Provider News

December 29, 2014

Guidelines for Treatment of Chronic Non-Cancer Pain

The Centers for Medicare & Medicaid Services (CMS) recommend limiting use of opioid analgesics to no more than 120mg morphine equivalent doses (MEDs) per day in the treatment of chronic non-cancer pain (CNCP). This recommendation comes amidst a wave of strong evidence that suggests that high MEDs do not improve CNCP. Instead, high MEDs put patients at risk for addiction, respiratory depression and death. This is a reversal of the previously held belief that the most appropriate way to manage these patients is to prescribe increasingly higher doses.

The Alliance has been working with providers to develop and share resources that may be of assistance in managing patients taking narcotic pain relievers including Medication Management Agreements, Clinical Practice Guidelines, Pharmacy Home Program, and information about naloxone and CURES. The following pages contain information regarding urine drug testing (UDT) for monitoring opioid therapy for chronic non-cancer pain.

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i. Using Urine Drug Testing (UDT) to Monitor Opioid Therapy for Chronic Non-cancer Pain[47-49]

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse and verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline UDT and screen all patients for risk level to develop an appropriate monitoring plan as well as a basis for consultation or referral. Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. The Prescriber should repeat random UDT based on the patient's risk category. There are several validated screening tools available to assess risk of aberrant behavior. The Opioid Risk Tool (ORT) provides a brief questionnaire that can easily be used in the primary care setting (see Appendix B).

Prior to drug testing, the prescriber should inform the patient of the reason for testing, frequency of testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify the drug screen for the individual circumstances and more accurately interpret the results.

Risk Category	UDT Frequency	Drugs or Drug Classes to Test	Consideration
Low Risk by ORT	Periodic (e.g. up to 1/year)	• Drug you are prescribing if not listed • Amphetamines • Opiates • Cocaine • Benzodiazepines • Alcohol • Barbiturates • Oxycodone • Methadone • Fentanyl • Marijuana Testing for all drug classes may not be necessary, depending on clinical situation.	Typically, the initial (screening) drug test uses an immunoassay method to identify the presence of a drug (presumptive positive). Because of cross-reactivity and different sensitivity and specificity between immunoassays, **a second confirmatory test is required** unless result is expected or the patient has disclosed drug use. Confirmatory drug tests use gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to verify a presumptive positive result. **Contact the laboratory director, toxicologist or a certified Medical Review Officer (MRO) in your area for questions about drug testing or result.** If a point-of-care (POC) device is used, contact technical support from the manufacturer for questions.
Moderate Risk by ORT	Regular (e.g. up to 2/year)		
High Risk by ORT **or** opioid doses >120 mg MED/d	Frequent (e.g. up to 3-4/year)		
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)		

UDT Results

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. The table on the next page may aid prescribers when interpreting UDT results. The following UDT results should be viewed as a "red flag", requiring confirmation and intervention:

- Negative for opioid(s) you prescribed
- Positive for drug (benzodiazepines, opioids, etc) you did NOT prescribe or have knowledge of
- Positive for amphetamine or methamphetamine
- Positive for alcohol
- Positive for cocaine or metabolites

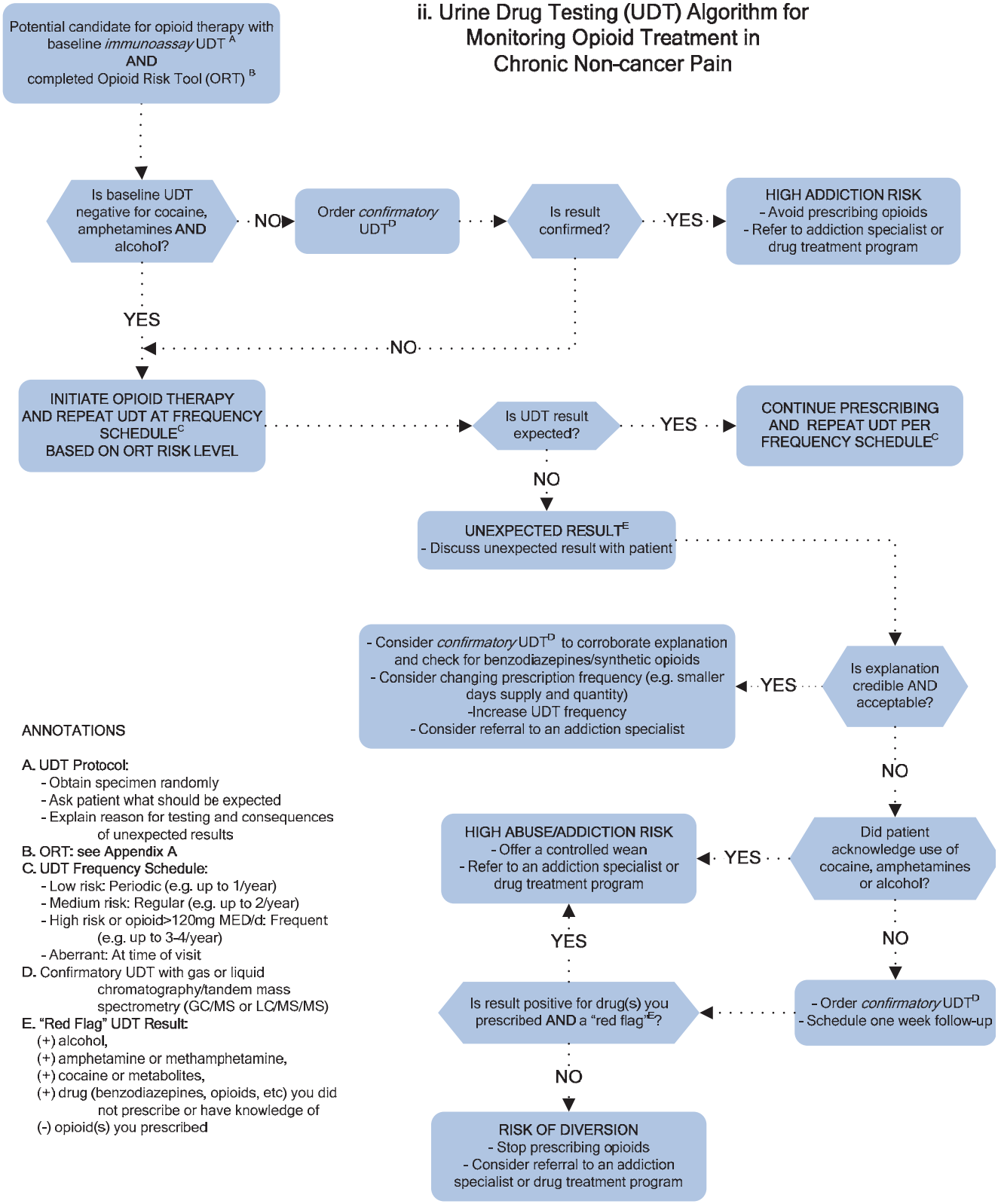
If a **confirmatory drug test** substantiates a "red flag" result AND is:

- **Positive for prescribed opioid(s)**, prescriber should consider a controlled taper and a referral to an addiction specialist or drug treatment program depending on the circumstances.
- **Negative for prescribed opioid(s)**, prescriber should stop prescribing opioid(s) and consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

Drugs or Drug Classes	Detection Time in Urine*	Test to Order	Expected Results	Consideration
Opioids or "opiates" – Natural (from opium)				
Codeine (Tylenol #2/3/4)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – codeine, possibly morphine & hydrocodone	Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.
Morphine (Avinza, Embeda, MS Contin, Kadian)	1-3 days		Opiates Immunoassay – positive GC/MS or LC/MS/MS – morphine, possibly hydromorphone	
Opioids – Semisynthetic (derived from opium)				
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – hydrocodone, possibly hydromorphone	"Opiates" immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS) is required to verify compliance with the prescribed semisynthetic opioid(s). Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.
Hydromorphone (Dilaudid, Exalgo)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS –hydromorphone	
Oxycodone (Roxicet, OxyContin)	1-3 days	Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – oxycodone possibly oxymorphone	
Oxymorphone (Opana)	1-3 days	Opiates or Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates or Oxycodone Immunoassay – positive GC/MS or LC/MS/MS – oxymorphone	
Opioids – Synthetic (man-made)				
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	GC/MS or LC/MS/MS – fentanyl & norfentanyl	**Current "opiates" immunoassays do not detect synthetic opioids.** Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.
Meperidine (Demerol)	1-3 days	GC/MS or LC/MS/MS Meperidine	GC/MS or LC/MS/MS – normeperidine, possibly meperidine	
Methadone (Methadose)	3-7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1-3 days	Propoxyphene Immunoassay + GC/MS or LC/MS/MS Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
Others				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate (EtS), can identify alcohol up to 80 hours after consumption.
Amphetamines	2-3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1-3 days w/short-acting; up to 30 days w/long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an intermediated-acting barbiturate indicates exposure within 5-7 days.
Benzodiazepines	1-3 days w/short-acting; up to 30 days w/long-acting	Benzodiazepines Immunoassay	Benzodiazepines Immunoassay – see Consideration GC/MS or LC/MS/MS – alprazolam, diazepam, clonazepam, lorazepam, etc.	Immunoassays for benzodiazepines have a 28% overall false negative rate and vary in cross-reactivity. Certain benzodiazepines (clonazepam and alprazolam) have limited detectability by most available immunoassays. Confirmatory testing is needed when use is expected or suspected.
Cocaine or benzoylecgonine	2-4 days	Cocaine Metabolites Immunoassay	Cocaine Metabolites Immunoassay – see Consideration	Cocaine immunoassays do not cross-react with other topical anesthetics that end in "caine" (e.g. lidocaine) and are highly specific for cocaine use.
Marijuana	2-4 days; up to 30 days w/chronic heavy use	Cannabinoids (THC) Immunoassay	Cannabinoids Immunoassay – see Consideration GC/MS or LC/MS/MS – THC	THC may be an indicator of the patient's risk category. Prescribers should have an office policy, discuss with the patients reason for use and adjust monitoring plan accordingly.

*detection time for most drugs depends on the drug, dose, frequency of use and individual metabolism

ii. Urine Drug Testing (UDT) Algorithm for Monitoring Opioid Treatment in Chronic Non-cancer Pain



ANNOTATIONS

A. UDT Protocol:
- Obtain specimen randomly
- Ask patient what should be expected
- Explain reason for testing and consequences of unexpected results

B. ORT: see Appendix A

C. UDT Frequency Schedule:
- Low risk: Periodic (e.g. up to 1/year)
- Medium risk: Regular (e.g. up to 2/year)
- High risk or opioid>120mg MED/d: Frequent (e.g. up to 3-4/year)
- Aberrant: At time of visit

D. Confirmatory UDT with gas or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS)

E. "Red Flag" UDT Result:
(+) alcohol,
(+) amphetamine or methamphetamine,
(+) cocaine or metabolites,
(+) drug (benzodiazepines, opioids, etc) you did not prescribe or have knowledge of
(-) opioid(s) you prescribed