BlueCross BlueShield Federal Employee Program.

FEP Medical Policy Manual

FEP 2.04.98 Drug Testing in Pain Management and Substance Use Disorder Treatment

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Related Policies:

5.70.032- Suboxone Drug Class
5.70.41- Methadone
Opioid Policies: 5.70.64, 5.70.066, 5.70.67, 5.70.70, 5.70.080
Fentanyl Policies: 5.70.01, 5.70.02, 5.70.07, 5.70.021, 5.70.31, 5.70.57

Drug Testing in Pain Management and Substance Use Disorder Treatment

Description

Description

Individuals in pain management programs and substance use disorder treatment may misuse prescribed opioids and/or may use nonprescribed drugs. Thus, these individuals 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 participant contracts.

OBJECTIVE

The objective of this evidence review is to determine whether urine, oral fluid, and/or hair testing for drug use improves the net health outcome in individuals with chronic pain receiving opioid treatment or with a drug addiction who are in substance use disorder treatment.

POLICY STATEMENT

In outpatient pain management, presumptive (i.e. immunoassay) drug testing may be considered **medically necessary** for:

- Baseline screening before initiating treatment or at the time treatment is initiated, when the following conditions are met:
    - An adequate clinical assessment of individual history and risk of substance use disorder is performed;

    - Clinicians have knowledge of test interpretation;
    - There is a plan in place regarding how to use test findings clinically;
    - Drug testing is ordered by a clinician during an office visit.
- Subsequent monitoring of treatment at a frequency appropriate for the risk level of the individual (see Policy Guidelines section).

In outpatient substance use disorder treatment, laboratory, in-office or point-of-care presumptive (i.e. immunoassay) drug testing may be considered **medically necessary** under the following conditions:

- Baseline screening before initiating treatment or at the time treatment is initiated (i.e. induction phase), 1 time per program entry, when the following conditions are met:
    - An adequate clinical assessment of individual history and risk of substance use disorder is performed;
    - Clinicians have knowledge of test interpretation;
    - There is a plan in place regarding how to use test findings clinically;
    - Drug testing is ordered by a clinician during an office visit.
- Stabilization and Maintenance phase -
    - Using an appropriate test, matrix, and frequency of testing for the risk level of the individual and the substance being used (see Policy Guidelines section)
    - Documentation in the medical record explains the following (see Policy Guidelines section):
        - Rationale for the specific test(s) ordered,
        - Individual's history of substance use,
        - How drug testing results will guide medical decision-making.

Definitive (i.e. confirmatory) drug testing, in outpatient pain management or substance use disorder treatment, may be considered **medically necessary** under the following circumstances:

- When immunoassays for the relevant drug(s) are not commercially available
- In specific situations for which definitive drug levels are required for clinical decision making (see Policy Guidelines section).

In outpatient pain management and outpatient substance use disorder treatment, drug testing is considered **investigational** when the above criteria are not met including but not limited to routine presumptive or definitive drug testing or standing orders (eg, testing at every visit, without consideration for specific individual risk factors or without consideration for whether definitive testing is required for clinical decision making) and validity testing when used as a separate evaluation (see Policy Guidelines).

Drug testing in the following settings may be considered **medically necessary**:

- Emergency rooms
- Ambulatory surgery
- Inpatient services
- An abrupt change in mental status (to rule out substance intoxication or delirium)
- Drug or alcohol exposure during pregnancy
- To rule out a fetal withdrawal syndrome by testing the mother for drug use.

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 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.

Opinions vary on the optimal frequency of urine drug screening to monitor individuals on opioid therapy for chronic pain. Screening frequency using a risk-based approach, as recommended by the Washington State interagency guideline (Washington State Agency Medical Directors' Group, 2015) is as follows:

- Low risk by ORT: Once a year
- Moderate risk by ORT: Twice a year
- High risk or opioid dose >120 morphine milligram equivalents/day: 3 to 4 times a year
- Recent history of aberrant behavior: Each visit

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'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 individual. 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 individual'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, individuals 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. Individuals 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
- Individual 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 individual (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 the individual ran out several days before test) • Ask individuals 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 individuals 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 addicted to the illicit drug • Cannabis is positive for patients taking certain medications (eg, dronabinol)	• Repeat urine drug test regularly • Assess for abuse/addiction and refer for addiction treatment as appropriate

UDS: urine drug screen.

BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

FDA REGULATORY STATUS

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

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

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.[10,]

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 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.[11,] 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.[12,]These were updated in 2023.[13,] The guidelines included the following recommendations on UDT (see Table 1).

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

Recommendation	LOE	SOE
"Comprehensive evaluation of pain history, medical history, psychosocial history, functional assessment, and appropriate consultations are recommended prior to initiation of opioid therapy."	Strong	Strong
"UDM should be implemented at the initiation of opioid therapy and conducted periodically for monitoring therapeutic compliance as per available guidance referential to mode and frequency of testing."	Moderate	Strong

LOE: level of evidence; SOE: strength of evidence; UDM: urine drug monitoring.

Centers for Disease Control and Prevention

In 2016, the Centers for Disease Control and Prevention published guidelines on opioids for chronic pain.[14,] In 2022, 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 [15,] 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.[8,] 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.[16,] 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 morphine-equivalent dose (MED)/d: 3 to 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.[17,] 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),[18] a white paper (2013) which provided background on the science and current practices of drug testing,[19] and guidelines (2017) on the effective use of drug testing.[9]

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."[18] 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."[19] 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.[9]

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]".[20]

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).[9]

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.

REFERENCES

1. Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part I--evidence assessment. Pain Physician. Jul 2012; 15(3 Suppl): S1-65. PMID 22786448
2. International Narcotics Control Board (INCB). Report of the International Narcotics Control Board for 2016. 2016; https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf. Accessed October 8, 2025.
3. International Narcotics Control Board (INCB). Report of the International Narcotics Control Board for 2020. 2020; https://www.incb.org/documents/Publications/AnnualReports/AR2020/Annual_Report/E_INCB_2020_1_eng.pdf. Accessed October 7, 2025.
4. International Narcotics Control Board (INCB). Report of the International Narcotics Control Board for 2023. 2023; https://unis.unvienna.org/unis/uploads/documents/2024-INCB/2325540E_INCB_Annaul_Report.pdf. Accessed October 5, 2025.
5. Fishbain DA, Cutler RB, Rosomoff HL, et al. Validity of self-reported drug use in chronic pain patients. Clin J Pain. Sep 1999; 15(3): 184-91. PMID 10524471
6. Manchikanti L, Atluri S, Trescot AM, et al. Monitoring opioid adherence in chronic pain patients: tools, techniques, and utility. Pain Physician. Mar 2008; 11(2 Suppl): S155-80. PMID 18443638
7. National Opioid Use Guideline Group (NOUGG). Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Part B: Recommendations for practice. Version 5.6. 2010; https://www.cpd.utoronto.ca/opioidprescribing/files/2016/11/opioid_guideline_part_b_v5_6.pdf. Accessed October 8, 2025.
8. Veteran's Affairs (VA) and Department of Defense (DoD) Opioid Therapy for Chronic Pain Work Group. Clinical practice guideline for the use of opioids in the management of chronic pain. 2022; https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf. Accessed October 8, 2025.
9. Jarvis M, Williams J, Hurford M, et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. J Addict Med. 2017; 11(3): 163-173. PMID 28557958
10. Nuckols TK, Anderson L, Popescu I, et al. Opioid prescribing: a systematic review and critical appraisal of guidelines for chronic pain. Ann Intern Med. Jan 07 2014; 160(1): 38-47. PMID 24217469
11. Argoff CE, Alford DP, Fudin J, et al. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. Pain Med. Jan 01 2018; 19(1): 97-117. PMID 29206984
12. Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, Safe, and Effective Prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. Pain Physician. Feb 2017; 20(2S): S3-S92. PMID 28226332
13. Manchikanti L, Kaye AM, Knezevic NN, et al. Comprehensive, Evidence-Based, Consensus Guidelines for Prescription of Opioids for Chronic Non-Cancer Pain from the American Society of Interventional Pain Physicians (ASIPP). Pain Physician. Dec 2023; 26(7S): S7-S126. PMID 38117465
14. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. Apr 19 2016; 315(15): 1624-45. PMID 26977696
15. Dowell D, Ragan KR, Jones CM, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR Recomm Rep. Nov 04 2022; 71(3): 1-95. PMID 36327391
16. Washington State Agency Medical Directors' Group. Interagency guideline on prescribing opioid dosing for pain. 2015; 3rd: http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf. Accessed October 7, 2025.
17. Washington State Agency Medical Directors' Group. Interagency guideline on opioid prescribing: long-term opioid therapy report and recommendations. 2020;https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2020/05/Bree-Long-Term-Opioid-Use-Recommendations-FINAL-20-05.pdf. Accessed October 8, 2025.
18. American Society of Addiction Medicine (ASAM). Public Policy Statement On Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in other Clinical Settings. 2010; https://www.asam.org/advocacy/public-policy-statements. Accessed October 5, 2025.
19. American Society of Addiction Medicine (ASAM). Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM). 2013; https://cmm.com.au/resources/drug-testing-a-white-paper-of-the-american-society-of-addiction-medicine-asam/. Accessed October 7, 2025.
20. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 2020; 14(2S Suppl 1): 1-91. PMID 32511106

POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
October 2016	New policy	
February 2017	Administrative update	Policy updated with literature review through October 25, 2016; references 7, 14, 16, and 22 added. In policy statements and policy guidelines, "qualitative, changed to "presumptive, and "quantitative, changed to "definitive,.
March 2018	Replace policy	Policy updated with literature review through October 16, 2017; references 8, 10, 18-19, 22-23, 31, 33, and 8 added. Policy statements unchanged except "not medically necessary, changed to "investigational in oral fluid drug testing and hair drug testing due to 510(k)and CLIA approval status of tests. Title changes to "Drug Testing in Pain Management and Substance Use Disorder Treatment,.
March 2021	Replace policy	Policy updated with literature review through July 23, 2019. Policy converted to review informed by guidelines format. Clarifications made to policy statements regarding documentation required in medical record; Policy Guidelines expanded to provide guidance regarding factors that determine appropriate testing modalities, intervals and matrices.
March 2021	Replace policy	Policy updated with literature review through October 12, 2020; references added. Terminology in policy statement corrected from "not medically necessary" to "investigational" when criteria are not met. Policy statements otherwise unchanged.
March 2022	Replace policy	Policy updated with literature review through September 29, 2021; references added. Policy statements unchanged.
March 2023	Replace policy	Policy updated with literature review through September 28, 2022; references added. Minor editorial refinements to policy statements; intent unchanged.
December 2023	Replace policy	Policy updated with literature review through September 21, 2023; references added. Policy statements unchanged.
March 2025	Replace policy	Policy updated with literature review through September 20, 2024; reference added. Policy statements unchanged.
March 2026	Replace policy	Policy updated with literature review through October 8, 2025; reference added. Policy statements unchanged.