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Thoughts on NC WC "Rules for the utilization of opioids…"

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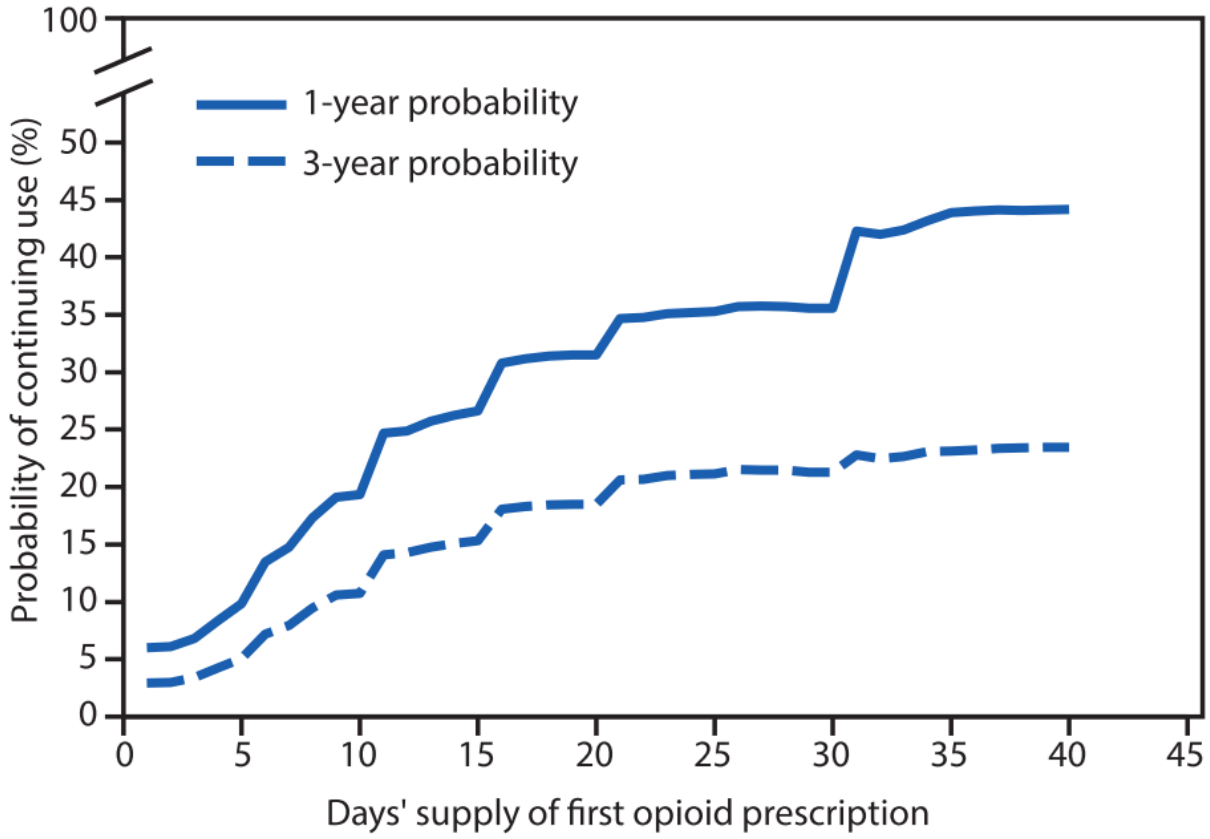
Overall, I think this is a good document. Most of my concerns are relatively minor. I do have significant concern with Section .0202. A 2nd prescription for acute pain that is 30 days long is going to greatly increase the number of poor outcomes, catastrophic claims, and costs. Please re-evaluate that.

- I think the guiding document should be the CDC should be the CDC Guidelines for Prescribing Opioids for Chronic Pain – 2016 (Dowell, Haegerich, & Chou, 2016). This has been adopted by the NC Medical Board for North Carolina.
- Initial prescription should be for 3 days or less in agreement with the CDC guidelines.
- Section .0101
  - No problems with this section
- Section .0102
  - No problems with this section
- Section .0201
  - Page 1, line 13-15
    - This recommendation should be congruent with the CDC Guidelines for the use of opioids in treating chronic pain (Dowell et al., 2016). The CDC guidelines were also adopted by the NC Medical Board as the standard of care in NC.
      - Opioids used for acute pain should be used for 3 days or less.
      - In rare circumstances, opioids may be used for 7 days.
      - There is no difference in the pain that comes from tissue damage from surgery compared to tissue damage with an injury. There should not be a difference in the guidelines regarding how the tissue damage occurred.
    - The article by Shah showed that the longer the initial prescription, the more likely it is that an individual will remain on opioids long term – meaning that the longer they are used for acute pain, the more likely they are to cause chronic pain. The graph below from the Shah article shows that this 3-10 day period is very important to decrease ongoing opioid prescribing. (Shah, Hayes, & Martin, 2017)
- Section .0202
  - **Page 1, line 13-14**
    - **This recommendation concerns me the most in this draft**. A second prescription for 30 days is unwise. An individual after a workplace injury

given a 30-day prescription for an acute injury is a very high risk for developing chronic pain and having high health care costs. According to the Shah study, an individual who is on initial opioids for 35+ days has about 45% chance of remaining on opioids one year later!
        - I would recommend the 2nd prescription to have a 7-day maximum and must receive a prior-authorization. Additional prescriptions for an opioid after that continue to have a 7-day (50 MME) max with prior-authorization each time.
        - I cannot emphasize enough how important it is to get people off their opioids quickly following an acute injury. Non-opioid medications are more effective for acute pain anyway and should be the cornerstone of treatment. (Teater, 2014)
        - Back pain. I think there should also be recommendations for back pain in this section. Evidence supports that opioids used for back pain usually result in worse outcomes. It is also important to note that opioid prescriptions for back pain are usually prescribed because of the mental health status of the patient more than the severity of the injury/pain (Breckenridge & Clark, 2003). For back injuries in Workers Comp, it has been shown that the amount of opioids prescribed initially is strongly correlated with long-term opioid use (Franklin, Rahman, Turner, Daniell, & Fulton-kehoe, 2009).
- Section .0203
    - It should be stated in this section that opioids should only be continued if there is clinically significant <u>functional</u> improvement. If there is not clinically significant functional improvement, then opioids should be discontinued. This is now the standard of care and is reflected in the 2nd recommendation of the CDC Guideline for Prescribing Opioids for Chronic Pain (Dowell et al., 2016).
        - Clinically significant functional improvement is determined when opioids are started. Examples include:
            - Return to work with restrictions in activity.
            - Daily participation in exercise and therapy.
            - Etc.
    - Page 3, line 15. Carisoprodol should not be prescribed when a patient is on chronic opioid tx. There is no proven benefit and risks are just too great.
- Section .0501
    - Page 1, line 3, 6, 9. The terms “dependence” and “addiction” should no longer be used. Dependence has multiple meanings and is confusing. Addiction can be considered pejorative. The term “substance use disorder” should be used instead.

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



(Shah et al., 2017)

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Franklin, G. M., Rahman, E. A., Turner, J. A., Daniell, W. E., & Fulton-kehoe, D. (2009). Opioid Use for Chronic Low Back Pain. A Prospective , Population-based Study Among Injured Workers. *Clin J Pain*, *25*(9), 2002–2005.

Shah, A., Hayes, C. J., & Martin, B. C. (2017). Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *MMWR. Morbidity and Mortality Weekly Report*, *66*(10), 265–269. https://doi.org/10.15585/mmwr.mm6610a1

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