North Carolina Medical Society
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December 6, 2017

Ms. Meredith Henderson, Executive Secretary
North Carolina Industrial Commission
1240 Mail Service Center
Raleigh, NC 27699-1240

Via email to meredith.henderson@ic.nc.gov

Re: NCMS Comments on Draft Rules for Opioid Utilization

Ms. Henderson,

The North Carolina Medical Society is pleased to submit the following initial comments and observations on the Industrial Commission's draft rules for the utilization of opioids, related prescriptions, and pain management treatment in workers' compensation claims. We appreciate this early opportunity to respond to the work and recommendations of the Commission's Workers' Compensation Opioid Task Force, and we look forward to collaborating with the Commission as it continues to work on this critical issue.

Pain Management in Emergency Situations

Draft rules .0201 and .0202 address the utilization of targeted controlled substances ("TCS") in an acute phase of medical treatment. A common scenario not specifically addressed in those provisions, however, is whether and how the proposed acute phase protocols should apply in urgent and emergency situations. This is important since some of the administrative requirements in these rules may prove unrealistic when a care team's goal is to stabilize a patient's emergency condition, including acute pain. Examples where compliance may be challenging include the pre-prescription documentation requirement in .0201(b), the CSRS check in .0201(k), and possibly the limitations on quantity and dose as well.

NCMS requests the Commission specifically consider whether the draft provisions should apply in these situations, and whether there are alternatives that are more achievable and would promote the Commission's overall goal of improving opioid prescribing and pain management practices.

Provider-Supervised Opioid Administration in Health Care Settings

Our understanding of the Commission's intent for the rules is to improve the prescribing of TCS that are taken orally; i.e., the opioid medications that a provider prescribes to the patient for pain, that a pharmacy then fills and dispenses to the patient, and that the patient uses outside of a health care setting.[1] However, we note that the Commission's draft rules currently do not clearly make this distinction, which has raised some questions about the sweep of some of the rules provisions.

[1] The 2017 Strengthen Opioid Misuse and Prevention Act acknowledges this distinction by encouraging – not requiring – practitioners to consult the CSRS when a TCS "is to be administered to a patient in a health care setting, hospital, nursing home ...." See S.L. 2017-74, sec. 12.

For example, paragraph (h) of draft Rules .0201 and .0202 state that fentanyl shall never be prescribed for pain in an acute phase. However, this drug is commonly prescribed and administered to patients intravenously in a health care setting to manage a patient's acute (surgical) pain. Again, our assumption is that with this particular provision, the Commission is referring to oral forms of fentanyl, but the provision is actually drafted much more broadly.

NCMS requests that the Commission revisit the draft rules with an eye toward distinguishing between oral and intravenous delivery of opioids, or for that matter, situations where any opioid (oral or otherwise) is prescribed and delivered while the patient is receiving treatment and pain management for an acute condition while in a health care setting.

Urine Drug Test Requirements

The draft rules for acute and chronic pain include a requirement for providers to administer a presumptive urine drug test, and depending on the circumstances, a confirmatory urine drug test as well. We agree that providers should have the flexibility to administer this test to patients on a random, unannounced basis.

In addition, we are exploring the extent to which providers who prescribe opioids – especially in the context of acute pain – also have the capacity in their practices to administer and analyze presumptive and confirmatory urine drug tests. It could be that under the Commission's proposed approach that when the other criteria are satisfied and continued opioid therapy is indicated, that the prescribing provider may need to refer the patient to another provider to complete the drug testing requirement.

We would also caution the Commission in its proposal to delineate specific CPT and HCPCS codes in the rules. While the use of the phrase "or its successors" was likely included to cover the possibility that codes are updated from time to time, it is also common for AMA and CMS to redefine and reclassify services completely, to the extent that there is no clear crosswalk from an old procedure code to a new procedure code. Moreover, we are concerned that carriers might interpret the rules to mean that these are the only codes that are acceptable for providers to use when the circumstances and proper coding conventions may dictate otherwise. NCMS will continue to research the coding provisions in these rules and look to provide additional guidance on the proposed approach.

Need for Authorization

Finally, given the Commission's desire to establish specific requirements on providers – both administrative and clinical – for opioid utilization in workers' compensation, NCMS would similarly request that the Commission consider restricting the ability of carriers and third party administrators to *also* require additional utilization review (preauthorization) requirements in this area to the maximum extent possible. This could be helpful in reducing administrative burden at the practice level.

Thank you again for the opportunity to respond to the Industrial Commission's draft rules on opioid utilization. NCMS looks forward to the Commission's continued development of these rules.

Sincerely,

Conor Brockett
Vice President, Legal & Regulatory Affairs