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Drug Testing in Pain Management and Substance Use Disorder Treatment

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0965

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Last Review
12/04/2023
Effective: 01/24/2020
Next Review: 10/10/2024

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Definitions

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Policy

Scope of Policy

This Clinical Policy Bulletin addresses drug testing in pain management and substance use disorder treatment. **Note:** This CPB does not address therapeutic drug monitoring, drug testing in the emergency room, or monitoring of persons prescribed drugs with abuse potential that are prescribed outside of a pain management program or substance use disorder program (e.g., amphetamines for attention-deficit hyperactivity disorder, benzodiazepines for anxiety disorders, certain controlled drugs indicated for seizure disorders).

I. Medical Necessity

Aetna considers the following as medically necessary unless otherwise stated:

A. Presumptive urine drug testing is considered medically necessary for the following indications for persons in chronic pain programs or substance use disorder program:

1. Persons who are initiating treatment in a pain management or substance use disorder program; *or*
2. Persons whose clinical evaluation suggests use of illegal substances or non-prescribed medications with abuse potential; *or*
3. Suspected drug overdose in persons with unexplained coma or altered mental status, severe or unexplained cardiovascular stability, unexplained metabolic or respiratory acidosis, or seizures of undetermined etiology; *or*
4. Monitoring of persons on chronic opioid therapy who are receiving treatment for chronic pain with prescription opioid or other potentially abused medications; *or*
5. Persons on chronic opioid therapy or other potentially abused medications who have a history of substance abuse, exhibit aberrant behavior (e.g., multiple lost prescriptions, multiple requests for early refill, obtained opioids from multiple providers, unauthorized dose escalation, and apparent intoxication), or who are otherwise at high risk for medication abuse (see appendix for validated standardized risk assessment tools); *or*
6. Persons in a pain management or substance abuse program when medical records document testing as part of an active treatment plan;

To be considered medically necessary, drug testing should be individualized to test for substances only specific to the individual member's plan of treatment. Clinical documentation must specify how the test results will be used to guide clinical

decision making. The medically necessary frequency of drug testing for any indication should be individualized to the treatment plan.

B. Definitive or confirmatory urine drug testing is considered medically necessary for persons who meet medical necessity criteria for presumptive urine drug testing, and have *any* of the following medically necessary indications for definitive testing:

1. A presumptive test for the specific drug is not commercially available; *or*
2. A presumptive test was negative for prescribed medications with abuse potential and the provider was expecting the test to be positive for the prescribed medication, and the member disputes the drug testing results; *or*
3. A presumptive test was positive for a prescription drug with abuse potential that was not prescribed to the member and the member disputes the drug testing results; *or*
4. A presumptive test was inconclusive or inconsistent; *or*
5. A presumptive test was positive for an illegal drug and the member disputes the presumptive drug testing results;

C. The following drug tests are considered not medically necessary:

1. Standing or blanket orders of drug tests (i.e., routine orders that are not individualized to the member's history and clinical presentation); *or*
2. Simultaneous performance of presumptive and definitive tests for the same drugs or metabolites at the same time (Definitive testing should be guided by the results of presumptive testing); *or*
3. Same-day testing of the same drug or metabolites from two different specimen types (e.g., both a blood and a urine specimen); *or*
4. Broad panels of drug tests (see Appendix) (to be considered medically necessary, the specific drugs being tested should be supported by the person's clinical presentation (e.g., drug abuse history, symptoms, physical findings). An

exception may be in an emergency setting for persons in a coma or with altered mental status where a reliable history is not available); *or*

5. Immunoassay (IA) testing to definitively identify or "confirm" a presumptive drug test result (e.g., performance by a clinician of a qualitative point-of-care test and ordering a presumptive test from a reference laboratory for the same drug). Definitive urine drug testing provides specific identification and/or quantification typically by gas chromatography-mass spectrometry (GC-MS) or liquid chromatography - tandem mass spectrometry (LC-MS/MS); *or*
6. Reflex definitive testing of point-of-care presumptive urine drug tests (see Appendix); *or*
7. Performance of definitive tests of excessive frequency not justified by medical necessity (for example, routine weekly ordering of definitive testing to confirm buprenorphine/norbuprenorphine levels without change in member status);

D. Testing ordered by or on the behalf of third parties (e.g., courts, school, employment, sports and recreation, community extracurricular activities, residential monitoring, marriage licensure, insurance eligibility) are considered not medically necessary treatment of disease;

E. Serum drug testing is considered medically necessary in emergency room settings or when urine testing is not feasible (e.g., persons in renal failure).

II. Policy Limitations and Exclusions

Note: Specimen verification is considered part of a laboratory's quality assurance process and is not separately reimbursed.

III. Related Policies

- CPB 0608 - Salivary Tests (../600_699/0608.html) for drug testing by oral fluid analysis

- CPB 0300 - Hair Analysis (../300_399/0300.html) for drug testing by hair analysis

CPT Codes / HCPCS Codes / ICD-10 Codes

CPT codes covered if selection criteria are met:

Code	Code Description
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service

Code	Code Description
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
80376	4-6
80377	7 or more
CPT codes not covered for indications listed in the CPB:	
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected
0143U - 0150U	Drug assay, definitive, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service

Code	Code Description
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation
0328U	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service
HCPCS codes covered if selection criteria are met:	
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

Code	Code Description
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase), performed in a single machine run without drug or class specific calibrations; qualitative or quantitative, all sources, includes specimen validity testing, per day
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
ICD-10 codes covered if selection criteria are met:	
F10.10 - F19.99	Substance use disorder, and drug abuse
G89.21 - G89.29	Chronic pain
T50.901A - T50.901S	Poisoning by unspecified drugs, medicaments and biological substances, accidental (unintentional)
T50.911A - T50.912S	Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances [suspected drug overdose]
Z79.891	Long term (current) use of opiate analgesic. Long term (current) use of methadone for pain management
Z86.59	Personal history of other mental and behavioral disorders [history of substance abuse]

Background

Urine Drug Testing is an important tool in the care of patients with substance use disorder, chronic pain and other medical conditions. The challenge for clinicians who order these tests is making sure that the test they order for each individual patient is the right test, done in the right order and right frequency in a manner consistent with clinical practice guidelines.

A presumptive urine drug test uses an immunoassay to qualitatively identify the presence or absence of one or more drugs or drug classes (ASAM, 2017).

Definitive urine drug testing is a quantitative test that identifies a specific drug or metabolite by a specific test such as gas chromatography mass spectrometry (GC-MS) or liquid chromatography tandem mass spectrometry (LC-MS/MS). Definitive urine drug testing is typically used to confirm a presumptive urine drug test (ASAM, 2017).

A white paper by the American Society of Addiction Medicine (ASAM, 2017) stated that, in general, a presumptive immunoassay test result need only be subjected to definitive testing when the results conflict with patients' account of their drug use or when drug specificity is needed in class-specific assays (i.e. amphetamines, benzodiazepines, opiates). The ASAM also stated that random testing schedules are preferred to fixed testing schedules.

The ASAM appropriate use criteria for drug testing in clinical addiction medicine (Jarvis, et al., 2017) state that presumptive testing provides immediate, albeit less accurate, results and should be a routine part of patient assessment. The ASAM stated that urine testing is the best specimen type for presumptive testing, as well as for testing at the point of care. The ASAM states that definitive testing should be used where highly accurate results are needed, when necessary to quantify substance levels, and where necessary to detect specific substances not identified by presumptive methods. The ASAM stated that definitive testing should be used when the results will inform decisions that have major implications for the patient, such as changes in medications,

transitions in treatment, and where test results have legal implications. They also stated that definitive testing should be done when the patient disputes the results of a presumptive test.

The ASAM appropriate use criteria for drug testing in addiction (Jarvis, et al., 2017) stated that the frequency of testing should be dictated by patient acuity and level of care. Clinicians should consider the tests' detection capabilities, including the window of detection, in determining the appropriate frequency of testing. Drug testing should be scheduled more frequently at the beginning of treatment, and less frequently as recovery progresses. They state that drug testing should occur on a random schedule, and recommend testing at least weekly during the intial phase of substance abuse treatment. They recommend at least monthly random drug testing once a patient is stable, with consideration of less frequent testing for patients in stable recovery. The appropriate use criteria noted that, although increasing the frequency of drug testing increases the likelihood of detection, there is insufficient evidence that increasing the frequency of drug testing affects the substance abuse itself.

An ASAM public policy statement on the ethical use of drug testing in addiction medicine (ASAM, 2019) states that drug tests should be selected based on an individualized clinical assessment of the patient. The scope of the analyte panel and the frequency of testing should be justified by the patient’s clinical status and the ordering clinician’s need for information. They state that clinicians should document the rationale for the drug tests they order and the decisions they make based on the test results. They state that panels that test for multiple drugs may be useful for new patients in addiction treatment programs, but follow-up testing should be individualized to the patient's history, needs, initial test results, and drugs commonly used in the patient’s geographic location and peer group. They noted that it is not appropriate to use drug testing panels for every patient at every testing time regardless of the patient’s individual clinical history and needs. The public policy statement said that it is inappropriate to repeatedly order definitive testing for all analytes in every drug test, without regard to the results from previous tests or the patient’s overall response to addiction treatment interventions.

American Pain Society (APS) and American Academy of Pain and Medicine (AAPM) joint clinical practice guidelines on the use of opioid therapy in chronic noncancer pain (Chou, et al., 2009) state that most urine drug screening tests utilize immunoassays, but cross-reactivity between various drugs and chemicals can cause false positive results. The guidelines state that urine tests based on gas chromatography-mass spectrometry are considered the most specific for identifying individual drugs and metabolites and are often used to confirm positive immunoassay results.

The Centers for Disease Control and Prevention (CDC) guidelines on opioids for chronic pain (Dowell, et al., 2016) recommends: “When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs."

The Washington State Agency Medical Directors' Group published an Interagency Guideline on opioid dosing for chronic non-cancer pain (AMDG, 2010). This guideline recommends that low risk individuals have urine drug testing up to once per year, moderate risk up to 2 per year, high risk individuals up to 3-4 tests per year, and individuals exhibiting aberrant behaviors should be tested at the time of the office visit.

Prediction of Opioid Misuse in Individuals Receiving Opioid Therapy for Cancer Pain

Yennurajalingam et al (2018) noted that opioid misuse is a growing crisis; and patients with cancer who are at risk of aberrant drug behaviors (ADB) are frequently under-diagnosed. These researchers examined the frequency and factors predicting a risk for ADB among patients who received an outpatient supportive care consultation at a comprehensive cancer center. Furthermore, the screening performance of the Cut Down-Annoyed-Guilty-Eye Opener (CAGE) questionnaire adapted to include drug use (CAGE-AID) was compared with that of the 14-item Screener and Opioid Assessment for Patients with Pain (SOAPP-14) tool as instruments for identifying patients at risk for ADB. A total of 751 consecutive patients with cancer who were referred to a supportive care clinic were reviewed. Patients were eligible if they had diagnosis of

cancer and had received opioids for pain for at least 1 week. All patients were evaluated using the Edmonton Symptom Assessment Scale (ESAS), the SOAPP-14, and the CAGE-AID. SOAPP scores of 7 or higher (SOAPP-positive) were used to identify patients who were at risk of ADB. Among the 729 of 751 (97 %) evaluable consults, 143 (19.6 %) were SOAPP-positive, and 73 (10.5 %) were CAGE-AID-positive. Multi-variate analysis revealed that the odds ratio (OR) of a positive SOAPP score was 2.3 for patients who had positive CAGE-AID scores ($p < 0.0001$), 2.08 for men ($p = 0.0013$), 1.10 per point for ESAS pain ($p = 0.014$), 1.13 per point for ESAS-anxiety ($p = 0.0015$), and 1.09 per point for ESAS-financial distress ($p = 0.012$). A CAGE-AID cut-off score of 1 in 4 had 43.3 % sensitivity and 90.93 % specificity for screening patients with a high risk of ADB. The authors concluded that these findings indicated a high frequency of an elevated risk of ADB among patients with cancer. Men and patients who exhibited anxiety, financial distress, and a prior history of alcoholism/illicit drug use were at increased risk of ADB. These researchers stated that further investigation is needed to establish effective management for these patients.

The authors stated that one of the drawbacks of this trial was that these investigators were unable to evaluate opioid use following the supportive care clinic consultation or to obtain real data on non-medical opioid use, such as urine drug screening (UDS). These researchers stated that further studies are needed, because this information will be very valuable in understanding how much aberrant opioid use behaviors will influence treatment and response in real practice.

Arthur et al (2021) stated that there is limited information on the true frequency of non-medical opioid use (NMOU) among individuals receiving opioid therapy for cancer pain. Data to guide patient selection for urine drug testing (UDT) as well as the timing and frequency of ordering UDT are insufficient. In a retrospective study, these researchers examined the frequency of abnormal UDT among patients with cancer who underwent random UDT and their characteristics. Demographic and clinical information for patients with cancer who underwent random UDT were reviewed and compared with a historical cohort that underwent targeted UDT. Random UDT was ordered regardless of a patient's risk potential for NMOU. Targeted UDT was ordered on the basis of a physician's estimation of a patient's risk for NMOU. A total of 552 of 573 eligible

patients (96 %) underwent random UDT. Among these patients, 130 (24 %) had 1 or more abnormal results; 38 of the 88 patients (43 %) who underwent targeted UDT had 1 or more abnormal results. When marijuana was excluded, 15 % of the random group and 37 % of the targeted group had abnormal UDT findings ($p < 0.001$). It took a shorter time from the initial consultation to detect 1 or more abnormalities with the random test than the targeted test (median, 130 versus 274 days; $p = 0.02$). Abnormal random UDT was independently associated with younger age ($p < 0.0001$), male sex ($p = 0.03$), CAGE-AID positivity ($p = 0.001$), and higher ESAS-anxiety ($p = 0.01$). The authors concluded that approximately 25 % of patients receiving opioids for cancer pain at a supportive care clinic who underwent random UDT had 1 or more abnormalities. Random UDT detected abnormalities earlier than the targeted test. These researchers stated that these findings suggested that random UDT was justified among patients with cancer pain. Moreover, these investigators stated that further studies are needed to ascertain these observations in different cohorts and clinical settings to better characterize its use in cancer pain management.

The authors stated that one drawback of this trial was its retrospective design. Furthermore, the study was carried out among patients with cancer who had a relatively high level of symptom burden and distress and a potentially higher level of NMOU; thus, these findings may not be generally applicable to other cancer patient populations receiving opioid therapy. Lastly, a normal UDT result does not always rule out NMOU. One of the most common forms of NMOU is taking prescribed opioids more frequently than directed. Unfortunately, such behavior could not be detected by UDT; therefore, such patients may have normal UDT but still be using the opioid in an excessive or maladaptive manner. It was possible that the frequency of NMOU was higher than what the authors found in this trial. The therapeutic decision-making process surrounding opioid therapy should not be based solely on UDT, and more research is needed.

Keall et al (2022) noted that cancer prevalence is increasing, with many patients requiring opioid analgesia. Clinicians need to ensure patients receive adequate pain relief; however, opioid misuse is widespread, and cancer patients are at risk. In a systematic review, these researchers identified screening approaches that have been used to evaluate and

monitor risk of opioid misuse in patients with cancer; compared the prevalence of risk estimated by each of these screening approaches; and compared risk factors among demographic and clinical variables associated with a positive screen on each of the approaches. Medline, Cochrane Controlled Trial Register, PubMed, PsycINFO, and Embase databases were searched for articles reporting opioid misuse screening in cancer patients, along with hand-searching the reference list of included articles. Bias was assessed using tools from the Joanna Briggs Suite. A total of 18 studies met the eligibility criteria, evaluating 7 approaches: UDT (n = 8); SOAPP and 2 variants, Revised and Short Form (n = 6); the CAGE tool and 1 variant, AID (n = 6); the Opioid Risk Tool (ORT) (n = 4); Prescription Monitoring Program (PMP) (n = 3); the Screen for Opioid-ABR (SOABR) (n = 1); and structured/specialist interviews (n = 1); 8 studies compared 2 or more approaches. The rates of risk of opioid misuse in the studied populations ranged from 6 % to 65 %, acknowledging that estimates were likely to have varied partly because of how specific to opioids the screening approaches were and whether a single or multi-step approach was used. UDT prompted by an intervention or observation of aberrant opioid behaviors (AOB) were conclusive of actual opioid misuse found to be 6.5 % to 24 %. Younger age, found in 8/10 studies; personal or family history of anxiety or other mental ill health, found in 6/8 studies; and history of illicit drug use, found in 4/6 studies, showed an increased risk of misuse. The authors concluded that younger age, personal or familial mental health history, and history of illicit drug use consistently showed an increased risk of opioid misuse. Clinical suspicion of opioid misuse may be raised by data from PMP or any of the standardized list of AOBs. Clinicians may use UDT to confirm suspicion of opioid misuse or monitor adherence; however, UDT failed to identify those at risk. There is no research to understand the psychosocial effects of screening and management of opioid misuse; there remains an urgent need for further research in this area given the increasing rates of opioid prescription. The authors stated that this systematic review had several drawbacks including the narrow search criteria to include only studies with active cancer diagnoses published in a peer-reviewed English language journal. The heterogeneity of the studies made comparative analysis challenging including detailing the reliability of some of the tools.

Preux et al (2022) stated that the opioid use disorder (OUD) is an international public health problem; and in the last 2 decades it has been the subject of numerous publications concerning patients treated for chronic pain other than cancer-related pain. Patients with cancer-related pain are also at risk of OUD. In a systematic review, these investigators examined the prevalence of OUD in patients with cancer-related chronic pain. Its secondary objective was to identify the characteristics of these opioid users. These researchers carried out a literature review of studies published over the past 2 decades, from January 1, 2000 to December 31, 2020 identified by searching the 3 main medical databases: PubMed, Cochrane, and Embase. A meta-analysis took account of between and within-study variability with the use of random-effects models estimated by the DerSimonian and Laird method. The prevalence of OUD was 8 % (1 % to 20 %) and of the risk of use disorder was 23.5 % (19.5 % to 27.8 %) with I2 values of 97.8 % and 88.7 %, respectively. The authors concluded that further studies are needed on the prevalence of OUD in patients treated for cancer-related chronic pain. These researchers stated that a screening scale adapted to this patient population is urgently needed.

Racial Disparities in Urine Drug Testing

Perlman et al (2022) noted that despite illicit substance use in pregnancy occurring across all demographic groups, minority pregnant and delivering patients with a low income tend to undergo testing at a higher rate than their counterparts. National guidelines for indications do not exist and ordering of toxicology testing may be applied inequitably. In a retrospective, cohort study, these researchers examined if any documented indications in a large cohort of patients were associated with a positive toxicology test; and whether indications for urine toxicology testing were applied consistently to different demographic groups. They reviewed pregnant and delivering patients who underwent toxicology testing on obstetrical units at 1 institution from May 30, 2015, to December 31, 2018. Age, race, marital status, median income of residential ZIP code, indications for testing, and test results were collected for each patient by individual chart review. Indications included pre-term complications (pre-term pre-labor rupture of membranes or pre-term labor), abruption or hypertension, reported substance use, fetal complications, maternal complications, and none. Multi-variate logistic

regression models were analyzed for the association between indication and test result and the likelihood of marijuana as the sole positive test result. Logistic regression was employed to examine the relationship of indication for testing with maternal race. Among 20,274 births, 551 patients underwent toxicology testing during the study period. No indication for drug toxicology testing was associated with a positive result, except reported current or previous substance use. Compared with White patients, Black and Hispanic women were 4.26 times (95 % confidence interval [CI]: 2.55 to 7.09) and 5.75 times (95 % CI: 2.89 to 11.43) more likely to have toxicology testing for an indication other than reported substance use, respectively. Of all patients with positive test results (n = 194), 48 % tested positive for marijuana only. The authors concluded that compared with their White counterparts, Black and Hispanic pregnant and delivering patients may be more frequently toxicology tested for indications less clearly associated with illicit substance use. The absence of evidence-based guidelines for toxicology testing on obstetrical units risks inequitable care and stigmatization of patient groups.

Peterson et al (2023) stated that drug use during pregnancy can have implications for maternal and fetal morbidity and mortality and legal ramifications for patients. The American College of Obstetricians and Gynecologists (ACOG) guideline states that drug screening policies during pregnancy should be applied equally to all individuals and notes that biological screening is not necessary, stating that verbal screening is adequate. Despite this guidance, institutions do not consistently implement urine drug screening policies that reduce biased testing and mitigate legal risks to the patient. In a retrospective, cohort study, these investigators examined the effects of a standardized urine drug testing policy in labor and delivery on the number of drug tests performed, self-reported racial makeup of those tested, provider-reported testing indications, and neonatal outcomes. A urine drug screening and testing policy was introduced in December 2019. The electronic medical record was queried for the number of urine drug tests carried out on patients admitted to the labor and delivery unit from January 1, 2019, to April 30, 2019. The number of urine drug tests performed between January 1, 2019, and April 30, 2019, was compared with the number of urine drug tests performed between January 1, 2020, and April 30, 2020. The primary outcome was the proportion of urine drug tests conducted based

on race before and after the implementation of a drug testing policy. The secondary outcomes included total number of drug tests, Finnegan scores (a proxy for the neonatal abstinence syndrome), and testing indications. To understand perceived testing indications, pre- and post-intervention provider surveys were administered. Chi-square and Fisher exact tests were used to compare categorical variables. The Wilcoxon rank-sum test was used to compare non-parametric data. The Student t-test and 1-way analysis of variance were employed to compare means. Multi-variable logistic regression was used to construct an adjusted model that included co-variates. In 2019, Black patients were more likely to undergo urine drug testing than White patients, even after adjusting for insurance status (adjusted OR of 3.4; CI: 1.55 to 7.32). In 2020, there was no difference in testing based on race after adjusting for insurance status (adjusted OR of 1.3; CI: 0.55 to 2.95). There was a reduction in the number of drug tests conducted between January 2019 and April 2019 compared with between January 2020 and April 2020 (137 versus 71; $p < 0.001$). This was not accompanied by a statistically significant change in the incidence of neonatal abstinence syndrome measured by mean Finnegan scores ($p = 0.4$). Before the implementation of a drug testing policy, 68 % of providers requested patient consent for testing; after the implementation of a drug testing policy, 93 % requested patient consent for testing ($p = 0.002$). The authors concluded that the implementation of a urine drug testing policy improved consent for testing and reduced disparities in testing based on race and the overall rate of drug testing without affecting neonatal outcomes.

Appendix

Documentation Requirements

Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the member's medical history or current clinical presentation. Each drug or drug class being tested for must be ordered by the clinician and documented in the member's medical record. Additionally, the clinician’s documentation must be specific to the member and accurately reflect the need for each test.

If definitive testing for an individual drug or drugs (qualitative or quantitative) is required based on the member's specific history and treatment plan and the indications above, a targeted and limited number of tests defined by codes in the CPT range 80320 - 80377 is generally medically necessary; the rationale for each test ordered should be included in the medical record.

If definitive testing for substances of abuse are medically necessary based on the member's specific history and treatment plan and the indications above, HCPCS G0480 (1 - 7 drug classes) or G0481 (8 - 14 drug classes) should be used. When choosing between G0480 and G0481, the clinician should consider which drug classes are pertinent to the care of each member based on the medical indications listed above; the target drug classes should be documented on the order for the test and in the medical record.

Definitive tests G0482 (15 – 21 drug classes) and G0483 (22 or more drug classes) are rarely medically necessary for routine testing in the outpatient setting. In the rare instances where these tests may be medically necessary, the medical record must include a specific rationale, based on the history and other relevant details (including a detailed list of all drug classes in question), for such expansive definitive testing.

Examples of Validated Risk Assessment Tools

The following are links to standard validated tools for assessing the risk for abuse:

- Screener and Opioid Assessment for Patients with Pain (SOAPP) (https://www.nhms.org/opioid-risk-screening-tools-and-articles)
- Opioid Risk Tool (https://www.nhms.org/opioid-risk-screening-tools-and-articles).

Note on Medical Necessity of Reflex Testing

Reflex definitive testing is not considered medically necessary when presumptive testing is performed at point of care because the clinician should have sufficient information to determine if confirmation of a presumptive test is needed, such as when the member admits to using a

particular drug, or the immunoassay cut-off is sufficiently low that the clinician is satisfied with the presumptive test . If the clinician is not satisfied, he can then order specific subsequent definitive testing.

Because reference laboratories do not have access to patient-specific data, it is considered medically necessary for a reference lab to reflex to a definitive test before reporting a positive presumptive result to the clinician. It is also considered medically necessary for a reference lab to reflex to a definitive test to confirm the absence of prescribed medications when a negative presumptive result is obtained for a prescribed medication listed by the ordering physician.

References

The above policy is based on the following references:

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