# Urine Drug Testing: No Fairy Tale

By: Dr. Melissa Bean, Medical Director, Coventry Workers' Comp Services

When Goldilocks wandered into the three bears' house, she was faced with choosing porridge that was neither too hot nor too cold, or a bed that was neither too hard nor too soft. In workers' compensation, the need for urine drug testing (UDT) is no fairy tale. It is a clinical best practice that can be used to help reduce the risk of dependence, abuse and misuse and to ensure compliance with the prescription regimen to promote safety and recovery. Achieving those goals cost effectively requires identifying the appropriate patients, test panels and testing frequency. This can be a difficult balance, and existing treatment guidelines don't always provide answers. The challenge is finding the approach that is "just right"—and that may be different for each injured employee.

## #1: Identify the appropriate patient

Opioids are frequently prescribed for pain relief in workers' comp cases. According to an evidence-based review of 67 studies cited in *Pain Physician*[1], opioid therapy led to addiction in 3.3 percent of chronic pain patients, and to abnormal behavior and illicit drug use in 11.5 percent. In 2013, Quest Diagnostics analyzed more than 422,000 patient test reports and found that 55 percent of patients tested misused prescription medications, potentially putting their health at risk.[2] Inconsistent test results indicate that the patient is not taking the prescribed medication, is taking a different drug instead, or is combining the prescribed medication with other drugs. The evidence demonstrates a need for testing—but not for everyone. It makes sense to identify appropriate patients for UDT based on risk.

Most UDT programs today identify candidates based on medication risk factors, such as high morphine equivalency dose, prescription "cocktails" or certain high-risk individual drugs, such as opioids, benzodiazepines or methadone. This is a good start, but a more comprehensive approach could provide a much more accurate risk assessment. Ideally, a program should incorporate a range of both medication and medical risk factors, including a history of drug abuse or addiction or high-risk diagnoses such as chronic pain, complex regional pain syndrome, failed back syndromes or post-laminectomy syndrome. Including medical risk factors may point to patients with an increased risk of opioid misuse or abuse, who might have been overlooked when using medication-only risk factors. Some of this information is available from state pharmacy drug monitoring programs (PDMP) or through comprehensive drug profiles that incorporate data from utilization review, bill review and case management programs. Several nationally recognized screening assessments are available, which may be useful in identifying medical risk factors.

Regardless of risk level, prior to prescribing opioids, the provider should require a written "pain agreement" that educates the injured worker about the risks of these medications and spells out actions and consequences in case of non-compliance.

## #2: Choose the appropriate testing panels

Once a candidate has been identified, it might be tempting to test for everything that could be problematic. That is being done in many cases—but it drives up cost unnecessarily. Ideally, test panels should be specific to each patient.

Testing the patient for currently prescribed medications ensures that he or she is adhering to the prescribed medication regimen. If results indicate that the patient is not taking the prescribed drug, it creates an opportunity for the provider to determine why not. Maybe the medications were lost or stolen. Maybe the patient could not tolerate the side effects and stopped taking them or maybe the patient is a rapid metabolizer. Whatever the reason, the UDT results should open the door to a conversation.

It is also important to test for non-prescribed drugs to help safeguard the patient from risk of overdose or drug interaction, to eliminate duplication of therapy, and to identify signs of opioid abuse or other behaviors that could negatively impact recovery. The Quest report cites 2012 Substance Abuse and Mental Health Services Administration data indicating that the number of

heroin users in the United States increased nearly 80 percent in five years, from 373,000 in 2007 to 669,000 in 2012.[2] The tendency here is to over-test—sometimes for as many as three dozen or more different drugs. In reality, it is probably only necessary to test for the 10 or 12 most commonly abused prescription or illicit drugs or drug classes. However, it is critical to test for the correct drugs and metabolites. Quest has found that 6.6 percent of patients test positive for certain heroin metabolites despite testing negative for morphine.[2]

Then there are the confirmation tests. Confirmation tests are only necessary if results are positive for one or more non-prescribed drugs; otherwise, they are an unnecessary expense. Once again, the results here should drive action—whether it is the provider withdrawing or weaning the prescribed opioids and/or discharging the patient from the practice, or the adjuster referring the patient for case management or to a pain specialist, or requesting a comprehensive drug review or an independent medical exam.

## #3: Determine testing schedule

As with the test panels themselves, the frequency of testing is not universal and should be based on the patient's risk level. With a comprehensive profile of the individual, as described above, it's possible to stratify risk into zero, low, moderate or high with a better degree of accuracy. Patients remain in their risk category until their risk factors change. Patients receiving opioids for any extended duration of time should receive a baseline UDT. Typically, for low-risk patients, it may only be necessary to retest annually. Moderate-risk patients should be tested approximately every six months. High-risk patients should be tested three to four times a year and at any visit with lost scripts or possible drug-seeking behavior. A risk-based retesting schedule increases patient safety without increasing costs unnecessarily. Ideally, providers should use random drug screening. This reduces the likelihood that the patient could thwart the UDT process by avoiding or taking drugs to "pass" the test.

## The rest of the story

By identifying appropriate candidates, test panels and test frequency, a risk-based urine drug monitoring program can play an important role in supporting positive outcomes—cost effectively—when opioids are used in workers' comp cases. But such a program is just the beginning. The information that UDTs provide is only valuable when it is reviewed, understood, communicated and used to provide recommendations for action. In next week's post, we'll dive into the details of how to make that happen and get it just right.

**About Dr. Melissa Bean**
Melissa Bean, DO, MBA, MPH, FACOEM has been Medical Director at Coventry Workers' Comp Services since 1997. She is board certified and residency trained in occupation medicine, with experience in corporate medicine, insurance and managed care. She plays a key role in developing clinical best practices for managing complex workers' comp claims and oversees the physician review impact within Coventry's Utilization Review and Case Management programs.

**About Coventry Workers' Comp Services**
Coventry Workers' Comp Services offers workers' compensation cost and care management solutions for employers, insurance carriers and third-party administrators. With roots in both clinical and network services, Coventry leverages more than 30 years of industry experience, knowledge and data analytics. The company offers an integrated suite of solutions, powered by technology to enhance network development, clinical integration and operational efficiencies at the client desktop, with a focus on total claims cost.

NOTES

1. Manchikanti, L. MD, Abdi, S. MD, PhD., & Atluri, S., MD, 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 July Special Issue 2013. 15:51-S1-S66. ISSN 1533-3159. Available at http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf. Accessed Oct. 20, 2014.
2. Quest Diagnostics. Prescription Drug Misuse in America: Diagnostic Insights into Managing the Drug Epidemic. Prescription Drug Monitoring Report 2014. Available at http://www.questdiagnostics.com/dms/Documents/health-trends/2014_health_trends_prescription_drug_misuse.pdf. Accessed Oct. 26, 2014.