioid abuse."	II-III	Moderate
"Presumptive UDT is implemented at initiation of opioid therapy, along with subsequent use as adherence monitoring, using in-office point of service testing, followed by confirmation with chromatography/mass spectrometry for accuracy in select cases, to identify patients who are not compliant or abusing prescription drugs or illicit drugs. UDT may decrease prescription drug abuse or illicit drug use when patients are in chronic pain management therapy."	III	Moderate

LOE: level of evidence; SOE: strength of evidence; UDT: urine drug testing.

Centers for Disease Control and Prevention
In 2016, the Centers for Disease Control and Prevention published guidelines on opioids for chronic pain. These guidelines were updated and expanded to include management of pain of a shorter duration, and to clarify that they are not applicable to sickle cell disease- or cancer-related pain or patients receiving palliative or end-of-life care, in 2022. The updated guidelines recommend the following regarding drug testing: "When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances." The authors note that such testing should not be used punitively, including as a basis for dismissing patients from care, and that clinicians should consider the benefits and risks of toxicology testing prior to initiation and at least annually during opioid therapy. The guideline authors further note that restricting definitive confirmatory testing to situations and substances for which results are expected to affect management (eg, results will influence decisions with major clinical or non-clinical implications, there is a need to detect specific agents or agents that cannot be identified in standard immunoassays, or to confirm unexpected screening test results) can reduce costs.

Department of Veterans Affairs and Department of Defense
In 2022, the Department of Veterans Affairs and Department of Defense updated clinical practice guidelines for managing opioid therapy for the treatment of chronic pain. The recommendations on risk mitigation to prescribed opioids include obtaining a UDT (with patient consent) before initiating opioid therapy, and then randomly at a follow-up to confirm appropriate use. Other strategies recommended include clinical assessment such as random pill counts and use of prescription drug monitoring programs.

The guidelines included the following specific recommendations on UDT as part of risk mitigation:

"We recommend implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include:

- Ongoing, random urine drug testing (including appropriate confirmatory testing)
- Checking state prescription drug monitoring programs
- Monitoring for overdose potential and suicidality
- Providing overdose education

- Prescribing of naloxone rescue and accompanying education"

The guideline states that gaining consent is required prior to a UDT; if a patient declines consent, "providers should factor that declination into their consideration about whether it is safe to continue opioids. Urine drug testing is required if long-term opioids are to be initiated or continued."

Washington State Agency Medical Directors' Group
In 2015, the Washington State Agency Medical Directors' Group updated its interagency guidelines on opioid dosing for chronic non-cancer pain. The guidelines included recommendations on UDT. Recommendations on testing frequency differed depending on the patient risk of opioid addiction and opioid dosage, as listed below:

- Low risk: Once per year
- Moderate risk: Twice per year
- High risk or opioid dose over 120 mg MED/d: 3-4 times per year
- Aberrant behavior: Each visit.

In 2020, Washington State Agency Medical Directors' Group released a guideline on long-term opioid therapy prescribing. Use of UDT was mentioned as an element of assessment of patients on long-term opioid therapy. No pain management guidelines were identified that had recommendations on oral fluid or hair testing.

Substance Use Disorder Treatment

American Society of Addiction Medicine
The American Society of Addiction Medicine (ASAM) has published several documents on drug testing: a public policy statement (2010), a white paper (2013) which provided background on the science and current practices of drug testing, and guidelines (2017) on the effective use of drug testing.

The ASAM's public policy statement asserts that: "Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care, and should not face undue restrictions." The ASAM recommended drug testing where medically appropriate in clinical

diagnostic settings and clinical treatment settings. The term "drug testing" in this document was a broad term that included urine or other body fluids or tissues.

The ASAM White Paper concluded that "The most important challenge in drug testing today is not the identification of every drug that we are technologically capable of detecting, but to do medically necessary and accurate testing for those drugs that are most likely to impact clinical outcomes." The paper acknowledged that more specific guidance on drug testing was needed, which led to the development of the 2017 guidelines, described below.

The ASAM (2017) guidance on appropriate drug testing in clinical addiction medicine advises health care providers that before choosing the type of drug test, they should first identify the questions they are seeking to answer and be aware of the benefits and limitations of the various drug tests. Table 2 summarizes the characteristics of urine, oral fluid, and hair drug tests that may inform the decision of what type of drug test to use.

The ASAM also published a focused update in 2020 focusing on the treatment of opioid use disorder. The guideline states that "urine drug testing is a reasonably practical and reliable method to test for adherence to medication and illicit drug use. However, other reliable biological tests for the presence of drugs may be used. The frequency of drug testing should be determined by a number of factors, including the stability of the patient, the type of treatment, and the treatment setting. Drug testing is required a minimum of eight times per year for patients in OTP [opioid treatment programs]".

Table 2. Summary of Drug Testing Characteristics

Characteristics	**Urine**	**Oral Fluid**	**Hair**
General detection period	Hours to days	Minutes to hours	Weeks to months
Point-of-care testing	Yes	Yes	No
Primarily detects	Drug metabolite	Parent drug compound	Parent drug compound
Best use in treatment setting	Intermediate-term detection in ongoing treatment	Short-term detection in ongoing treatment	Long-term monitoring, 3-month history

Ease of collection	Requires restroom	Easily collected	Easily collected
Resistance to tampering	Low	High, with some uncertainty	High when chemically untreated
Retesting same sample	Possible	Difficult	Easy

Adapted from Jarvis et al (2017).

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

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Policy History

Original Effective Date: 09/18/2013
Current Effective Date: 09/09/2024

09/05/2013	Medical Policy Committee review
09/18/2013	Medical Policy Implementation Committee approval. New policy.
10/02/2014	Medical Policy Committee review
10/15/2014	Medical Policy Implementation Committee approval. Changed a phrase in the Policy Guidelines to read that, "quantitative mass spectrometry testing that is subsequently performed is only covered for confirmation of unexpected screening results, or for positive results for a prescribed drug." Changed a phrase in the Policy Guidelines to read that, "extensive custom profile panels of quantitative testing will not be covered without initial immunoassay screening on the drug classes of interest and coverage will be limited to those drug classes need for confirmation as described above."
01/01/2015	Coding Update
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
10/08/2015	Medical Policy Committee review
10/21/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

01/01/2016	Coding update
10/06/2016	Medical Policy Committee review
10/19/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/06/2016	Medical Policy Committee review
10/19/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes and CPT coding update.
10/05/2017	Medical Policy Committee review
10/18/2017	Medical Policy Implementation Committee approval. Title changed from "Urinary Drug Testing" to "Drug Testing in Pain Management and Substance Abuse Treatment". Revised our entire policy to incorporate more updated guidelines for frequency and terminology.
04/01/2018	Coding update
10/04/2018	Medical Policy Committee review
10/17/2018	Medical Policy Implementation Committee approval. Title changed from "Drug Testing in Pain Management and Substance Abuse Treatment" to "Drug Testing in Pain Management and Substance Use Disorder Treatment". The term "abuse" replaced with "substance use" to align text with title change. Coverage eligibility unchanged.
05/29/2019	Coding update
06/17/2019	Coding update
10/03/2019	Medical Policy Committee review
10/09/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/01/2020	Medical Policy Committee review
10/07/2020	Medical Policy Implementation Committee approval. Added an Eligible For Coverage section for drug testing settings. Added the open criteria bullet "Drug testing is ordered by a clinician during an office visit" to the first two sets of Patient Selection Criteria. Removed "urine" to specify drug testing in the coverage section. Revised the stabilization and maintenance phase criteria bullets into one bullet for coverage of outpatient substance use disorder treatment, in-office or point-of-care (POC) presumptive (i.e., immunoassay) drug testing. Moved a *Note* from the coverage section to the Policy Guidelines regarding drug testing for complicated

	patients. Added a criteria bullet, "Need to detect a specific substance not adequately identified by presumptive methods" to the coverage for definitive (i.e., confirmatory) drug testing, in outpatient pain management or substance use disorder treatment. Added "and validity testing when used as a separate evaluation (e.g. pH, specific gravity, nitrates, chromates, and creatinine). Removed the When Services Are Investigational section. Policy Guidelines expanded to provide guidance regarding factors that determine appropriate testing modalities, intervals and matrices. The Policy Guidelines section has added examples for frequency of drug testing for the stabilization and maintenance phases of drug testing.
10/07/2021	Medical Policy Committee review
10/13/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/06/2022	Medical Policy Committee review
10/11/2022	Medical Policy Implementation Committee approval. Coverage criteria sections replaced to align with Avalon's policy T2015 – Prescription Medication and Illicit Drug Testing in the Outpatient Setting.
06/01/2023	Medical Policy Committee review
06/14/2023	Medical Policy Implementation Committee approval. The use of drug testing in outpatient pain management and outpatient substance use disorder treatment when the criteria are not met was changed from Not Medically Necessary to Investigational. Coverage eligibility unchanged.
08/03/2023	Medical Policy Committee review
08/09/2023	Medical Policy Implementation Committee approval. Replaced RiskViewRxPlus with CareView360 in the Not Medically Necessary statement. Coverage eligibility unchanged.
08/01/2024	Medical Policy Committee review
08/14/2024	Medical Policy Implementation Committee approval. Revisions to coverage criteria are primarily clarifying statements aligning with Avalon.

Next Scheduled Review Date: 08/2025

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.