OPIOID PRESCRIBING RULES
FOR WORKERS' COMPENSATION

AN OVERVIEW BY THE NORTH CAROLINA MEDICAL SOCIETY - MAY 2018

THE RULES: IN EFFECT MAY 1, 2018

[CSRS REQUIREMENT: IN EFFECT NOVEMBER 1, 2018]

APPLY TO:

Opioid prescriptions and outpatient pain management treatment modalities in workers' comp claims.

DO NOT APPLY TO:

- An employee who has received opioid treatment for more than 12 consecutive weeks immediately preceding May 1, 2018.
- Any medications administered in a health care setting.
- Treating cancer-related pain.

Providers, employees and carriers/employers can agree to a course of treatment that may be inconsistent with the rules.

The Industrial Commission may waive the rules on a case-by-case basis upon request.

NOTE: Providers and employees should work through carriers/employers first.

To request a waiver, the employee (or his/her attorney) should file a **medical motion**.

For additional details and guidance, access the Industrial Commission's website: www.ic.nc.gov/OpioidRulesResourcePage.html

North Carolina Medical Society
Leadership in Medicine

OPIOID PRESCRIBING IN THE ACUTE PHASE

REFER TO THESE RULES WHEN THE EMPLOYEE IS IN THE **FIRST 12 WEEKS OF TREATMENT** FOR PAIN FOLLOWING:

- An injury or occupational disease, or
- Subsequent aggravation of an injury or occupational disease, or
- Surgery for an injury or occupational disease.

WHEN THE EMPLOYEE IS IN THE ACUTE PHASE, PROVIDERS CANNOT:

- Write more than one opioid prescription at a time.
- Prescribe an alternative opioid preparation, unless oral opioids are contraindicated.
- Prescribe fentanyl for pain.
- Prescribe benzodiazepines for pain or as muscle relaxers.

NOTE: *If the employee is already taking a benzo or carisoprodol, the provider **must** first advise the employee of the risks of taking an opioid in combination **and** inform the prescriber of the benzo/carisoprodol of the opioid prescriptions.*

WHEN THE EMPLOYEE IS IN THE ACUTE PHASE, PROVIDERS SHOULD:

- Consider ordering any other non-opioid treatment for pain.
- Consider a co-prescription for naloxone if prescribing an opioid.

THE FIRST OPIOID PRESCRIPTION

Before prescribing, the provider **must**:

a. Document that non-pharmacological and non-opioid therapies are insufficient to treat pain.

b. Review the employee's 12-month history in the CSRS. Document results and potential contraindications.

c. Impose limits on quantity and dose:

- Providers must write for the fewest days necessary to treat the employee's pain, and **not more than a 5-day supply**.

  EXCEPTION: 7-days' supply allowed, but only for post-op pain immediately following surgery

- Providers must write for the lowest effective dosage, not to exceed 50 morphine equivalant dose (MED) per day using a **short-acting** opioid.

  EXCEPTION: If the employee was on opioid therapy **immediately prior** to the prescription, the provider may exceed 50 MED/day.

SUBSEQUENT OPIOID PRESCRIPTION

Before prescribing additional acute-phase opioids, the provider **must**:

a. Document that non-pharmacological and non-opioid therapies are insufficient to treat pain.

b. Review the employee's 12-month history in the CSRS. Document results and potential contraindications.

c. Drug Testing Requirement: Complete the steps in ***Diagram A*** (see graphic below).

d. Administer a validated opioid risk assessment and screening tool (see graphic below).

e. Impose limits on quantity and dosage (see graphic below).

DIAGRAM A: REQUIREMENTS IN THE ACUTE PHASE

HAS THE EMPLOYEE ALREADY RECEIVED 35-37 DAYS' SUPPLY OF AN OPIOID IN THE ACUTE PHASE?

IF YES...

Administer a presumptive urine drug test (UDT) of the employee and document results; *Random and/or unannounced administration is OK.*

ABNORMAL/UNANTICIPATED RESULTS

If the UDT is positive for undisclosed drugs or negative for opioids, the provider must order a confirmatory test. The Provider may...

1. Prescribe a limited supply after completing assessment / screening tool.

OR

2. Await test results before prescribing additional opioid.

NORMAL/ANTICIPATED RESULTS

Administer a validated opioid risk assessment and screening tool and document results. Screening tool examples:

- NIDA Quick Screen V1.0 and NIDA-Modified ASSIST V2.0
- Screener & Opioid Assessment for Patients with Pain (SOAPP)

Review and document whether any data from the earlier steps indicate increased risk of opioid-related harm to the employee. *If so, and opioid therapy continues, also document the justification.*

IF NO...

Impose limits on quantity and dose

- Providers must prescribe the fewest days necessary to treat the employee's pain; no specific limit on days' supply.
- Providers must write for the lowest effective dosage, not to exceed 50 MED/day using short-acting opioids.

EXCEPTION: Providers may write 50-90 MED/day, but must document the justification for the higher dosage with a comparison of expected benefits and risks to the employee.

Review and document the effectiveness of the higher dosage at all subsequent visits.

OPIOID PRESCRIBING IN THE CHRONIC PHASE

REFER TO THESE RULES WHEN THE EMPLOYEE **CONTINUES TREATMENT FOR PAIN IMMEDIATELY FOLLOWING 12 WEEKS OF OPIOID TREATMENT**.

WHEN THE EMPLOYEE IS IN THE CHRONIC PHASE, PROVIDERS CANNOT:

- Prescribe an alternative preparation of a Schedule II opioid, unless oral opioids are contraindicated.

  NOTE: The provider must seek preauthorization before prescribing transdermal fentanyl.

- Prescribe benzodiazepines for pain or as muscle relaxers.
- Write more than **two** opioid prescriptions at a time.

  NOTE: If two are indicated, document the justification. Providers may only write **one short-acting** and **one long-acting**.

WHEN THE EMPLOYEE IS IN THE CHRONIC PHASE, PROVIDERS SHOULD:

- Consider ordering any other non-opioid treatment for pain.
- Consider a co-prescription for naloxone if prescribing an opioid.
- Request authorization before prescribing methadone for pain.
- Request authorization before prescribing both an opioid and carisoprodol.

NOTE: *If the employee is already taking a benzo or carisoprodol, the provider **must** first advise the employee of the risks of taking an opioid in combination **and** inform the prescriber of the benzo/carisoprodol of the opioid prescriptions.*

Before prescribing, the provider **must**:

a. Document that non-pharmacological and non-opioid therapies are insufficient to treat pain.

b. Review the employee's history in the CSRS **before prescribing or every 3 months, whichever is more frequent.** Document results and contraindications.

c. Drug Testing Requirement: Complete the steps in Diagram B (see graphic on next page).

d. Administer a validated opioid risk assessment and screening tool if necessary (see graphic on next page).

e. Impose limits on quantity and dosage (see graphic on next page).

DIAGRAM B: REQUIREMENTS IN THE CHRONIC PHASE

A PRESUMPTIVE URINE DRUG TEST (UDT) MUST BE GIVEN AT THE **START** OF THE CHRONIC PHASE, **AND** 2-4 TIMES PER YEAR TO EMPLOYEES IN THE CHRONIC PHASE.

- The carrier/employer may authorize additional tests if requested.
- The 4-test limit without authorization does not apply if the employee is prescribed an opioid for the treatment of substance use disorder (SUD).

Administer a presumptive UDT of the employee and document results; *random and/or unannounced administration is OK.*

ABNORMAL/UNANTICIPATED RESULTS

If the UDT is positive for undisclosed drugs or negative for opioids, the provider must order a confirmatory test. The Provider may...

1. Prescribe a limited supply after completing assessment/ screening tool.

OR

2. Await test results before prescribing additional opioid.

NORMAL/ANTICIPATED RESULTS

If the employee is new to the provider's practice, administer a validated opioid risk assessment and screening tool and document results. Screening tool examples:

- NIDA Quick Screen V1.0 and NIDA-Modified ASSIST V2.0
- Screener & Opioid Assessment for Patients with Pain (SOAPP)

Review and document whether any data from the earlier steps indicate increased risk of opioid-related harm to the employee. *If so, and opioid therapy continues, also document the justification.*

Impose limits on quantity and dose

- Providers must prescribe the fewest days necessary to treat the employee's pain.
- Providers must write for the **lowest effective dosage**, not to exceed 50 MED/day.

EXCEPTION: Providers may write 50-90 MED/day but must document the justification for the higher dosage with a comparison of expected benefits and risks to the employee. *Review and document the effectiveness of the higher dosage at all subsequent visits.*

EXCEPTION: If a dosage exceeding 90 MED/day is necessary, the provider must seek preauthorization from the carrier or employer. If authorized, the provider must review at subsequent evaluations whether the employee experienced the expected benefits and whether to continue at the higher dosage.