HOW DOES THE STOP ACT IMPACT YOU?

PAs in Pain Management Clinics (Effective July 1, 2017)

PAs and NPs practicing in a facility that **primarily engages in the treatment of pain by prescribing narcotics OR advertises in any medium for any time of pain management services** must *personally consult** with their supervising physician prior to issuing a prescription for a **targeted controlled substance** if the prescription will, or is expected to exceed, a period of 30 days. Additionally, if the prescription is continually prescribed to the same patient, the PA or NP must *consult** with their supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient. Work with your employer to understand if your place of employment falls under the above description of facilities that the personal consultation requirement applies to.

Targeted Controlled Substance: Any controlled substance included in G.S. 90-90(1) or (2) and G.S. 90-91(d). *Broadly speaking, this is any Schedule II or III opioid. Please refer to the final page of this document for an exhaustive list of what controlled substances fall under G.S. 90.90(1) or (2) and G.S. 90-91(d).*

*IMPORTANT NOTE: The North Carolina Medical Board (NCMB) is responsible for establishing the rules to enforce this bill. While there are no rules on what qualifies as "personally consulting" and "consulting", the NCMB issued some guidance in a STOP FAQ. They wrote, "The most important consideration is whether a meaningful consultation about the patient and the recommended treatment occurs and is documented in the patient record". The Medical Board is currently working on defining these terms, and during the July 2017 Advanced Practice Provider and Allied Health Committee meeting, staff stated that they plan to consider definitions to these terms at the September 2017 meeting.

Hospice & Palliative Care Providers (Effective July 1, 2017)

Hospice and palliative care providers who prescribe targeted controlled substances administered in home for the purpose of in home palliative or hospice care, must provide written and oral information to the patient and his or her family as to how to properly dispose of the controlled substance. The information shall include the availability of drug drop boxes and "drug take back" events, such as drug disposal boxes and events identified through the North Carolina Operation Medicine Drop.

Opioid Antagonist Prescribing (Effective July 1, 2017)

Practitioners, acting in good faith and exercising reasonable care, may directly or by standing order prescribe an opioid antagonist to any governmental or non-governmental organization for the purpose of distributing the opioid antagonist to a person at risk of experiencing an opiate-related overdose, or a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.

Governmental and non-governmental organizations include:

- Local health departments
- Law enforcement agencies
- An organization that promotes scientifically proven methods of mitigating health risks associated with substance use disorders and other high risk behaviors.

Prescribing Limits (Effective January 1, 2018)

Prohibits a practitioner from prescribing more than a FIVE-DAY supply of any targeted controlled substance upon initial consultation and treatment of a patient for ACUTE PAIN.

Prohibits a practitioner from prescribing more than a SEVEN-DAY supply of any targeted controlled substance for POST-OPERATIVE ACUTE PAIN RELIEF immediately following a surgical procedure.

Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance.

No part of this applies to any prescriptions for targeted controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home, hospital facility, or residential care facility.

Provides immunity from civil liability or disciplinary action from the North Carolina Medical Board for all practitioners acting in accordance with these limitation on prescriptions.

The following definitions apply--

Acute Pain: Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

Chronic Pain: Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

Surgical Procedure: A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

Controlled Substances Reporting System Requirements

Effective July 1, 2017

Allows the Department of Health and Human Services to notify practitioners and the North Carolina Medical Board of prescribing behaviors that increase risk of diversion of controlled substances, increase risk of harm to patient, or is an outlier among other practitioner behavior.

Requires emergency departments and hospital acute care facilities to provide the Department of Health and Human Services with a list of delegations who are authorized to receive data on behalf of providers within the facility.

Effective TBD*

Requires practitioners to review a patient's 12-month history in the CSRS prior to prescribing any targeted controlled substance, and to review the patient's 12-month history every three months thereafter, while the targeted controlled substance remains part of the patient's medical care plan.

All 12-month reviews must be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents a review. If an outage were to occur, the practitioner must review the 12-month history upon restoration of the CSRS.

Does NOT require, but allows for practitioners to review the patient's CSRS history in the following circumstances:

1. The controlled substance is administered to a patient in a health care setting, hospital, nursing home, outpatient dialysis facility, or residential care facility.
2. The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.
3. The controlled substance is prescribed to a patient in hospice care or palliative care.

Requires the Department of Health and Human Services to conduct periodic audits of review of the CSRS by prescribers and report prescribers in violation to the North Carolina Medical Board.

**Effective 30 days after the North Carolina Chief Information Officer notifies the state Revisor of Statutes that the CSRS upgrades described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of SL 2016-94 have been completed and the upgraded CSRS is fully operational and connected to the statewide health information exchange.*

E-Prescribing Mandate (Effective January 1, 2020)

Electronic prescriptions are required for ALL targeted controlled substances unless they meet the following exceptions:

- A practitioner, other than a pharmacist, who dispenses directly to a user
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis facility, or residential care facility
- A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically. Practitioner must document the reason for exception on the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy on federal property. Practitioner must document the reason for exception on the patient's medical record.
- A person licensed to practice veterinary medicine.

TARGETED CONTROLLED SUBSTANCES

Updated 7/21/17 to reflect changes made in SL 2017-115

SCHEDULE II

Any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, unless specifically excepted or unless listed in another schedule:

a. Opium and opiate, or opioid and any salt, compound, derivative, or preparation of opium and opiate, excluding apomorphine, nalbuphine, dextrorphan, naloxone, naltrexone and nalmefene, and their respective salts, but including the following:
    1. Raw opium.
    2. Opium extracts.
    3. Opium fluid extracts.
    4. Powdered opium.
    5. Granulated opium.
    6. Tincture of opium.
    7. Codeine.
    8. Ethylmorphine.
    9. Etorphine hydrochloride.
    10. Any material, compound, mixture, or preparation which contains any quantity of hydrocodone.
    11. Hydromorphone.
    12. Metopon.
    13. Morphine.
    14. Oxycodone.
    15. Oxymorphone.
    16. Thebaine.
    17. Dihydroetorphine.

b. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph 1 of this subdivision, except that these substances shall not include the isoquinoline alkaloids of opium.
c. Opium poppy and poppy straw.
d. Cocaine and any salt, isomer, salts of isomers, compound, derivative, or preparation thereof, or coca leaves and any salt, isomer, salts of isomers, compound, derivative, or preparation of coca leaves, or any salt, isomer, salts of isomers, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocanized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine.
e. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrine alkaloids of the opium poppy).

Any of the following opiates or opioids, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation unless specifically exempted or listed in other schedules:

a. Alfentanil.

b. Alphaprodine.
c. Anileridine.
d. Bezitramide.
e. Carfentanil.
f. Dihydrocodeine.
g. Diphenoxylate.
h. Fentanyl.
i. Isomethadone.
j. Levo-alphacetylmethadol. Some trade or other names: levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM.
k. Levomethorphan.
l. Levorphanol.
m. Metazocine.
n. Methadone.
o. Methadone – Intermediate, 4-cyano-2-dimethylamino-4, 4/ydiphenyl butane.
p. Moramide – Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid.
q. Pethidine.
r. Pethidine – Intermediate – A, 4-cyano-1-methyl-4/y-phenylpiperidine.
s. Pethidine – Intermediate – B, ethyl-4-phenylpiperidine-4-carboxylate.
t. Pethidine – Intermediate – C, 1-methyl-4-phenylpiperidine-4-carboxylic acid.
u. Phenazocine.
v. Piminodine.
w. Racemethorphan. x. Racemorphan.
x. Remifentanil.
y. Sufentanil.
z. Tapentadol.

SCHEDULE III

Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof unless specifically exempted or listed in another schedule:

1. Not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit with an equal or greater quantity of an isoquinoline alkaloid of opium.
2. Not more than 1.80 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
3. Not more than 1.80 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
4. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
5. Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
6. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
7. Buprenorphine.