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North Carolina Industrial Commission
Chairman Charlton L. Allen
1236 Mail Service Center
Raleigh, NC 27699-1236

Delivered via email to kendall.bourdon@ic.nc.gov

Re: Comments on Proposed Changes to Rule 10M – Utilization of Opioids

Dear Chairman Allen:

We appreciate the opportunity to comment on the proposed opioid utilization rule. Mitchell International is prominently engaged around the country promoting policies to help reduce opioid use among injured workers. We are a leading provider of managed pharmacy care, managed medical care, bill review and electronic billing services in the workers' compensation systems in all fifty states. We have witnessed firsthand the growth in the use of opioids since their introduction into the marketplace and the impact their use has had on injured workers. We applaud the efforts of the North Carolina Industrial Commission to address the use of opioids in your state.

We generally support the rule as drafted and offer the following comments and suggested changes for your consideration.

- In the definitions section of the rule, a confirmatory drug test is to include testing for the lowest number of drug classes necessary, but not to exceed 21 classes. We question why 21 classes were chosen as the maximum. We would recommend that enough flexibility be allowed in testing to ensure that the confirmatory test is adequately addressing and assessing the potential risks factors. We strongly support the use of urine drug testing anytime an injured worker enters a phase where a targeted medication is prescribed for a period exceeding 30 days. Drug testing has proven to be a valuable tool in identifying potential abuse or diversion of prescribed targeted medications and can also detect the use of illicit drugs along with other medications that could present added risk when taken with prescribed targeted medications.
- We support the proposed limitations on targeted drugs in the acute phase.
- We support the proposed limitations on targeted drugs in the chronic phase.
- We support the proposed requirement that the use of transcutaneous, transdermal, transmucosal, or buccal opioid preparations be allowed only after the physician has documented that oral opioids are contraindicated. We recommend the Commission consider strengthening this section by requiring the physician complete a pre-authorization process prior to prescribing the medications. Our experience has demonstrated that these types of preparations frequently lack documented efficacy over traditional dosage forms, and can be costly without a commensurate medical benefit.
- In Section .0301, dealing with opioid antagonists, we recommend this section be amended to provide guidance to the physician if risk factors 3-6 are present. The guidance should indicate the

prescribing of opioids should be avoided until all other potential options to relieve pain have been exhausted. Risk factors 3-6 have proven to create a high degree of likelihood for opioid abuse or dependence and a significant increase in risk of overdose. In the rare cases where an opioid is absolutely necessary, prescribing an antagonist is a prudent course of action.

- The proposed rule lists examples of non-pharmacological treatments for pain. We recommend that the language be amended to read, "Examples include, **but are not limited to**…" Groups across the country are seeking new and innovative ways to reduce or eliminate pain without medications and we think it is important that treating providers not be constrained to consider only currently known treatment options.
- Section .0500 addresses treatment for substance abuse disorder. The rule, as proposed, states the employer or insurance carrier "may" request additional information if treatment is recommended. We recommend that suggested treatment be approved through a pre-authorization process to allow the original treating physician, the SAD referred physician and the medical director of the employer or insurance carrier to discuss the various treatment options to determine the best course of action for the specific injured worker. This collaborative approach can expose the injured worker to a broader set of treatment options and, by keeping the employer in the loop, can aid in the injured worker's long-term recovery as they return to the workplace.
- In reviewing the rule, we did not see any specific language to guide how injured workers currently receiving targeted medications that exceed the recommendations in these proposed guidelines should be transitioned or managed. We recommend including a rule provision that would provide a definitive time frame (6 months) for evaluating and developing a treatment plan for injured workers currently receiving targeted medications that fall outside of or exceed the proposed recommendations. The goal should be to reduce targeted medications to the levels indicated by these guidelines. In cases where a reduction is not feasible, a long-term plan should be developed to maintain appropriate care with periodic evaluation to review treatment and consider moving the injured worker to utilization patterns consistent with these guidelines.
- We recommend moving the effective date to September 1, 2018, to allow sufficient time for rule amendments to be considered and incorporated and then to allow for sufficient time for employers, carriers and their pharmacy benefit managers to program for the changes recommend by the rule.

Thank you for considering our comments and recommendations related to this proposed rule. Should you have any questions or need further clarification, please contact Brian Allen, vice president of government affairs, at Brian.Allen@mitchell.com or at 801-661-2922.

Sincerely,

Brian Allen
Vice President Government Affairs