STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

MARCH 2, 2018

PUBLIC HEARING BEFORE THE FULL COMMISSION

REGARDING

NINE RULES PROPOSED FOR ADOPTION IN SUBCHAPTER 10M

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A P P E A R A N C E S

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Christopher C. Loutit, Commissioner

Tammy R. Nance, Commissioner

I N D E X

E X H I B I T S

P R O C E E D I N G S

CHAIRMAN ALLEN: Good afternoon. We are on the record. Today is March 2nd, 2018. I am Charlton Allen, Chairman of the North Carolina Industrial Commission. In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, I remind all members of the Commission of their duty to avoid conflicts of interest under Chapter 138A. I also inquire as to whether there is any known conflict of interest to the matter coming before the Commission at this time. Okay. Hearing none, we will proceed. This is a North Carolina Industrial Commission public hearing on proposed rulemaking. The purpose of this hearing is to receive comments from the public regarding the adoption of nine rules proposed for permanent rulemaking by the Commission and published in the *North Carolina* Register on January 16, 2018. These proposed rules will be a new Subchapter 10M, “Rules for the Utilization of Opioids, Related Prescriptions, and Pain Management Treatment in Workers’ Compensation Claims.” We have received to date four written comments from the public, and the record will be held open to receive written comments from the public through the close of business on March 19, 2018. At

this time, I would like to introduce my fellow Commissioners. To my right is, first, Vice-Chairman Yolanda Stith, and then Commissioner Christopher Loutit, and to my left is Commissioner Tammy Nance and Commissioner Philip Baddour. Anyone who wishes to speak at this hearing must sign-up to do so with Kendall Bourdon - Ms. Bourdon, would you please raise your hand – so that we have the correct spelling of your name and can call you in order – in order to speak. If anybody would like to speak and has not yet signed up, please do so now. Anyone else? Okay. The first speaker will be Kendall Bourdon, the rulemaking coordinator for the Commission, followed by the members of the public in the order that they have signed up.

KENDALL BOURDON

CHAIRMAN ALLEN: Ms. Bourdon, will you please state your name, position and whom you work for?

MS. BOURDON: My name is Kendall Bourdon, and I am the rulemaking coordinator for the North Carolina Industrial Commission.

CHAIRMAN ALLEN: And do you have prepared exhibits that you would like to place into the record of these proceedings?

MS. BOURDON: Yes. I have Exhibit 1, which is a

copy of the proposed rules as published in the *North Carolina Register* on January 16th, 2018. Next, I have Exhibit 2, which is a copy of Session Law 2017-203, Section 4, of which contains a legislative directive and an exemption from the APA's Fiscal Note requirement.

(Exhibit Numbers 1 and 2 are identified for the record.)

CHAIRMAN ALLEN: Would you briefly give us some background and list the rules that would be affected by the proposed rulemaking?

MS. BOURDON: We have nine rules for adoption which have a proposed effective date of May 1st, 2018. These rules will be cited in Chapter 10 of the Administrative Code, Subchapter M, Rules for the Utilization of Opioids, Related Prescriptions, and Pain Management Treatment in Workers' Compensation Claims. We intend to adopt the following rules: .0101, Purpose and Applicability of the Rules, .0102, Definitions, .0103, Waiver of Rules, .0201, First Prescription of Medication for Pain in an Acute Phase, .0202, Prescription of Medication for Pain in an Acute Phase Following the First Prescription, .0203 titled "Prescription of Medication for Pain in a Chronic Phase," .0301 titled "Co-Prescription of Opioid

Antagonist," Rule .0401, Nonpharmacological Treatment for Pain, and .0501, Treatment for Substance Use Disorder Involving a Targeted Controlled Substance. These rules are submitted to you as Exhibit 1. In Session Law 2017-203, Section 4(a) – see Exhibit 2 – the General Assembly instructed the Industrial Commission to adopt rules and guidelines consistent with the North Carolina General Statute 97-25.4 for the utilization of opioids, related prescriptions, and pain management treatment. The proposed rules for the utilization of opioids and pain management in workers' compensation claims are proactive measures aimed at curtailing opioid misuse and addiction in workers' compensation claims. The rules proposed for adoption are promulgated to ensure that injured workers are provided the services and care intended by the Workers' Compensation Act and that medical costs are adequately contained. Additionally, the proposed rules are intended to facilitate the timely and effective delivery of appropriate medical treatment for pain management in workers' compensation claims. Further, in Session Law 2017-203, Section 4(b), the General Assembly exempted the Industrial Commission from the fiscal note requirement of North Carolina General Statute 150B-21.4 in developing and

implementing the rules and guidelines for opioids, related prescriptions, and pain management treatment; therefore, in accordance with this waiver, no fiscal note has been prepared for these rules. The Commission has followed the permanent rulemaking procedures of the Administrative Procedure Act in proposing these rules. The statutory authorities are North Carolina General Statutes 97-25, 97-25.4, 97-80(a) and Session Law 2017-203, Section 4. The proposed rules were filed with a notice of text to the Office of Administrative Hearings on December 19th, 2017. They were then published in the January 16, 2018 Issue of the *North Carolina Register*, and on that same date – January 16th – the Commission published a notice of this rulemaking on the Commission's website, as required, and also emailed notice with a link to these proposed rules to the Industrial Commission's Listserv. This Listserv is an interested person's Listserv that we are required to maintain for rulemaking purposes. Copies of the rules were also provided to the North Carolina League of Municipalities and the North Carolina Association of County Commissioners as required by statute.

CHAIRMAN ALLEN: Is it correct that these proposed rules are subject to be transferred to Title 11 due to

the Commission's transfer to the Department of Insurance together with all other Industrial Commission rules at some date to be determined?

MS. BOURDON: Yes, that is correct. Any transfer in the code of the Industrial Commission rules will be subsequent to this currently pending rulemaking. It is the intention of the Commission to transfer the rules from Title 04 to Title 11 by approximately May 1st, 2018, to be in line with the proposed effective date for these rules. At such time as the title of the Industrial Commission's rules are transferred in the North Carolina Administrative Code, these rules will then be cited as 11 NCAC 10M .0101 through .0103, .0201 through .0203, .0301, .0401 and .0501.

CHAIRMAN ALLEN: Do any members of the Commission have questions for Ms. Bourdon? Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: All right. The first speaker will be Connie Wilson.

CONNIE WILSON

CHAIRMAN ALLEN: If you would, please step up to the podium and state your name, your residence and any affiliated organization that you're here to represent.

MS. WILSON: As long as I don't have to give you

my weight, I'm fine with that. My name is Connie Wilson. I am the lobbyist for the North Carolina Orthopedic Association here in North Carolina, and, today, we were hoping to have Dr. Chad Mather who's a physician and a surgeon out at Duke, and he's still in surgery, so you're stuck with me today, and he would have been able to answer a lot of great questions for you. He's awesome and would love to have him come and visit with you if there are any additional questions because sometimes having a surgeon who's going through what you're dealing with with the rule can really make a big difference in the practicality of how everything is administered. So what I'd like to do today is just read quickly through a letter that we're going to be submitting, and I'd be happy to answer any questions, and I'll give you the best answer I can, and if I can't give you an answer, I'll get back with you, but we want to applaud the Industrial Commission for their efforts to safeguard injured workers in North Carolina. We realize firsthand that this is a major epidemic crisis in North Carolina and it's something that needs to be addressed at many different levels, and so we are excited that the Industrial Commission is looking at adopting new rules to ensure the safety of patients

and their families. We had just a few little concerns about the rule that we think will actually enhance, help patients and also line up with what is already out there with the STOP Act. Rule 04 .0201 titled "First Prescription of Medication for Pain in an Acute Phase" - we're asking here for more flexibility than the fifty milligram of Morphine equivalent in consideration not only for surgery, but also for a new injury. What the rule considers is if there's surgery that's occurred, but many times there's an additional injury, and if somebody is already on an opioid, there's a resistance that's out there and a threshold that now needs to be met at a higher level, so that's something that we would kindly ask that you consider, and we would be happy to meet to discuss further. In the STOP Act, something that was of great discussion during the 2017 short Session was the implementation date of the CSRS, and what was agreed to was a later phase-in date of that requirement so that any technical issues that were out there would be – and I – and I need – I want to actually go to the bill itself – would have to be met before it would be implemented. And what the STOP Act said in Section 15(e) – it said, "The remainder of this act is effective when it becomes law and applies to acts

committed 30 days after the date the State Chief Information Officer notifies the Revisor of Statutes that the upgrades to the Controlled Substance Reporting System database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7…," and then it goes on with the Session Law that's referenced. They realized that that system still had some issues, and we would ask that this rule also have that same effective date so that you're – that physicians aren't having problems with, okay, is this a workers' comp patient, is this not a workers' comp patient, and knowing that there are some issues that are out there with the CSRS. Let me see. The other issue that we had out there was an unusual – a little bit different, but we have some innovative physicians who like to use different things and would apply the fact that there are utilization rules for non-pharmacological treatments for pain in that Section .0400, and what we're asking is that hypnosis also be added, and I know it's a main line which - that you have there, but that's something that's being used more and more that would not have the problems that the opioids would have. Again, we thank you for your time and your help on these. We'd be happy to meet at any time, and I'd be happy to answer questions

whenever that's appropriate.

CHAIRMAN ALLEN: Ms. Wilson, I will ask a question regarding your last comment about hypnosis. Is it your reading of the rule that has been proposed that hypnosis would be precluded?

MS. WILSON: It's not precluded, but the whole list that you've got there does not have any term that references hypnosis; that there's something behavioral that doesn't apply to hypnosis, so this would be a little more – this would ensure that that was part of it, and I'd have to go back to the rule. Conor's got that rule. I know you got that rule memorized. But in checking all the definitions, hypnosis was not covered. I've got – I've got an Amen in the corner.

CHAIRMAN ALLEN: Okay. Because it's my reading of the rule that it says, "A health care provider shall consider and may prescribe non-pharmacological treatments for pain. Examples of these treatments include the following…."

MS. WILSON: That's right. And we're not saying that it's excluded. We're just saying it would be nice to have it added.

CHAIRMAN ALLEN: Okay.

MS. WILSON: Okay.

CHAIRMAN ALLEN: Are there any other modalities

that would also be, as you put it, nice to have it added?

MS. WILSON: After we looked at this at our board level and - hypnosis was the only thing we lacked. All the other stuff you got.

CHAIRMAN ALLEN: Okay. Any other questions?

MS. WILSON: Thank you.

CHAIRMAN ALLEN: Okay. Thank you, Ms. Wilson.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: The next speaker will be Mr. Conor Brockett.

CONOR BROCKETT

MR. BROCKETT: Good afternoon, Mr. Chairman, members of the Commission. My name is Conor Brockett. I am the vice-president of Legal and Regulatory Affairs with the North Carolina Medical Society. The NCMS is the oldest professional association in North Carolina. We got our start back in 1849. Today, we represent more than twelve thousand licensed, practicing physicians and physician's assistants who are located across the entire State and practice in all different medical specialties and who care for patients in every type of practice setting. At NCMS, many of our individual members share a long history of collaboration with the North Carolina Industrial

Commission, both in the Commission's individual adjudication of workers' compensation claims and on broader policy matters like the one we're here to discuss today that address how injured workers receive the care that they need, so we certainly appreciate the opportunity to be here today to share our thoughts and recommendations on the Commission's proposed opioid utilization rules. I'd like to start with Rule .0101, Purpose and Applicability. We believe the Commission made a very good clarification in paragraph (b) that the rules – these rules will not apply for opioids administered in health care settings, so this would cover your pain management of products for surgical procedures, you know, pain management administered in the emergency department for traumatic events, and so we think that was a good change. Thank you for incorporating that. That was actually a provision that the Medical Society suggested during the draft phase of these rules, so we were very glad to see it included here. Exempting – staying with paragraph (b), exempting opioid treatment for cancer-related pain is a very common provision that we are – we are comfortable with. The Commission might also consider before it finalizes these rules specifically excluding opioids prescribed in Hospice

and palliative care situations since the objective for those patients in those settings is fundamentally different. The idea there is it's more about keeping the patient as comfortable as possible, optimizing quality of life when curative options may no longer be available or chosen to be pursued by the patient, so we see opioid prescriptions and regulation of opioids in those contexts commonly exempted from stricter oversight or regulation and would encourage you all to think about that. Turning to Rules .0201, .0202 and .0203, there is an exception. I believe that Connie mentioned an exception for opioid-tolerant patients. It appears in paragraph (e) of each of those three rules. It's substantially identical in all three versions. And what the Commission is proposing to do is establish a general rule that the lowest effective dosage be used at all times, not to exceed 50 MMEs per day, in each of those three rules. And the Commission then acknowledges, and I think very appropriately so, that in some cases a dose above 50 MMEs per day would be justified when a patient who is opioid tolerant, opioid experienced is involved and who may need additional pain management treatment, but I want to hone in on the exception in Rule .0201 specifically. This is the same one that you heard Connie mention

moments ago. It looks different from the exceptions in Rule .0202 and .0203, and so I'd like to direct our attention there. As drafted, the prescriptions exceeding 50 MMEs would only be allowed for post-operative pain following a surgical procedure and if the patient was already above 50 MMEs for the work comp injury prior to surgery, so we read that as a very narrow exception that could be invoked to that general rule of 50. In our review, the physicians I was collaborating with on this – the question that was raised over and over was essentially, "If the I.C. is going to acknowledge and provide exceptions for opioid-tolerant patients in each of these rules, why would you limit the exception in .0201 to only those who may need it following surgery? Why not open it up more broadly to opioid-tolerant individuals?" The example of a traumatic workplace accident comes to mind where somebody had been on therapy, but then ends up in the emergency department and needs some short-term opioid therapy for acute pain management following. And what if surgery isn't part of that individual's treatment plan long term? They would not be able to exceed that general rule of 50 under this – under this proposal, so we would think that – we think generally that the – that the provisions in .0202 and

.0203(b) are the right way to go and would encourage you all to think about doing something similar for .0201, also. So I'd like to look next at the restriction on alternative opioid preparations. It's in paragraph (f) of each of those three rules - .0201, .0202 and .0203. I'm happy to share that there was generally widespread agreement on this provision. There was one caveat or warning that our pain specialist – one of our pain specialists shared with us that I wanted to pass along, and that is this idea that new products are always emerging, right, and many of these will offer improved safety and effectiveness than what has traditionally been available. Many of the traditional products that I think this rule is targeting are highly addictive, have been prone to abuse and that's the justification for the provision we're talking about, but an example of what this pain doc was talking about is a new – relatively new buccal – let me try to say this right – buccal Buprenorphine film. It's one of these little patches that goes on the inside of the cheek, and he said it's an example of a treatment that would be prohibited under paragraph (f), but is relatively safe, very effective for treating chronic pain, not addiction. It's been FDA approved for treating chronic pain and

has little risk for abuse comparatively to the other traditionally available products, low value on the street. Because of that – and he points out that under this provision, the doctor managing a chronic pain patient would only be able to prescribe a product like this if the patient was first put on an oral opioid which, as we all know, can be highly addictive, more dangerous to that individual patient, and the patient did not do well on that oral opioid. It uses - the regulation uses the word “contraindicated,” meaning they have to have tried it and it not worked very well or, in fact, somehow harmed the ability of the patient to manage pain. And you know a lot about opioids. They tend to work. They tend to work too well sometimes, so, yeah, the question was, “Why does the first path have to be an oral opioid before he could prescribe something that’s potentially much more effective and much safer?” so something to keep in mind about paragraph (f). Now I want to pick up next on the requirement to consult the CSRS that Connie mentioned you have currently in Rule .0201, .0202 and .0203 as paragraph (k). And it’s important – I want to underscore from the very beginning that the North Carolina Medical Society fully supports the policy that physicians and all prescribers check the CSRS

prior to prescribing an oral opioid medication, so the concern that I'm about to share really is not about the substantive requirement; it's about the timing, the implementation and ultimately compliance challenges we have with paragraph (k). So, as you've heard, last year, a similar mandate for all prescribers to check the CSRS for all patients was adopted in – by the General Assembly in Section 12 of the STOP Act. That particular provision has not yet taken effect, and this is the tricky part: We don't know exactly when it will. Instead of identifying a date certain, what the – what the legislature chose to do was to do – say that the mandate to check, which is our shorthand for what we're talking about here – the mandate to check would only take effect upon the satisfaction of certain technological upgrades to the CSRS database itself. And, of course, the General Assembly has directed that those upgrades be made, has appropriated money to do that. That process is underway. We just currently have no idea where that work stands. I was calling over to DMH earlier this week, trying to get an estimate and never got what I was looking for. We are fairly confident, though, that the STOP Act's – the STOP Act's effective date for that mandate to check will not come before May 1st,

and that's obviously the effective date of these rules and the mandate to check in paragraph (k). So, since the passage of the STOP Act, we have been out there as the Medical Society with fairly broad, consistent messaging telling our members, "You need to know this is coming. We don't know exactly when. When we have a better idea, we will be in touch with you. Go ahead, you know, get familiar, get your systems ready and be on the lookout for the announcement that this mandate to check is in effect." The Medical Board, other interested stakeholders have been doing the same thing. The messaging has been very consistent, and so our fear is essentially a compliance concern. If the – if the Industrial Commission's mandate to check goes in in two months, essentially, I'm just afraid communication about it is not going to be – is not going to be heard. Folks will start asking questions, but why do I have to do it for just my workers' comp patients? Why is it not everybody who…? I just foresee there being some confusion and difficulty with implementation if the mandate to check kicks in that much sooner in the workers' comp context. Finally, there's one other thing going on that is not immediately apparent, but I have to point out. The General Assembly has also placed a requirement on

nearly all North Carolina providers to connect their electronic medical record system to the Statewide Health Information Exchange. The deadline for that is June 1st, 2018, so that's another State-prompted health IT scramble that a lot of our members are dealing with right now, trying to implement, trying to meet. The stakes for not doing that are much higher. They could potentially lose their ability to participate in the State Medicaid Program and as a participating provider in the State Health Plan, so we are – they are going to be in the final month of preparations for that, also, right around the time that this potential May 1st effective date takes effect. So how do we fix it? I think there are several options that the Commission has. One you heard Connie mention, which was delay the effective date of those rules that contain the mandate. Another one that we thought of that might be of interest is – and I have some language here that could be added to paragraph (k) specifically: "Upon the effective date specified in Section 15(e) of North Carolina Session Law 2017-74, the health care provider shall review the information in CSRS pertaining to the employee…," and the provision goes on. The idea being here that if the Commission were to tie paragraph (k) – the effective date of that to the same effective

date in the STOP Act for the mandate to check, we would be one hundred percent consistent. There would be far less trouble communicating out of a different effective date. All patients, all prescribers would be more or less on the same timeline, so that is ideally what we are looking for to solve this particular issue. Those were really complicated and a lot of words there, so I hope that makes sense. Okay. Next, I'd like to discuss the urine drug testing provisions in Rules .0202 and .0203. Again, I'm pleased to say that with regard to these requirements there is – there was a high level of comfort with – from our group with the proposal, even though these requirements do go beyond what was legislated in the STOP Act. Much of what we see in the rules tracked some best practices that appear in the CDC guidelines, which I think is a good thing. We also appreciate and acknowledge the acknowledgment that these tests can be given randomly and in unannounced ways that can improve the effectiveness of the opioid treatment, but I do want to talk specifically for a moment about the presumptive – the requirement for presumptive testing. Now these tests are more common, fairly inexpensive and are generally good tools. However, I've learned that they often – they can often result in false

positives and false negatives when screening for opioids specifically, so having access to the confirmatory test that is both more sensitive and more specific is also a good thing. One recommendation we have as it relates to the results – the result of a presumptive test is to also include the language "other unexpected findings" among the criteria that would justify ordering a confirmatory test. So, to put it in context, the applicable provisions in .0202 and .0203 could read – the language is there now – "If the test results are positive for non-disclosed drugs […] negative for prescribed controlled [drugs]," and new provision – a new language would say, "…or provide another unexpected finding, the health care provider shall obtain a confirmatory [test]…," so the idea being if there's anything that comes up in that presumptive drug test that's unusual, or if the doctor suspects there's a false positive or a false negative, they would be able to order that confirmatory test. In this same general area and due to some of the limitations I was talking about with the presumptive tests, the requirement to order a confirmatory test seemed a little bit strong for our reviewers because there are often situations where the doctor sitting there with a patient has no reason to doubt that

there's a compliance problem or that other drugs are involved. There are no sort of red flags going on; yet, the presumptive test comes back with, say, a suspected – it just didn't detect the Oxycodone, for example, that may have been prescribed. So, in other words, where there's maybe a suspected false negative and no reason to believe something strange may be going on, do we really want to force the provider - if she or he thinks, you know, we're good here, I'm not really worried about this, do we really want to force the provider to have to order that more expensive confirmatory test? And right now, the language in this rule – in these two rules seem to mandate that. You know, the suggested alternative we got from our members was to change the "…shall obtain confirmatory […] drug testing…" to something like "may obtain" or "shall consider obtaining the confirmatory test." So what this really boils down to is wanting to trust the clinician's training sitting there face to face with the patient in those interactions is going to be a preferable way to go instead of sort of requiring what the next step is going to be, not providing that flexibility. So, staying on the urine drug testing for a moment, but shifting specifically to Rule .0203, we've heard from different specialties that the

restriction of four presumptive drug tests without authorization is simply not enough. There are many, many patients who need close management of their opioid therapy for chronic pain specifically. We certainly appreciate the additional flexibility that the Commission provided. I believe it was the North Carolina Psychiatric Association who weighed in at the draft stage just pointing out that patients needing help with chronic pain and substance use disorder should not be subject to those authorization requirements. There's some new language that I believe was added in. I think that's the right direction to go - for the Commission to go in, but, essentially, we would like to request access to monthly presumptive drug testing without authorization. So it doesn't need to be a mandate of twelve times a year, but make twelve – make one a month available without having to go to the carrier, without having to go to the employer to ask permission, so make it available. You can still mandate two to four. I think there's comfort for that, but raise the – raise the cap on how many can be ordered without authorization, and this was a – this was a broadly shared – this was one that almost every last physician we checked in with raised this as a

potential challenge. Switching real quickly, I believe that brings me to the rules – is it .0301 and .0401 and .0501? We share the view on Rule .0401, the Nonpharmacological Treatment of Pain, that it's fairly clear here that the idea is want to encourage providers to feel comfortable prescribing other non-pharmacological treatment methodologies. I think what would give us even more comfort is if some words making clear in the list of examples that that's not meant to be a limiting list, so if we did "examples of these treatments may include, but are not limited to, the following," I think that would – that would go a long way, provide some additional comfort, resolve the issue with the hypnosis recommendation. You know, we expect there to be, just as I was mentioning, new products coming out of the market. There could very well be new non-pharmacological approaches to pain management that come along later that we want to ensure are on the table. I believe that was – that concludes my remarks. We do plan to file written comments before the deadline, and we appreciate the Commission working on these issues. A lot of good work was done to generate these proposed rules, and thank you for listening.

CHAIRMAN ALLEN: Mr. Brockett, if you would, I

have a couple of questions, and the other Commissioners may have questions as well. I want to ask a very general question of you about this, particularly since I suspect that you have great familiarity with the rulemaking procedure, and I take it from the remarks that you made today that what you are proposing we consider would rise to the level of being substantive amendments to the rules that have been proposed. If we were to go down that road, would that not require republication?

MR. BROCKETT: I believe we are in – this is a permanent rulemaking process. I'm not – I had not considered whether the suggestions that I – we're making would rise to the level of substantive. I do believe there is a requirement that substantive changes would obviate the need to republish and – it could. I think---

CHAIRMAN ALLEN: Right.

MR. BROCKETT: ---that's a fair point, Mr. Chairman.

CHAIRMAN ALLEN: And if that were the case, these rules – well, I think beyond likely they could not take effect until a later date and could, in fact, be delayed until the 2019 General Assembly Session, is my understanding. Is that consistent with your

understanding of the rulemaking procedure and calendar?

MR. BROCKETT: I'm not familiar with the calendar, so I'm not sure about the timing. If there is, I would need to – I would need to consult that. I – but the General Assembly involvement, if I'm not mistaken, is only necessary if there are objection letters, and I don't---

CHAIRMAN ALLEN: That is correct.

MR. BROCKETT: I don't---

CHAIRMAN ALLEN: That's correct.

MR. BROCKETT: ---know that that would necessarily occur here.

CHAIRMAN ALLEN: Right. Well, given the Commission's experience in rulemaking, we have to at least, you know, consider that potential scenario. Would it not be more appropriate---? And, you know, this is maybe something that you need to consider in providing your written comments. Would it not be more appropriate under these circumstances to look at the issues and concerns that you've raised as potential subsequent rulemaking items for the Commission to consider so that these rules can take effect at an earlier date?

MR. BROCKETT: I mean that's, of course, an

option. I would like to go back and consider your original question, which is how many of the recommendations that the Medical Society is making today would rise to the level of substantive changes. I don't believe that that many of them are – you know, would require massive rewrites of any of the provisions as proposed, for example, or that would change the spirit or the underlying intent that the Commission has to control opioid prescribing in workers' comp. I think all of those goals that we heard articulated at the beginning of the hearing would still be honored and achieved by these rules, even with – I mean we honestly think these changes would make these rules better and more effective in practice. So we can certainly address that in our – in our written comments to the Commission and plan to do so.

CHAIRMAN ALLEN: And, of course, given the rulemaking process and the experience this Commission has had with the rulemaking process, we also have to understand that even if your organization agrees that a proposed change is non-substantive, even if we conclude that it's non-substantive, at the end of the day, that may not be the final verdict if it's challenged in court, so, you know, that's something

that we have to also consider in these circumstances. Let me ask a more specific question regarding the issues you raised about the drug testing proposal, and particularly monthly drug testing. Do you know how much that would cost on average to have monthly drug testing for an opioid-prescribed patient?

MR. BROCKETT: I don't have a hard number to give you. I can tell you that the presumptive drug screen tests are very inexpensive generally. I mean I think the cost ranges anywhere from six or eight bucks to twenty or thirty bucks. I mean it's not one of these several hundred dollars per test rates. Now the confirmatory tests are very expensive – can be very, very expensive, several hundred dollars each, which is why I was hoping the Commission would – might think very closely about not requiring a confirmatory drug test on, you know, every positive or negative, whatever the – whatever the case may be, presumptive tests. I think that would – that underscores – that underscores the importance of that recommendation that we've made, but the – I don't think you would necessarily see higher rate or a big cost sort of increase by increasing the number of available presumptive tests without authorization. I don't think it would necessarily be all that big. You also

have to consider the number of chronic pain patients that would require that amount of testing. I'm sure there are a lot of them, but it's not – it's not the most common condition, I would say---

CHAIRMAN ALLEN: Okay.

MR. BROCKETT: ---if that answers your question. It's – that's as specific as I can get, but, again, something else we might be able to put in our letter, Mr. Chairman.

CHAIRMAN ALLEN: That would be fine, sir. Any other questions from a Commissioner? Very well. Thank you, Mr. Brockett.

MR. BROCKETT: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: At this time, does anyone else wish to address the Commission? Okay. Very well. Ms. Wilson, and, Mr. Brockett, if you – oh. I'm sorry.

MR. GRUBB: May I (inaudible)?

CHAIRMAN ALLEN: Yes, please.

CHRISTOPHER GRUBB

DR. GRUBB: (Inaudible) intending to speak. My name is Christopher Grubb, and I am an anesthesiologist in Greenville, North Carolina. I also practice pain management. I've represented the

North Carolina Society of Anesthesiologists with the Industrial Commission with their taskforce this past fall and this past summer, so I wanted to respond in some way to some of the comments that the other two speakers have raised so that the Commission can understand the discussion and the issues that went into play in all of our meetings with the taskforce and that all of these issues that have been brought up have been discussed and detailed and numerous experts have been consulted about it. So, to start, to address what Ms. Wilson had mentioned about the orthopedic society – and I've worked myself as a lecturer for the North Carolina Orthopedic Association, so I'm very familiar with their concerns and what they deal with in the operating room and outside of the operating room dealing with injured workers. Their flexibility regarding the 50 Morphine milligram equivalents is a problem not even just for orthopedic surgeons, but for all surgeons in particular because surgeons over the last twenty or thirty years, at least in our State, are used to prescribing a whole lot of short-acting opioids after surgery which most of the experts believe have led to extra pills being in medicine cabinets across the State. In fact, I think a study recently was

published in one of the surgical journals looking at what percent of patients after surgery have extra opioid pills left over, and it is well over sixty percent that say they have some left over. And then of those that say they have some left over, as many as ninety plus percent of the pills in the bottle are left in the medicine cabinet, so when the CDC came out with their guidelines, that was part of what drove their guidelines for this minimum necessary dose and minimum necessary supply of a short-acting opioid for acute pain or for surgical pain, which is one in the same for surgical pain. And with regard to flexibility, that's where the timing comes into play. So there's, even with the STOP Act, a five-day limit for acute pain that's not surgical in nature, a seven-day limit for acute pain that's surgical. And then at that point in time, at five days or seven days, there's no restriction within the STOP Act. There's provisions within, I believe, the language already in the proposed rules here for a refill to take place so that at five days, if a patient has gone through all 50 Morphine milligram equivalents per day for each of those days for five or seven days, depending on whether there was surgery or not, then they can get a refill. They can get another

prescription, but to be more specific about their concern of tolerance – and that is a concern and that is something that was discussed at length with the taskforce – is that patients who are already on an opioid, with the exception of those that are in some sort of treatment plan with a psychiatrist or with an addiction medicine specialist, for pain that is – for chronic pain, they're already being treated given – being given those medications by another doctor, usually a pain management physician; if not that, another type of physician that's treating chronic pain, and so that 50 Morphine milligram equivalent restriction is not a restriction on what they're already getting. They can get an extra 50 Morphine milligram equivalents to handle maybe that additional pain or the pain that might even be different from the pain that they're normally dealing with. If someone has, for example, chronic back pain and they're taking large doses of opioids, and then they get another injury – let's say a foot injury at work – then they can get a little extra opioid for their surgical or their acute pain through these – through these rules, so I think the issue of tolerance has been contemplated by these rules as well. There's also a major point that I think gets mixed up with the STOP

Act, and I want to make sure to separate things here – the STOP Act from standard of care practice. So, as we're all aware with the STOP Act from last summer, it was a major step from a legislative point of view to enter into laws that restrict physicians for prescribing opioids, which is a big step - to get into a physician's world now with a law. We're all used to insurance companies restricting what we can do and making certain recommendations and the Industrial Commission over the years having certain requirements and rules with regard to what we can do and what types of surgery we can perform and what maybe are not approved or not recommended by a payer like an insurance company. That's not the same thing as a law. And, of course, the CDC – and in our case in North Carolina, the North Carolina Medical Board, I think about a year ago, voted to make those same CDC guidelines the same guideline in position statement of the North Carolina Medical Board, meaning that every physician and every PA, which are the providers – all of those providers that are governed by the North Carolina Medical Board are now expected to comply with the CDC guidelines, and the CDC guidelines say specifically as 50 Morphine milligram equivalents as being what they recommend as kind of that starting

dose. So I think for physicians to feel that they are not mandated by the STOP Act, allows them to practice outside of the standard of care would not be – certainly not be good for our injured workers. In my opinion, our injured workers deserve the highest level of care, and if a provider is not willing to provide that highest level of care, particularly for opioid therapy which is a dangerous type of therapy, well, then, maybe they shouldn't be treating our injured workers, so I think that's an expectation for any physician who wants to treat injured workers. As for the issue of the CSRS system, the Controlled Substances Reporting System, that again is a very specific issue in the STOP Act that was contemplated by the legislature as it relates to the law of physicians. The expectation of the Medical Board, again, as I just mentioned, is that every physician before every opioid is prescribed – that they check that database. That is the standard of care, but for the CDC, the North Carolina Medical Board and just good practice in general, even if the North Carolina Medical Board didn't mandate it on their end, it's an expectation certainly within this opioid crisis that we're in. And to be more urgent about the CSRS system, it's functional now. There is nothing that is

unfunctional (phonetic), for lack of a better word – malfunctional (phonetic) with the CSRS system. It is fully in use and has been used for many years. In fact, we currently have a law that's in effect that the effective date has already passed - I mean it was last July - for all physicians and all prescribers in North Carolina to be registered with the system. It doesn't make much sense to register with a system you wouldn't think would be useful or you could ever use or it would maybe crash when you tried to search for a patient. It's used. It's part of the standard of care. And in every state in this country without – with one exception being Missouri, I think, they have these databases; the opioid epidemic gets worse because this is the main tool that prescribers can use to prevent doctor shopping. The CSRS system is essential in fighting this epidemic, and if we're going to have any guidance, whether it be the Medical Board who's already said that they expect physicians to use the CSRS system or the Industrial Commission expecting physicians who take care of injured workers to use it, that's one in the same. That's not some sort of a conflict with the standard of care currently in North Carolina. And one more thing about this start date with the CSRS. There are a lot of upgrades

that have been talked about with the CSRS system, and most of those have actually already been implemented – not all of them, but, for example, one of the biggest ones that the legislature was concerned about last summer was interstate connectivity. Are physicians in North Carolina able to check the Virginia database? Are they able to check the South Carolina database? Those were the two big states that we were concerned about, and now there is a link right there on – when I access the CSRS system to check South Carolina or – and/or check Virginia for that same patient, so that functionality is already there. I think there were some other concerns about what company might be providing this service. There's a – there's a RFP, I think, that's going to come up with DHHS about who they're going to use to maybe operate this system long term, and that could change things in terms of what type of user friendliness there might be with it, and so the user friendliness was another issue that was contemplated with the STOP Act, so they wanted all of those to ideally be done before they have an effective date for the law. Urine testing – I think this is my last point, thankfully. Urine testing is another critical part of safe opioid prescribing and fighting the opioid epidemic. If the urine drug testing is not

implemented or is implemented in a not so effective way – which I'll get into that in a minute – then we'll have people out there either abusing the medications that the providers prescribe or, worse than that, diverting those medications, which would be the comment that was raised before about a patient testing negative for a drug that they're prescribed. For example, the – I think that it was mentioned by the representative from the Medical Society that sometimes someone might test negative for Oxycodone in just a simple, presumptive-type study. Then that makes sense. Send that sample for a confirmation because a lot of times certain drugs are not picked up in that more basic screening test that would then be picked up in that confirmation type of study. So, if somebody is negative on their test for what you're prescribing, the implication there is that it's being diverted somewhere, either given away, sold, that kind of thing, so, as far as the use of it, I think it's critical to use it. Now what proper use means, referencing what I just mentioned, if I get a urine test on someone every month when they come in to get their refill, well, that patient knows they're getting a urine test that day. That's not random. The proper use of urine testing, which again is part of the CDC

guidelines, is that the test be done in a random fashion, not every month, not I'm telling this patient every three months even, you're going to come in and we're going to get your urine, so you better watch out. Well, no, I don't want the watching out part with the patients. I want to ask them in a random fashion, and the standard for that would be calling them in between appointments, so I would challenge those physicians who might be asking to get a – I guess it was just a screening test that the physicians were asking for every month. I would challenge them, are you doing random screening tests every month. That's kind of tough. And talk about expense - the expense of that is more than just the test; which, by the way, screening tests – there's a lot of different types of screening tests with a lot of different prices. There's a little cup that you can buy. I actually had a rep in my office two days ago that offered me a cup that we could just have them do this little dipstick while they're there. Four dollars was the cost to the practice, and I don't know what the reimbursement would be, maybe twelve dollars - I don't know – but that's not the most commonly used test for screening purposes. Even the rules allow, and the details of that - I think Rule .0102 - is that it

isn't just a dipstick test that the rule contemplates for the screening test. It can also be a more advanced screening test using a little bit more advanced technology called immunoassay, and those tests - I believe the reimbursement even on Medicare, Medicaid is around seventy dollars, which is certainly not cheap when it's a monthly test. So, first of all, I want to make sure it's clear. A monthly test is not useful. A random test is useful. And if someone is so high risk that they need to be followed so closely so as to test them every month, then that type of patient – a good doctor would know they need to be followed by an addiction medicine specialist because they're high risk for addiction at the minimum. I also want to make one more point about these urine guidelines just to represent in some degree another physician who participated greatly with our taskforce – Dr. Bob Wilson, who is one of the leaders of The Pain Society of the Carolinas. And I'm – I've been a member of The Pain Society of the Carolinas before, and I know that every – just about every pain doctor in the State is part of that society. That society has been communicating back and forth with Dr. Wilson and, therefore, with this taskforce and has also signed off on these same rules as being fair. It

doesn't mean all of their people are happy. If we really look at what's going on out there – and I don't know if any of you are aware of some of these clinics out there, but I'll admit I have a bias against them. I call them pill mills. There are clinics in this town and almost every town – every large town in the State where – and they're not orthopedic surgeons, that they're not – frequently not even primary care providers; they're billing themselves as pain physicians who get that urine test every month. If they make the money on the urine tests every month, then that becomes an incentive to continue opioid therapy. The goal of all of our efforts here, including with the Industrial Commission, is to get people treatment in a multimodal fashion, including maybe hypnosis as well, so that they don't need opioids. The problem is if the urine test becomes lucrative, as it currently is, then now that becomes an incentive to put someone on an opioid and keep them on an opioid, and I consider that a pill mill, so I know that some states have already passed laws about that, and they have some specific statutes in some states about urine drug testing and how much you can – you can use, but in our case, I think we found a good balance. Thank you very much.

CHAIRMAN ALLEN: Okay. Dr. Grubb, let me check---

DR. GRUBB: Yes?

CHAIRMAN ALLEN: ---and make sure there---

DR. GRUBB: Sure.

CHAIRMAN ALLEN: ---are no questions. Any questions?

VICE-CHAIRMAN STITH: No.

CHAIRMAN ALLEN: Okay. All right.

DR. GRUBB: Thank you.

CHAIRMAN ALLEN: Thank you, Dr. Grubb. Victor Farah, I take it you wish to address the Commission.

MR. FARAH: Yeah, just real quickly.

VICTOR FARAH

MR. FARAH: I'm Victor Farah. I'm an attorney at Farah Cammarano. We represent injured workers in our workers' comp cases, and I too served on the opioid taskforce, but I also know Connie and Conor both pretty well, and I think they raised fair points, and, as Dr. Grubb said, we did spend a lot of time talking about most of those issues. One of the things I would hope is that everybody can take a look at the provision – was it .0103, the waiver of the rules provision - and that was sort of one of my pet peeves. You always love to have a way out in appropriate circumstances, and I'm just wondering and would ask –

and I'd be happy to talk with Conor and Connie about it – to what extent can some of the issues that have been raised be dealt with by the patient invoking the waiver of the rule provision? So that would be one suggestion I'd have in the hopes of keeping it on track, if we can. I'm also happy to talk to especially Conor about those issues that may or may not be substantive. As I was listening to them, it seemed like some probably are substantive, but others, I think, might be tweakable in a way that our experts might say are not subjecting us to additional republishing and public hearing. The other thing I want to point out about the – sort of the strictness of the rule we did have several people on. Scarlett is here and Joe Abriola from Key Risk was on it. I don't think anybody anticipates that under circumstances in which people look at it and go, of course this person needs monthly, you know, unlike what Dr. Grubb said, there may be people who need monthly. There's nothing in this rule that prevents the parties, even short of having to file for a waiver – and we hope to make this clear as we go along - you can voluntarily agree to a waiver till. I mean it doesn't mean you can't do more if both sides agree. I understand there will be certain things

where if the doc says, this person needs to be on 100 MED a day for the week following surgery, but they weren't on it before, it might not be practical to seek the waiver, and it might not be done timely, but I think this leads to my final comment, and that is that this rule while pretty comprehensive doesn't preempt the whole field on medical issues in workers' comp and by the Industrial Commission. There are still the medical motions procedures – one of which is an emergency procedure, which in real emergencies, you know, you can get decisions out of the Commission in a matter of single digit days, and sometimes even quicker than multiple days, so there are also other provisions in the Act and in the Commission's procedures that can deal with situations, especially when they're outlier situations. I think if there are things that are common across the board that the taskforce is sort of – must stop, and then those are worth taking a serious look at, but if we're talking about outliers or the occasional thing, I think we have things in place that can deal with those. Thank you.

CHAIRMAN ALLEN: Any questions from the Commissioners?

VICE-CHAIRMAN STITH: No.

CHAIRMAN ALLEN: All right. Thank you, Mr. Farah. Does anyone else wish to address the Commission? All right. If any of the speakers have prepared a summary of your remarks, please provide these to the court reporter at this time or at the conclusion of the hearing, and we thank you for your input, and we'll consider your comments. Thank you all for participating in this public hearing. The period for written comments will be held open through the close of business on March 19, 2018, so if you have any comments or further comments, please send them to Kendall Bourdon as directed in the hearing notice and the *North Carolina Register* and on the Commission website. I would strongly encourage anyone intending to submit a written public comment to please do so at your earliest convenience. Due to the particular timeframe for this rulemaking, we encourage you to send in your comments in advance of the closing deadline. The written comments and the comments made at the hearing today will be made part of the public record of these proceedings. We would like to include in the transcript of this proceeding the materials submitted by Ms. Bourdon as Exhibit 1 and Exhibit 2, and also any written summary of remarks by the speakers will be exhibits in sequential order.

(Exhibit Numbers 1 and 2 are admitted into the record.)

CHAIRMAN ALLEN: Are there any further matters to come before this public hearing? Hearing none, the hearing is adjourned. We will go off the record and thank you very much.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

RECORDED BY MACHINE

TRANSCRIBED BY: Lisa D. Dollar, Graham Erlacher and Associates

STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

C E R T I F I C A T E

I, Kelly K. Patterson, Notary Public, in and for the State of North Carolina, County of Guilford, do hereby certify that the foregoing forty-five (45) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was recorded by Graham Erlacher & Associates.

I further certify that I have no financial interest in the outcome of this action. Nor am I a relative, employee, attorney or counsel for any of the parties.

WITNESS my Hand and Seal on this 12th day of March 2018.

My commission expires on December 3, 2018.

Kelly K. Patterson

NOTARY PUBLIC

Kelly K. Patterson
Notary Public
Guilford County
North Carolina
My Commission Expires 12/3/2018

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Notice is hereby given in accordance with G.S. 150B-21.2 that the Industrial Commission intends to adopt the rules cited as 04 NCAC 10M .0101-.0103, .0201-.0203, .0301, .0401, and .0501.

Link to agency website pursuant to G.S. 150B-19.1(c): *http://www.ic.nc.gov/proposedl0M.Notice-011618.pdf*

Proposed Effective Date: *May 1, 2018*

Public Hearing:
Date: *March 2, 2018*
Time: *2:30 p.m.*
Location: *Room 240, 2nd Floor, Department of Insurance, Albemarle Building, 325 North Salisbury Street, Raleigh, NC 27603*

Reason for Proposed Action: *In Session law 2017-203, Section 4.(a), the General Assembly instructed the Industrial Commission to adopt rules and guidelines, consistent with NC General Statute § 97-25.4, for the utilization of opioids, related prescriptions, and pain management treatment. The proposed rules for the utilization of opioids and pain management in workers' compensation claims are proactive measures aimed at curtailing opioid misuse and addiction in workers' compensation claims. The rules proposed for adoption are promulgated to ensure that injured workers are provided the services and care intended by the Workers' Compensation Act and that medical costs are adequately contained. Additionally, the proposed rules are intended to facilitate the timely and effective delivery of appropriate medical treatment for pain management in workers' compensation claims.*
Further, in Session Law 2017-203, Section 4.(b), the General Assembly exempted the Industrial Commission from the fiscal note requirement of NC General Statute § 150B-21.4 in developing and implementing the rules and guidelines for opioids, related prescriptions, and pain management treatment. Therefore, in accordance with this waiver, no fiscal note is required for these rules.

Comments may be submitted to: *Kendall Bourdon, 1233 Mail Service Center, Raleigh, NC 27699-1233; phone (919) 807-2644; email Kendall.Bourdon@ic.nc.gov*

Comment period ends: *March 19, 2018*

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).
- ☐ **State funds affected**
- ☐ **Environmental permitting of DOT affected**
  Analysis submitted to Board of Transportation
- ☐ **Local funds affected**
- ☐ **Substantial economic impact (≥$1,000,000)**
- ☐ **Approved by OSBM**
- ☒ **No fiscal note required by G.S. 150B-21.4** *(Session Law 2017-203, Section 4.(b) contains a waiver.)*

CHAPTER 10 - INDUSTRIAL COMMISSION

SUBCHAPTER 10M – RULES FOR THE UTILIZATION OF OPIOIDS, RELATED PRESCRIPTIONS, AND PAIN MANAGEMENT TREATMENT IN WORKERS' COMPENSATION CLAIMS

SECTION .0100 – GENERAL PROVISIONS

04 NCAC 10M .0101 PURPOSE AND APPLICABILITY OF THE RULES

(a) The rules in this Subchapter shall apply to all claims arising under the provisions of the Workers' Compensation Act. However, Section .0200 of this Subchapter shall not apply to claims in which the employee received treatment with a targeted controlled substance for more than 12 consecutive weeks immediately preceding the effective date of the rules.

(b) The rules in this Subchapter apply to the prescription of targeted controlled substances as defined in Rule .0102 of this Section and the prescription of other modalities of pain management treatment for the outpatient treatment of non-cancer pain in claims in which the employer is providing medical compensation pursuant to the Workers' Compensation Act. The rules in this Subchapter do not apply to prescriptions for medications to be administered in a health care setting.

(c) The rules in this Subchapter are promulgated to ensure that employees are provided the services and care intended by the Workers' Compensation Act and that medical costs are adequately contained. The Rules are intended to facilitate the timely and effective delivery of appropriate medical treatment for pain management in workers' compensation claims. The Rules address the utilization of opioids, related prescriptions, and pain management treatment in workers' compensation claims. The Rules do not constitute medical advice or a standard of medical care. Disputes regarding the treatment addressed by these Rules shall be governed by G.S. 97-25 and Rule 04 NCAC 10A .0609A.

Authority G.S. 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

04 NCAC 10M .0102 DEFINITIONS

As used in this Subchapter:

(1) "Acute phase" means 12 weeks of treatment for pain following an injury by accident,

occupational disease, surgery for an injury by accident or occupational disease, or subsequent aggravation of an injury by accident or occupational disease. There may be more than one acute phase during treatment for an injury or occupational disease.

(2) "Chronic phase" means continued treatment for pain immediately following a 12-week period of treatment for pain using a targeted controlled substance.

(3) "Confirmatory urine drug test" means a definitive urine drug test that verifies the results of a presumptive urine drug test. A confirmatory urine drug test identifies individual drugs and drug metabolites. Health care providers shall use a confirmatory drug test for the lowest number of drug classes necessary based on the results of the presumptive urine drug test, not to exceed 21 drug classes.

(4) "CSRS" means the Controlled Substances Reporting System as referenced in the North Carolina Controlled Substances Reporting System Act, Article 5E of Chapter 90 of the North Carolina General Statutes.

(5) "Long-acting opioid" or "extended-release opioid" means any targeted controlled substance that is formulated to release the drug gradually into the bloodstream or to have a long half-life for prolonged activity with an analgesic effect of 8-72 hours or longer.

(6) "Lowest effective dosage" means the lowest dose necessary to achieve the clinical goal.

(7) "Morphine equivalent dose" means conversion of various opioids to an equivalent morphine dose by using the most current conversion guidelines provided by the Centers for Disease Control and Prevention ("CDC"). The CDC Opioid Prescribing Guideline Mobile App and the CDC's guidelines for Calculating Total Daily Dose of Opioids for Safer Dosage are hereby incorporated by reference, including any subsequent amendments or editions. These materials are available online at no additional cost at https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf and https://www.cdc.gov/drugoverdose/pdf/App_Opioid_Prescribing_Guideline-a.pdf.

(8) "Opioid antagonist" means the term as defined in G.S. 90-12.7(a).

(9) "Pain" means pain resulting from an injury by accident or occupational disease.

(10) "Presumptive urine drug test" means an initial urine drug test that identifies negative specimens and presumptive positive specimens, and is interpreted through visual examination. Examples include dipstick tests and drug test cups. A health care provider who is providing pain management treatment in the chronic phase to an employee may administer a presumptive urine drug test that is qualitative and interpreted or analyzed with instrumental or chemical assistance if the health care provider believes, in his or her medical opinion, that a more sensitive presumptive urine drug test is appropriate and is likely to reduce the need for a confirmatory urine drug test.

(11) "Short-acting opioid" means any targeted controlled substance with a quick onset of action and short duration of analgesic activity that is formulated for dosing at intervals of two to six hours.

(12) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

Authority G.S. 90-12.7(a); 90-90; 90-91; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

04 NCAC 10M .0103 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;

(2) the party's responsibility for the conditions creating the need for a waiver;

(3) the party's prior requests for a waiver;

(4) the precedential value of such a waiver;

(5) notice to and opposition by the opposing parties; and

(6) the harm to the party if the waiver is not granted.

Authority G.S. 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

SECTION .0200 – UTILIZATION RULES FOR OPIOID AND OTHER PHARMACOLOGICAL PAIN MANAGEMENT TREATMENT

04 NCAC 10M .0201 FIRST PRESCRIPTION OF MEDICATION FOR PAIN IN AN ACUTE PHASE

(a) This Rule applies to the first prescription of any medication to an employee for pain in an acute phase.

(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.

(c) A health care provider shall not prescribe more than one targeted controlled substance at the time of the first prescription. A health care provider shall not provide at the time of the first prescription any additional prescription for a targeted controlled substance to be dispensed at a later time.

(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or

her medical opinion to treat an employee's pain, not to exceed a five-day supply. However, the first prescription of any targeted controlled substance for post-operative pain immediately following a surgical procedure may exceed five days but shall not exceed a seven-day supply.

(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed a 50 mg morphine equivalent dose per day, using only short-acting opioids. However, a health care provider may prescribe more than a 50 mg morphine equivalent dose per day for post-operative pain immediately following a surgical procedure if the employee was being prescribed more than a 50 mg morphine equivalent dose per day for the injury or occupational disease immediately prior to surgery.

(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.

(g) A health care provider shall not prescribe fentanyl for pain in an acute phase.

(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in an acute phase.

(i) A health care provider shall not prescribe carisoprodol and a targeted controlled substance in an acute phase.

(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.

(k) A health care provider shall review the information in the CSRS pertaining to the employee for the 12-month period preceding the first prescription. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS.

Authority G.S. 90-106(a3); 90-113.74C(a); 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

04 NCAC 10M .0202 PRESCRIPTION OF MEDICATION FOR PAIN IN AN ACUTE PHASE FOLLOWING THE FIRST PRESCRIPTION

(a) This Rule applies to prescriptions for medication to an employee for pain during an acute phase that are written after a first prescription as described in Rule .0201 of this Section.

(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.

(c) A health care provider shall not prescribe more than one targeted controlled substance at a time in an acute phase.

(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or her medical opinion to treat an employee's pain.

(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed 50 mg morphine equivalent dose per day, using only short-acting opioids. However, the health care provider may prescribe a morphine equivalent dose higher than 50 mg per day, but not higher than 90 mg per day, after documenting the medical justification for the prescription, including a comparison of the expected benefits to the employee versus any potential risks of increasing the employee's dosage. If the health care provider prescribes a morphine equivalent dose higher than 50 mg per day in an acute phase, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits and consider whether to continue the higher dosage and document the medical record accordingly.

(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.

(g) A health care provider shall not prescribe fentanyl for pain in an acute phase.

(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in an acute phase.

(i) A health care provider shall not prescribe carisoprodol and a targeted controlled substance in an acute phase.

(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.

(k) A health care provider shall review the information in the CSRS pertaining to the employee for the preceding 12-month period every time the health care provider prescribes a targeted controlled substance in an acute phase. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS.

(l) After an employee has received the first prescription of a targeted controlled substance as described in Rule .0201 of this Section and an additional 30 days of treatment with a targeted controlled substance, the health care provider may only continue treatment with a targeted controlled substance after fulfilling the following requirements:

(1) The health care provider shall administer and document in the medical record the results of a presumptive urine drug test as defined in Rule .0102 of this Subchapter. The health care provider may meet this requirement by requiring that the employee take a random, unannounced urine drug test. If the test results are positive for non-disclosed drugs or negative for prescribed controlled substances, the health care provider shall obtain confirmatory urine drug testing as defined in Rule .0102 of this Subchapter. Nothing herein prevents a health care provider from ordering confirmatory urine

drug testing for a medical reason other than the presumptive urine drug test results if the medical reason is documented in the medical record. The health care provider may obtain the confirmatory urine drug test results before prescribing a targeted controlled substance. Alternatively, the health care provider may order a limited supply of a targeted controlled substance pending the results of the confirmatory urine drug test. The results of any confirmatory urine drug test shall be documented in the medical record.

(2) The health care provider shall administer and document in the medical record the results of a tool for screening and assessing opioid risk that has been validated by clinical studies. Examples of these tools include the following:

(A) NIDA Quick Screen V1.0 and NIDA-Modified ASSIST V2.0 (National Institute on Drug Abuse), available at https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013(1).pdf;

(B) Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 (Inflexxion, Inc.), available at http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf;

(C) SOAPP-Revised (Inflexxion, Inc.), available at https://www.painedu.org; and

(D) Opioid Risk Tool (ORT)(Lynn Webster, MD), available at http://agencymeddirectors.wa.gov/Files/opioidrisktool.pdf.

(3) The health care provider shall review and document in the medical record whether the information obtained by complying with Paragraph (k) of this Rule or Subparagraphs (1) or (2) of this Paragraph, or any other aspects of the employee's medical records or examination, indicate an increased risk for opioid-related harm. If the health care provider continues the prescription of a targeted controlled substance despite any increased risks identified, the health care provider shall document in the medical record the reasons justifying the continued prescription.

Authority G.S. 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

04 NCAC 10M .0203 PRESCRIPTION OF MEDICATION FOR PAIN IN A CHRONIC PHASE

(a) This Rule applies to prescriptions for medication to an employee for pain during a chronic phase.

(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.

(c) A health care provider shall not prescribe more than one targeted controlled substance at a time in a chronic phase without documentation of justification in the medical record. A health care provider shall not prescribe more than two targeted controlled substances at a time in a chronic phase, to include no more than one short-acting opioid and one long-acting or extended-release opioid.

(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or her medical opinion to treat an employee's pain.

(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed 50 mg morphine equivalent dose per day.

(1) However, the health care provider may prescribe a morphine equivalent dose higher than 50 mg per day, but not higher than 90 mg per day, after documenting the medical justification for the prescription, including a comparison of the expected benefits to the employee versus any potential risks of increasing the employee's dosage. If the health care provider prescribes a morphine equivalent dose higher than 50 mg per day in the chronic phase, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits and consider whether to continue the higher dosage and document the medical record accordingly.

(2) If a health care provider considers it necessary to prescribe a morphine equivalent dose higher than 90 mg per day to treat an employee's pain, the health care provider shall seek preauthorization from the employer or carrier. If the employer or carrier authorizes, or the Commission orders, authorization of a prescription of a morphine equivalent dose higher than 90 mg per day, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits of the increased dosage and consider whether to continue the higher dosage and document the medical record accordingly.

(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations included in G.S. 90-90(1) or (2) without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.

(g) A health care provider shall seek preauthorization from the employer or carrier before prescribing transdermal fentanyl. A health care provider shall seek preauthorization from the employer or carrier before prescribing methadone for pain in a chronic phase.

(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in a chronic phase.

(i) A health care provider shall seek preauthorization from the employer or carrier before prescribing carisoprodol and a targeted controlled substance in a chronic phase. A health care provider

shall advise the employee of the potential risks of combining a targeted controlled substance and carisoprodol if both medications are prescribed.

(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.

(k) A health care provider shall review the information in the CSRS pertaining to the employee for the preceding 12-month period at every appointment with the employee at which a targeted controlled substance is prescribed or every three months, whichever is more frequent. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS.

(l) Before first prescribing a targeted controlled substance in a chronic phase, a health care provider shall administer and document in the medical record the results of a presumptive urine drug test as defined in Rule .0102 of this Subchapter.

(m) Following compliance with Paragraph (l) of this Rule, a health care provider shall administer a presumptive urine drug test as defined in Rule .0102 of this Subchapter and document the results in the medical record a minimum of two times per year and a maximum of four times per year during a chronic phase, unless additional urine drug tests are authorized by the employer or carrier at the request of the health care provider. The limitation on the number of urine drug tests to be conducted per year without authorization by the employer or carrier for additional urine drug tests shall not apply in those cases where a patient is being prescribed targeted controlled substances for the purpose of substance use disorder treatment in addition to pain management.

(n) The health care provider may meet the requirements of Paragraphs (l) and (m) by requiring that the employee take random, unannounced urine drug tests.

(o) If the result of a presumptive urine drug test administered pursuant to this Rule is positive for non-disclosed drugs or negative for prescribed medications, the health care provider shall obtain confirmatory urine drug testing as defined in Rule .0102 of this Subchapter. The health care provider may obtain the confirmatory urine drug test results before prescribing a targeted controlled substance. Alternatively, the health care provider may order a limited supply of a targeted controlled substance pending the results of the confirmatory urine drug test. The results of any confirmatory urine drug test shall be documented in the medical record. Nothing herein prevents a health care provider from ordering a confirmatory urine drug test for a medical reason other than the presumptive urine drug test results if the medical reason is documented in the medical record.

(p) If an employee's medical treatment involving the prescription of targeted controlled substances is transferred to a health care provider in a different health care practice from the one that administered the opioid risk screening and assessment tool required by Rule .0202(l)(2) of this Section, the new health care provider shall administer and document in the medical record the results of a tool for screening and assessing opioid risk that has been validated by clinical studies. Examples of these tools include the following:

(1) NIDA Quick Screen V1.0 and NIDA-Modified ASSIST V2.0 (National Institute on Drug Abuse), available at https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013(1).pdf;

(2) Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 (Inflexxion, Inc.), available at http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf;

(3) SOAPP-Revised (Inflexxion, Inc.), available at https://www.painedu.org; and

(4) Opioid Risk Tool (ORT)(Lynn Webster, MD), available at http://agencymeddirectors.wa.gov/Files/opioidrisktool.pdf.

(q) A health care provider shall document in the medical record whether the information obtained by complying with Paragraphs (k), (l), (m), (o) or (p) of this Rule indicates an increased risk for opioid-related harm. If the health care provider continues the prescription of a targeted controlled substance despite any increased risks identified, the health care provider shall document in the medical record the reasons justifying the continued prescription.

Authority G.S. 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

SECTION .0300 – UTILIZATION RULES FOR OPIOID ANTAGONISTS

04 NCAC 10M .0301 CO-PRESCRIPTION OF OPIOID ANTAGONIST

(a) A health care provider prescribing a targeted controlled substance shall consider co-prescribing an opioid antagonist to the following:

(1) employees taking benzodiazepines and a targeted controlled substance;

(2) employees whose dosage exceeds a 50 mg morphine equivalent dose per day;

(3) employees with a history of drug overdose;

(4) employees with a history of substance use disorder;

(5) employees with a history of an underlying mental health condition that places them at an increased risk for overdose;

(6) employees with a medical condition such as respiratory disease, sleep apnea, or other comorbidities that places them at an increased risk for opioid toxicity, respiratory distress, or opioid overdose.

(b) If a health care provider prescribes an opioid antagonist pursuant to one or more of the conditions listed in Paragraph (a) of this Rule, the health care provider shall write the prescription to allow for product selection by the employer or carrier, including an intranasal formulation approved by the United States Food and Drug Administration.

Authority G.S. 97-25.3; 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

SECTION .0400 – UTILIZATION RULES FOR NONPHARMACOLOGICAL TREATMENT FOR PAIN

04 NCAC 10M .0401 NONPHARMACOLOGICAL TREATMENT FOR PAIN

A health care provider shall consider and may prescribe non-pharmacological treatments for pain. Examples of these treatments include the following: physical therapy, chiropractic, acupuncture, massage, cognitive behavioral therapy, biofeedback, and functional restoration programs. The employer or carrier may request additional information from the health care provider regarding the prescribed treatment by any method allowed pursuant to the Workers' Compensation Act.

Authority G.S. 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

SECTION .0500 – UTILIZATION RULES FOR TREATMENT FOR SUBSTANCE USE DISORDER

04 NCAC 10M .0501 TREATMENT FOR SUBSTANCE USE DISORDER INVOLVING A TARGETED CONTROLLED SUBSTANCE

(a) If a health care provider believes, in his or her medical opinion, that an employee may benefit from an evaluation for discontinuation or tapering of a targeted controlled substance or for treatment for substance use disorder involving a targeted controlled substance, the health care provider may refer the employee to a health care provider specializing in such treatment for evaluation. The employer or carrier may request additional information from the health care provider regarding the referral by any method allowed pursuant to the Workers' Compensation Act.

(b) If treatment is recommended following the evaluation referenced in Paragraph (a) of this Rule, the employer or carrier may request additional information from the recommending health care provider regarding the treatment by any method allowed pursuant to the Workers' Compensation Act.

Authority G.S. 97-25.4; 97-80(a); S.L. 2017-203, s. 4.

TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice is hereby given in accordance with G.S. 150B-21.2 and G.S. 150B-21.3A(c)(2)g. that the Child Care Commission intends to adopt the rules cited as 10A NCAC 09 .1715, .2204, .2207, .4001, amend the rules cited as 10A NCAC 10A NCAC 09 .1101, .1729, readopt with substantive changes the rules cited as 10A NCAC 09 .0401, .0513-.0515, .1904, .2201-.2203, .2205, .2206, .2208, .2209, .2213, .2216, .2217, .2703, .2801, .2802, .2804-.2809, .2817-.2826, .2827-.2830, and readopt without substantive changes the rules cited as 10A NCAC 09 .0516, .2701, .2702, .2704, and .2831.

Pursuant to G.S. 150B-21.2(c)(1), the text of the rule(s) proposed for readoption without substantive changes are not required to be published. The text of the rules are available on the OAH website: http://reports.oah.state.nc.us/ncac.asp.

Pursuant to G.S. 150B-21.17, the Codifier has determined it impractical to publish the text of rules proposed for repeal unless the agency requests otherwise. The text of the rules are available on the OAH website at http://reports.oah.state.nc.us/ncac.asp.

Link to agency website pursuant to G.S. 150B-19.1(c): *http://ncchildcare.dhhs.state.nc.us/general/whatsnew.asp*

Proposed Effective Date: *June 1, 2018*

Public Hearing:
Date: *February 12, 2018*
Time: *1:00 p.m.*
Location: *Dix Grill, Employee Center, 1101 Cafeteria Drive, Raleigh, NC 27603*

Reason for Proposed Action: *The NC Child Care Commission proposes rulemaking to rules in 10A NCAC 09 and to readopt rules in accordance with G.S. 150B-21.3A as part of the periodic review of rules process as follows: Rated License and Minimum Standards rules - .0513, .0514, .0515, .0516, .1101, .1705, .1729, .2801, .2802, .2804, .2805, .2806, .2807, .2808, .2809, .2817, .2818, .2819, .2820, .2821, .2822, .2823, .2824, .2825, .2826, .2827, .2828, .2829, .2830, and .2831.*
Rules in 10A NCAC 09 .2800 promote the quality of child care for children enrolled in child care facilities that choose to participate in the two through five star rated license process. The most important substantive changes involved applying rules previously required only of 2-5 star facilities to minimum requirements required of all child care centers as was requested by the North Carolina Child Care Commission. All family child care homes will now be required to develop and implement written operational policies and procedures and complete a self-study and self-assessment of the Family Child Care Rating Scale. All child care centers will now be required to develop administrative policies, operational/personnel policies, and parent participation policies currently required for centers that hold a 2-5 star rated license. Also during its review of rules, the Commission proposes to reorganize the rules so that they are sequential and user friendly to the provider and the public. Please note the following rules will be transferred to a new rule number: .2804 to .0513, .2805 to .0514, .2807 to .0515, .2808 to .0516.

Administrative Actions, Civil Penalties and Criminal Records Check rules - .0401, .1904, .2201, .2202. .2203, .2204, .2205, .2206, .2207, .2208, .2209, .2213, ,2216, .2217, .2701, .2702, .2703, .2704 and .4001. The rules in Section .2200 pertain to the implementation of administrative actions and civil penalties that a facility could be penalized for if the regulations aren't practiced. These changes add clarification to the existing rules. Rules .0401, .1904, and .2208 are proposed for repeal. Rules in Section .2700 Criminal Records Check sets the standards for obtaining background checks for potential owners and employees that choose to work in child care. The proposed rules promote the

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

SESSION LAW 2017-203
SENATE BILL 407

AN ACT TO ENACT THE EMPLOYEE FAIR CLASSIFICATION ACT, TO REQUIRE THE INDUSTRIAL COMMISSION TO IMPLEMENT RULES RELATED TO OPIOIDS AND PAIN MANAGEMENT, TO REMOVE THE REQUIREMENT THAT THE INDUSTRIAL COMMISSION STUDY CAUSES OF INJURY AND RECOMMEND WAYS TO PREVENT INJURIES, AND TO DELAY THE EFFECTIVE DATE FOR A REQUIREMENT THAT EMPLOYERS RESPOND TO UNEMPLOYMENT INSURANCE CLAIMS IN TEN DAYS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"Article 82.
"Employee Fair Classification Act.

"**§ 143-761. Title.**

This Article shall be known and may be cited as the "Employee Fair Classification Act."

"**§ 143-762. Definitions; scope.**

(a) The following definitions apply in this Article:

(1) Chairman. – The Chairman of the Industrial Commission.

(2) Employ. – As defined by G.S. 95-25.2(3). For the purposes of this Article, an entity or individual shall not be deemed to be an employer of an individual hired or otherwise engaged by or through the entity or individual's independent contractor.

(3) Employee. – Any individual that is defined as an employee by either G.S. 95-25.2(4), 96-1(b)(10), 97-2(2), or 105-163.1(4). The term does not mean an individual who is an independent contractor.

(4) Employee Classification Section or Section. – The Employee Classification Section within the Industrial Commission.

(5) Employee misclassification. – Avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the General Statutes by misclassifying an employee as an independent contractor.

(6) Employer. – Any individual or entity that employs one or more employees as defined by G.S. 97-2(3).

(7) Public notice statement. – Notice as set forth in G.S. 143-764(a)(5).

(b) Nothing in this Article shall be construed or is intended to change the definition of "employer" or "employee" under any other provision of law.

"**§ 143-763. Establishment of Employee Classification Section.**

(a) The Employee Classification Section is established within the Industrial Commission.

(b) The Chairman shall appoint a director of the Section to serve at the Chairman's pleasure with such authority as the Chairman deems necessary to direct and oversee the Section in carrying out the purposes of this Article.

(c) The Chairman may employ clerical staff, investigators, and other staff within the Section as is necessary for the Section to perform its duties under this Article.

(d) The Office of the State Chief Information Officer shall ensure that the Section is provided with all necessary access to the Government Data Analytics Center and all other information technology services.

(e) The Secretary of Revenue, the Commissioner of Labor, the Chairman, and the Assistant Secretary of Commerce for the Division of Employment Security shall each designate an employee of their respective agencies to serve as liaisons to the Section.

"**§ 143-764. Section powers and duties.**

(a) The Section shall have the following duties:

(1) Be available during business hours to receive reports of employee misclassification by telephonic, written, or electronic communication.

(2) Investigate reports of employee misclassification and coordinate with and assist all relevant State agencies in recovering any back taxes, wages, benefits, penalties, or other monies owed as a result of an employer engaging in employee misclassification.

(3) Coordinate with relevant State agencies and district attorneys' offices in the prosecution of employers and individuals who fail to pay civil assessments or penalties assessed as a result of the employer's or individual's involvement in employee misclassification.

(4) Provide all relevant information pertaining to each instance of reported employee misclassification to the North Carolina Department of Labor, the Division of Employment Security within the North Carolina Department of Commerce, the North Carolina Department of Revenue, and the North Carolina Industrial Commission to facilitate investigation of potential violations of Chapter 95, 96, 97, 105, or 143 of the General Statutes.

(5) Create a publicly available notice that includes the definition of employee misclassification.

(6) Develop methods and strategies for information sharing between State agencies in order to proactively identify possible instances of employee misclassification.

(7) Develop methods and strategies to educate employers, employees, and the public about proper classification of employees and the prevention of employee misclassification.

(b) No later than October 1 of each year, the Section shall publish annually to the Office of the Governor and to the Joint Legislative Commission on Governmental Operations a report of the administration of this Article, together with any recommendations as the Section deems advisable. This report shall include, at a minimum, the number of reports of employee misclassification received, the number and amount of back taxes, wages, benefits, penalties, or other monies assessed, the amount of back taxes, wages, benefits, penalties, or other monies collected, and the number of cases referred to each State agency.

(c) The Section may adopt rules in accordance with Article 2A of Chapter 150B of the General Statutes for the purpose of carrying out the provisions of this Article and establishing the processes and procedures to be used under this Article.

"**§ 143-765. Occupational licensing boards and commissions; notice requirement; applicant certification and disclosure.**

(a) Every State occupational licensing board or commission that is authorized to issue any license, permit, or certification shall include on every application for licensure, permit, or certification, or application for renewal of the same, the following:

(1) Certification by the applicant that the applicant has read and understands the public notice statement.

(2) Disclosure by the applicant of any investigations for employee misclassification and the result of the investigations for a time period determined by the occupational licensing board or commission.

(b) An occupational licensing board or commission shall deny the license, permit, or certification application of any applicant who fails to comply with the certification and disclosure requirements of this section.

"**§ 143-766. Confidentiality; access to records.**

(a) The records of the Section are not public records under G.S. 132-1.

(b) The Section shall exchange information as required by this Article.

(c) The Section may share information with other State and federal agencies as permitted or required by law.

"**§ 143-767. Exchange of information among coordinating agencies.**

The North Carolina Department of Revenue, the North Carolina Department of Labor, the Division of Employment Security within the North Carolina Department of Commerce, and the North Carolina Industrial Commission shall disclose all reports and investigations of employee misclassification to the Section. The Section shall distribute the information to the other agencies to allow each agency to conduct an investigation."

SECTION 2. G.S. 105-259(b) is amended by adding a new subdivision to read:

"(53) To furnish to the North Carolina Department of Labor, the Division of Employment Security within the North Carolina Department of Commerce, the North Carolina Industrial Commission, and the Employee Classification Section within the Industrial Commission employee misclassification information pursuant to Article 82 of Chapter 143 of the General Statutes."

SECTION 3. G.S. 95-25.15(c) reads as rewritten:

"(c) A poster summarizing the major provisions of this Article shall be displayed in every establishment subject to this Article. This poster shall also include notice indicating the following in plain language:

(1) Any worker who is defined as an employee by either G.S. 95-25.2(4), 143-762(a)(3), 96-1(b)(10), 97-2(2), or 105-163.1(4) shall be treated as an employee unless the individual is an independent contractor.

(2) Any employee who believes that the employee has been misclassified as an independent contractor by the employee's employer may report the suspected misclassification to the Employee Classification Section within the Industrial Commission.

(3) The physical location, mailing address, telephone number, and e-mail address where alleged incidents of employee misclassification occurred may be reported to the Employee Classification Section within the Industrial Commission."

SECTION 4.(a) The Industrial Commission shall adopt rules and guidelines, consistent with G.S. 97-25.4, for the utilization of opioids, related prescriptions, and pain management treatment.

SECTION 4.(b) The Industrial Commission is exempt from the fiscal note requirement of G.S. 150B-21.4 in developing and implementing the rules and guidelines for opioids, related prescriptions, and pain management treatment.

SECTION 5. G.S. 97-81(c) is repealed.

SECTION 6. Section 3.2(b) of S.L. 2017-8 reads as rewritten:

"**SECTION 3.2.(b)** This section becomes effective ~~October 1, 2017,~~ July 1, 2018, applies to claims for benefits filed on or after that date, and applies to tax calculations on or after that date."

SECTION 7. Sections 1, 2, and 3 of this act become effective December 31, 2017. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 3rd day of August, 2017.

s/ Bill Rabon
Presiding Officer of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Roy Cooper
Governor

Approved 2:20 p.m. this 11th day of August, 2017