FAQs: The Strengthen Opioid Misuse Prevention (STOP) Act of 2017

NCMB has received numerous calls and emails from licensees seeking guidance about various provisions of the state’s new opioids law, the STOP Act. NCMB staff cannot definitively state how the Board may ultimately interpret the law. The FAQs below are meant to offer the current informal opinions of the Board staff.

Q: The STOP Act requires that, effective July 1, 2017, PAs and NPs practicing in pain clinics “consult” with their supervisors before prescribing any Schedule II or Schedule III opioid or narcotic. This provision took effect July 1, 2017. How does NCMB define a “consultation” between a physician assistant or nurse practitioner and his or her supervising physician?

A: The Board has not yet determined this. An important consideration is whether a meaningful consultation about the patient and the recommended treatment occurs and is documented in the patient record. The Board might ultimately leave it to the discretion of PAs, NPs and their supervising physicians to determine how consultations occur (e.g. in person, via telephone or other electronic means).

Q: How is “pain clinic” defined in the STOP Act so PAs or NPs know whether they practice in one?

A: The STOP Act defines a pain clinic as “a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.” This definition would not normally include recognized hospice or palliative care practices which may, as a part of their usual practice, provide palliative care for pain. Nor would a family practice that offers pain management as part of a full scope of general internal medicine services.

Q: Effective Jan. 1, 2018, the STOP Act establishes limits on initial prescriptions for acute pain and post-surgical pain to a five day supply and a seven day supply, respectively. Is it permissible for the prescriber to authorize additional pain medication if the patient’s pain persists after the initial prescription is exhausted?

A: Yes, a prescriber may authorize additional pain medications if he or she determines more medication is clinically indicated after the initial supply has been exhausted.

Q: Is it acceptable to issue a new prescription sooner than five or seven days if the patient did not tolerate the initial prescription?
A: Yes, as long as the issuance of the new prescription is consistent with good medical practice and the rationale is documented.

**Q: Is it acceptable to prescribe less than a five or seven-day supply of opioids?**

A: Yes, as long as the decision to prescribe less than a five or seven-day supply is consistent with good medical practice. The *CDC Guideline for Prescribing Opioids for Chronic Pain*, for example, recommends prescribing opioids no more than three days for acute pain and five days for post-surgical pain. The Board recognizes that such guidelines may not meet the needs of all patients.

**Q: Is it appropriate to give the patient, at the time of the initial prescription, an additional prescription for a targeted controlled substance that does not permit the prescription to be filled until seven days after the initial prescription?**

A: No. The STOP Act states “Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance.” (Emphasis added) This language requires the prescriber to decide, based on the circumstances at a later time, whether it is necessary to continue opioid therapy.

**Q: The law states: “Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance.” Do I need to physically see the patient back in the office in order to renew/refill the prescription or to issue a new prescription for a different amount and/or different drug?**

A: No. “Follow up consultation” does not require an in-person visit for the same issue before a refill/renewed prescription or a new prescription may be authorized. The patient can submit a request for a prescription for the same pain via phone or online portal. The patient or patient representative will still need to come to the office to pick up Schedule II prescriptions unless the practice has the capability to e-prescribe controlled substances.

**Q: Does the STOP Act place any limits on how much pain medication may be initially prescribed to a patient for the treatment of chronic pain?**

A: No. The STOP Act limits only initial prescriptions for acute pain and post-surgical pain. There are no limits on the amount of medication that can be prescribed to treat chronic pain in a new or established patient, although any treatment recommended should be consistent with current accepted standards of care. The prescriber would be obligated to comply with the STOP Act provision that calls for a mandatory review of the
patient’s 12-month prescription history with NC CSRS before authorizing any prescription for chronic pain. Periodic CSRS reviews should be conducted every three months after the initial prescription for a Schedule II or Schedule III opioid or narcotic is written, for as long as the patient continues on the medication.

Q: How should the prescriber determine three month intervals for the purpose of periodically reviewing the 12-month NC CSRS prescription history of a patient who is continuing on Schedule II or Schedule III opioids or narcotics? (Mandatory use of NC CSRS will not be in effect until system upgrades are completed – date TBD)

A: NC DHHS will determine this through the NC Controlled Substances Reporting System (NCCSRS), as the STOP Act identifies NC DHHS as the agency that will audit prescribers for compliance with this provision. The most obvious option is to review the 12-month prescription history three months after the initial prescription is written (review of the 12-month history prior to the initial prescription is also required). However the prescriber chooses to calculate the three month period, it seems important that the required review be performed before issuing another prescription for the targeted controlled substance. It might also be beneficial to be consistent and use the same method each time.

Q: How are prescribers going to manage the additional work involved with conducting NC CSRS queries and reviewing results in order to comply with the STOP Act provisions related to mandatory use of the prescription monitoring system?

A: There is no question that complying with mandatory NC CSRS use provisions will create additional work for prescribers and their staff. However, here are some points to keep in mind:

- Provisions related to mandatory registration for and use of NC CSRS do not have a firm effective date, so prescribers will have time to plan and prepare. The provisions will not go into effect until NC DHHS makes technical upgrades to NC CSRS in order to make the system more user-friendly, improve reporting capabilities, provide inter-state connectivity with other Prescription Drug Monitoring Systems, and connect to the statewide health information exchange. Mandatory CSRS registration and use provisions become effective once the State Chief Information Officer confirms the required upgrades to NC CSRS are fully operational within the Department of Information Technology and the system is connected to the statewide health information exchange.
- The STOP Act also includes provisions to streamline the process of registering delegates (nurses, medical office staff) with NC CSRS. Delegates can conduct NC CSRS queries for the prescriber, who can then review the information before the patient visit. This allows the prescribers to share the workload with other members of the health care team.
Q: My hospital/practice EHR has lots of prescribing information regarding patients and is connected to state/national prescribing information. May I check that information in lieu of an NC CSRS query?

A: No. To fulfill the requirement of the law, it is necessary to review the patient’s prescription history with NC CSRS. Additionally, most HER systems have limitations related to availability of information from other systems, access to prescriptions obtained outside of insurance coverage, etc.

Q: Are Ritalin and other medications used to treat Attention Deficit Hyperactivity Disorder (ADHD) considered “targeted controlled substances” and, thus included in the electronic prescribing and mandatory CSRS use provisions of the STOP Act?

A: No. Targeted controlled substances are Schedule II and III opioids and narcotics per the North Carolina Controlled Substances Act, specifically those listed in N.C. Gen. Stat. § 90-90(1), (2) or 90-91(d). Ritalin and other stimulants are listed in N.C. Gen. Stat. § 90-90 (3) and, thus, are not considered targeted controlled substances under the STOP Act.

Suggest additional FAQs

Question not on our list? Suggest additional FAQs by emailing news@ncmedboard.org