



## **CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022**

### **Recommendation 10**

*When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed meds as well as other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).*

### **Implementation Considerations**

- Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical info to inform and improve pt care. Clinicians should not dismiss pts from care on the basis of a toxicology test result. Dismissal could have adverse consequences for pt safety, potentially including the pt obtaining opioids or other drugs from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.
- Before starting opioids and periodically (at least annually) during opioid tx, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and nonprescription controlled substances that increase risk for OD when combined w/opioids, including nonprescribed and illicit opioids and BZDs.
- Clinicians, practices, and health systems should aim to minimize bias in testing and should not apply this rec differentially on the basis of assumptions about pts.

- Predicting risk is challenging, and available tools do not allow clinicians to reliably identify pts who are at low risk for substance use or substance use disorders. Clinicians should consider toxicology screening results as potentially useful data, in the context of other clinical info, for all pts and consider toxicology screening whenever its potential limitations can be addressed.
- Clinicians should explain to pts that toxicology testing will not be used to dismiss pts from care and is intended to improve their safety.
- Clinicians should explain expected results (e.g., presence of prescribed med and absence of drugs, including nonprescribed controlled substances not reported by the pt) and ask pts in a nonjudgmental manner about use of prescribed and other drugs and whether there might be unexpected results.
- Limited toxicology screening can be performed w/ a relatively inexpensive presumptive immunoassay panel that tests for opiates as a class, BZDs as a class, and several nonprescribed substances. Toxicology screening for a class of drugs might not detect all drugs in that class. For example, fentanyl testing is not included in widely used toxicology assays that screen for opiates as a class.
- Clinicians should be familiar w/ the drugs included in toxicology screening panels used in their practice and should understand how to interpret results for these drugs. For example, a positive opiates immunoassay detects morphine, which might reflect pt use of morphine, codeine, or heroin, but does not detect synthetic opioids and might not detect semisynthetic opioids. In some cases, positive results for specific opioids might reflect metabolites from opioids the pt is taking and might not mean the pt is taking the specific opioid that resulted in the positive test.

- Confirmatory testing should be used when
  - toxicology results will inform decisions w/ clinical or nonclinical implications for the pt;
  - a need exists to detect specific opioids or other drugs w/in a class, such as those that are being prescribed, or those that cannot be identified on standard immunoassays; or
  - a need exists to confirm unexpected screening toxicology test results.
- Restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect pt mgmt can reduce costs of toxicology testing.
- Clinicians might want to discuss unexpected results w/ the local lab or toxicologist and should discuss unexpected results w/ the pt.
- Clinicians should discuss unexpected results w/ pts in a nonjudgmental manner, avoiding use of potentially stigmatizing language (e.g., avoid describing a specimen as testing “clean” or “dirty”).
- Discussion w/ pts before specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and remove the need for confirmatory testing during that visit. For example, a pt might explain that the test is negative for prescribed opioids because they felt opioids were no longer helping and discontinued them. If unexpected results from toxicology screening are not explained, a confirmatory test on the same sample using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography–mass spectrometry) might be warranted.

- Clinicians should use unexpected results to improve pt safety (e.g., optimize pain mgmt strategy, carefully weigh benefits and risks of reducing or continuing opioid dosage, reevaluate more frequently, offer naloxone, and offer treatment or refer the pt for treatment w/ meds for OUD, all as appropriate).