CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: STATE MEDICAL BOARD OF OHIO

Regulation/Package Title: Controlled Substance Prescribing-Limits for Prescribing of Opioids for Acute Pain

Rule Number(s): 4731-11-01, 4731-11-02 and New 4731-11-13

Date:

Rule Type:

- **xNew**
- **xAmended**
- ☐ **5-Year Review**
- ☐ **Rescinded**

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

Section 3719.062 of the Revised Code (effective 4-6-17) allows health related licensing boards to adopt rules limiting the amount of an opioid analgesic that may be prescribed pursuant to a single prescription by an individual licensed by the board. The Medical Board is proposing amendments to two existing rules and one new rule.

(1) Rule 4731-11-01:
- Adds definitions for acute pain, morphine equivalent dose, minor, extended-release or long-acting opioid analgesic, opioid analgesic, palliative care and terminal condition.

(2) Rule 4731-11-02
- Adds requirement that physicians and physician assistants must follow Rules 4729-5-30 and 4729-5-13, Ohio Administrative Code. This will include the requirement that prescriptions for controlled substances will need to include the diagnosis.

(3) New Rule 4731-11-13
- Limits prescriptions for opioid analgesics to treat acute pain to no more than a seven-day supply for adults and a five-day supply for minors. If the physician determines that the pain is expected to persist for longer than seven days, the physician may prescribe for a longer period, but the reason for exceeding the limits and for prescribing an opioid analgesic must be documented in the patient's medical record. The prescription is also limited to average daily dose of 30MED (Morphine Equivalent Dose) and provides an exception in limited circumstances.
- Requires that the patient and the parent or guardian of a minor patient is advised of the benefits and risks of the opioid analgesic, including the potential for addiction.
- Allows for exceptions for prescriptions for opioid analgesics used to treat patients receiving hospice or palliative care, cancer and terminal illness, and medication assisted treatment for addiction.

The provisions of these proposed rules will be applicable to physician assistants through Rule 4730-2-07, Ohio Administrative Code, Standards for Prescribing. The other healthcare boards (Board of Nursing and Dental Board) are promulgating rules with the same provisions. The Board of Pharmacy is promulgating rules consistent with these limits.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

The rules are authorized by Sections 3719.062 and 4731.05, Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   The rules do not implement a federal requirement.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   This question is not applicable.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Ohio is experiencing an opioid epidemic that negatively impacts public health resulting in profound consequences to Ohio's economy and way of life. The Governor has directed that the state's professional licensing boards take action by rule to help affect change and improve health outcomes. The public purpose for the rule package is to reduce the frequency and amount of opioids prescribed for acute pain, while preserving the ability for providers to prescribe beyond limits specified in the rule when clinically appropriate and with proper documentation. The rule package also seeks to significantly limit the amount of unused opioids that are available for diversion.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

Outcomes reflecting the impact of the limits on opioid prescribing resulting in benefits for public safety will be measured by OARRS data, public health and law enforcement statistics. The success of the regulations will also be measured by having rules written in plain language, licensee compliance with the rules, and minimal questions from licensees, medical practices and medical facilities regarding the provisions of the rule.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   Governor Kasich and his Governor's Cabinet Opiate Action Team (GCOAT) were instrumental in reviewing state and federal standards and OARRS trends that

indicated now is the right time to move forward in collaboration with government and public stakeholders to establish certain standards for opioid use in the treatment of acute pain. Directors and staff from the Board of Nursing, Dental Board, Board of Pharmacy and State Medical Board have all met to discuss the need for consistent standards of practice reflective of a common goal to reduce the frequency and amount of opioids prescribed for acute pain, while preserving the ability for providers to prescribe beyond limits specified in the rule when clinically appropriate and with proper documentation.

The draft rules were discussed at the Medical Board's Policy Committee meeting on April 12, 2017. This meeting is open to the public. The draft rules were provided to the Physician Assistant Policy Committee and discussed at the May 9, 2017 meeting, which is also open to the public.

On April 13, 2017, the rules were circulated to the Medical Board's prescriber licensees (allopathic, osteopathic and podiatric physicians and physician assistants) via an e-news blast. The rules were placed on the Board's website and were circulated to associations and other interested parties via e-mail.

The public and interested parties had the opportunity to comment on the enclosed draft rules from April 13, 2017 through the close of business on April 28, 2017. The State Medical Board received 189 comments on the draft rules through email and the website.

On May 10, 2017, the draft rules, comments received and suggested amendments to the draft rules were discussed with the Medical Board's Policy Committee and the full Board. Both meetings were open to the public.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

The Medical Board received 189 comments from interested parties, including physicians and associations. A spreadsheet outlining the comments is attached. A summary of the comments is set forth below. Please note that the numbers are approximate and that some responses contained comments in more than one category. Twenty-nine comments were generally supportive of the rules, with no suggested changes.

1. Thirty-five comments were generally not in favor of the rules, but provided no specific recommendations for changes.
2. One hundred and six comments raised concerns that the prescribing limits (5-7days or 30MED) were too restrictive for certain procedures or conditions. (Post-surgery, post-fracture and post-trauma were the most often cited examples).
3. Twenty-seven comments raised privacy or technical concerns regarding the inclusion of diagnosis codes on the prescriptions for controlled substances.

4. Five comments raised concerns that documentation requirements were overly burdensome.
5. Six comments raised concerns that non-opioid pain relief, including NSAIDs are not appropriate for certain patient populations.
6. Four comments raised concerns with having a prescription limit or consent process that was different for minors.
7. One comment raised concerns that the exception language for allergy will allow diversion.
8. One comment raised concerns that the exception for cancer pain should be amended to except only those patients with active cancer pain.

Many of the comments received on this issue address the concern that patients may require doses higher than a 30MED average to adequately address pain following orthopedic surgery, burns, amputations, or another serious trauma. Based on the comments, the Medical Board approved amendments to 4731-11-13, OAC, that allows for some limited circumstances in which the physician may exceed the 30MED average daily dose.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The rules were developed through input from physicians and professionals at the Department of Mental Health and Addiction Services, Department of Medicaid, the State Medical Board's Policy Committee, the Ohio Board of Nursing, the Ohio Dental Board and the Ohio Board of Pharmacy. The Acute Guidelines developed by GCOAT in 2016 and OARRS data were relied upon as foundational sources for the rules in this package, including the day dose limits and the corresponding 30 MED limits. OARRS data suggests that the state could see an estimated reduction of 109 million opiate doses once the new rules are in effect.

In addition to Ohio, the following states have proposed or finalized legislation, regulations or executive orders limiting opioid prescriptions:

Arizona, Connecticut, Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

Senate Bill 892, limiting opioid prescriptions for the initial treatment of acute pain to a 7-day supply or the limit established under state law, was recently introduced in the U.S. Senate.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    The Board assisted the Governor and GCOAT in Ohio's collaborative efforts to curb use of opioids unless medically necessary. Ohio has authored several written guidelines in its efforts to assist prescribing licensees, the public and other stakeholders change practice patterns that result in increased risk of opioid abuse. Considering the continuing opioid epidemic and public protection concerns and to further consistency in prescribing practices, and the common direction of the other healthcare licensing boards in this focused effort, the Board did not consider further regulatory alternatives.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    The Board did not propose performance-based regulations in this rule package due to the necessity of setting established processes and standards to achieve its public protection mandate.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The Medical Board coordinated the rule amendments to reflect requirements for controlled substance prescriptions in rules promulgated by the Board of Pharmacy, and in coordination with the Governor, stakeholder Cabinet agencies, and other healthcare licensing agencies.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

The rules will be posted on the Medical Board's website, information concerning the rules will be included in informational materials e-mailed to licensees, and notices will be sent to associations, individuals, and groups. Medical Board staff members are available by telephone and e-mail to answer questions. Medical Board staff members also give presentations to groups and associations who seek an update on physician practice regulations.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The scope of the impacted business community would be licensees of the Medical Board who are authorized to prescribe controlled substances, including opioids. This includes physicians holding a M.D., D.O., or D.P.M. license and physician assistants who are authorized to prescribe.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Prescribers who prescribe opioids for acute pain will need to be aware of the limits and may need to more frequently see the patients receiving these prescriptions. In addition, prescribers will need to add a diagnosis code to the prescription and will need to provide more documentation if the five or seven day and 30 MED limits are exceeded. Physicians and physician assistants who are found to have violated these rules could be subject to a disciplinary action, which could include a monetary fine.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

Individuals who receive formal disciplinary action for violating these rules will be subject to civil penalties as set forth in 4731.225, Ohio Revised Code.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Ohio is in the midst of a serious opioid epidemic. In CY 2014, 2,482 Ohio residents died from unintentional drug overdoses. Based on law enforcement drug seizures, Ohio has seen a major increase in drug reports involving fentanyl, a more lethal opiate, more than 30-50 times more potent than heroin. Key to reversing this trend is reducing the abuse and diversion of opiate prescriptions. Many individuals who are addicted to opioids received their first pill through a prescription opioid, either from a valid prescription or diverted from a friend or family member. The state is interested in limiting the number of opioid analgesics that are available and placing the limits on the prescribing of opioids for acute pain will help to limit the number of opioids available for diversion and improper use. Research also shows that the majority of acute pain issues resolve in 5-7 days. The State has a compelling interest in promoting safe treatment of acute pain while avoiding risks associated with the diversion, theft of opioids.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Treatment of patients with opioids is a complex matter which impacts the health and safety of patients. The public safety requirements relevant to these rules require consistency in their application to all licensees and are not amenable to exemptions or alternative means of compliance for small businesses.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Due process requires the Medical Board to consistently apply its rules regarding controlled substance prescribing such that all prescriber licensees are equally treated.

18. **What resources are available to assist small businesses with compliance of the regulation?**

Medical board staff members are available by telephone and e-mail to answer questions. Personnel from the Nursing Board, Dental Board and Board of Pharmacy will also be available to provide information to their affected licensees.

Name	Email	Organization	Comments	Attachments
John Doe	jondoe@yahoo.com	Medical Board	here is what they said in the email	pdf or Word document (link)
Charles Whitaker, MD	Cfw43@aol.com		Cross-coverage should recognize that physician cross-cover physicians in bordering states	
Minnie Goddard, MD	Minerva734@msn.com		Questions 30 MED when have conditions such as end stage renal disease or severe GI side effects from NSAIDs	
Edward Miller, MD	nosoupforuoneyr@aol.com		So we let the Pharmacy Board dictate what MD and DO's do. Is this political about just decreasing scripts or addressing the options/heroin problem. As I'd argue the heroin problem is worse.	
Nora Singer, MD	ngs@case.edu		I suggest serious radiographic damage from arthritis and arthritis related disease should qualify as a condition that is a non-cancer exception to the one week rule for narcotics	
Anas Riehani, MD	Anas.Riehani@hc.msu.edu		Fully agree with the proposed rules	
Peter Barre, MD	mailto:pbarre@PremierHealth.com		7 days of narcotics for acute pain is too short. I am inclined to say 4 weeks of narcotics for acute orthopaedic problems is appropriate. The State Board needs to allow clinicians to use their judgement to treat acute pain, particularly in specialities such as mine, orthopedic surgery. Orthopedic injuries and orthopedic surgical procedures cause severe musculoskeletal pain and despite the use of non-opiod and multimodal techniques, most human beings require some level of opiods to control their pain in the post operative or post injury period. This period is not usually limited to the seven days proposed in this rule, and these new regulations are not only going to cause an undue burden to patients access to medications and care, but represent a philosophical over-reach by a regulatory agency.	
Kumar Amin,MD	mailto:kamin@trinityhealth.com		While a one week supply of opioids post hospital discharge might be sufficient for most surgical procedures, it is unlikely to be sufficient for thoracotomy and thoracoabdominal procedures. Failure to adequately control the pain associated with such procedures in the early post hospital discharge period may result in increased respiratory complications and contribute to poor patient outcomes. In addition, studies have shown that poor pain control in the early postoperative period is associated with pain sensitization and chronic pain that could translate into future narcotic tolerance and addiction.	
Faisal Bakeen, MD	BAKAEEF@ccf.org		I work full-time as a corrections physician for the state of Ohio. Thank you for creating sensible rules to curb the use of narcotics. I care for literally hundreds of inmates who provide a similar story- "It all started with what seemed to be innocuous pain meds and all paths led to heroin and a felony addiction."	
Matthew Chase MD	mchasemd@gmail.com	Madison Correctional, London, OH		
Dana Houser, MD, MHSA, CISSN	dhouser@mchs.com	Big Run Internal Medicine, Mount Carmet Medical Group	no explicit mention of CHRONIC pain; Reply from Sallie: Proposed rules not applicable to chronic pain	
Souhaila Solaiman, MD	souhaila.solaiman@yahoo.com		I suggest to limit the duration of treatment for acute pain for adults to 3days and for children to 1 day. Pain persisting beyond that is no longer acute, and the prescriber needs to consider long term strategies. To make exceptions is paving the way for addiction and would create pressure on prescribers to provide immediate pain relief.	
Neetu Radhakrishnan,	radhaknu@UCMAIL.UC.EDU	University of Cincinnati	I am writing to ask the board to consider changing the definition of cancer related pain to 'active cancer related pain' to better define the reasons for continued narcotic precribing.	
Richard Frankhouser	rfankhauser@mchs.com		a 7 day opioid prescription limit (presumably arbitrary and not evidence based) will create a hardship for my patients who have had major reconstructive surgery or have acute fractures, both of which, in my 35+ years of experience, usually require opioid analgesia for significantly more than 7 days.	
Steven Eby, MD	Stephen_Eby@trihealth.com		My comment is that I find it sad, and more than a little frightening that the solution to inappropriate prescribing is coming as legislation.	
Charlotte Wagamon	cwagamon@hotmail.com		The new opiate rules seem way too restrictive. The majority of physicians use caution and judgement when prescribing narcotics. These rules are like a teacher punishing the whole class for a few bad students. You have prescribing information and can selectively pursue those physicians who are overprescribing without having to make all of us suffer.	
Charles Russel, MD	chuck1737@gmail.com		As an Addiction Medicine and Emergency Medicine boarded physician, I am very concerned about the 30 MED, as it doesn't allow for the chronic pain patient who suffers an acute injury or acutely painful condition to be managed appropriately. Such a patient may already be on a MED that is at or above 30 prior to an acute injury.....perhaps the rule should say, "or an average increase of 30 MED above the patients baseline if on opiate therapy chronically....."	

Katherine Hewitt, MD	craw10s1@netscape.net		There needs to be more flexibility in some fashion for post op pain prescribing beyond 7 days!!!!!On the other hand the ongoing unlimited prescribing of opioids while in a "treatment program" needs to be severely limited
Linda Cabral, PA	lindacabral@sbcglobal.net		I think the proposed rule is too strict. There should be more discretion given to the clinicians to decide the appropriate treatment.
Kristine Kunesh-Part, MD	kkpart@icloud.com		this is totally inadequate for a substantial number of post- operative patients. I see that this can be prescribed by adding extra documentation, But as a surgeon I am already overburdened by documentation - the tendency will now become to under treat pain as it will be such a burden to prescribe for pain adequately post op.I feel 3- 4 weeks is much more reasonable as that is commonly when patients return to see their surgeon
Frederick Klippert, MD	FKLIPPER@augusta.edu		I concur with the changes recommended.
Kevin Sneider, MD	ksneider@cros.net		Requiring us to report the diagnosis is ridiculous. 2. It is great that narcotic prescriptions have decreased, but part of the reason for this is that doctors are no longer writing the scripts, EVEN on patients that NEED the medications and in appropriate situations because the physicians no longer want to jump through all the hoops. Therefore, the patients that SHOULD be getting these drugs ARE NOT, because of bureaucracy.3Diagnosis reporting is just another situation where Big Brother is accumulating data at the expense of physicians/honest businessment (trying to make a living and pay the bills) without reimbursing us for our time and effort
Edward S. Umlauf, D.O.	hbarfarkle@gmail.com	Genesis Hospital	As a physician for 28 years and a Hospitalist, I am delighted to see the action taken by the Board on opiate prescribing. I must say it is many years overdue. I have long been of the opinion that many of the problems with scheduled drug abuse and addiction has stemmed from physicians “taking the easy way out”, in dealing with pain and that a large portion of the chronic pain being treated is not treating pain, but rather treating withdrawal symptoms. I also believe we need tighter controls on Pain Clinics due to the high number of addicted patients I see in the hospital with drug-seeking behavior who have been receiving long-term opiate prescriptions from pain clinics.
Ronald Rasor, MD	ronald.rasor.2.ctr@us.af.mil		Is this really necessary? What happened to the government that governs the best governs the least? Are you working on laws to tell beautic Is this really necessary? What happened to the government that governs the best governs the least? Are you working on laws to tell beauticians not to burn hair, and to maintain records of all patients who have had curling irons used on them? I would think those working in the congress of Ohio have better things to do with the people's money than keep lawyers employed writing this stuffians not to burn hair, and to maintain records of all patients who have had curling irons used on them? I would think those working in the congress of Ohio have better things to do with the people's money than keep lawyers employed writing this stuff.
John Arnold, MD	mailto:n148km@gmail.com]		I don't see the medical evidence or anecdotal common sense that even begins to support the "three days is enough" statement advanced in this proposed rule. Clearly the pendulum needed to swing towards conservatism, away from the nonsense directives and incentives of HCAPHS-based patient satisfaction related to whether or not their provider fed their addiction. However, 3 days, post op, is not realistic. physicians. Instead, stop the hospital administrations and the federal government policies (JAHCO, CMS, etc.) from promoting and pushing the doctors into prescribing opiates. In addition, make policies stronger that promotes high-quality physicians and to eliminate low quality practicing physicians. Lastly, stop replacing physicians with mid-level providers, they are less trained and they are becoming
Jay Bernstein, MD	mailto:jarmymed@gmail.com		more and more autonomous and this is lowering the quality of the practice. I find it all the mid-level providers prescribe more opiates (and more inappropriately) than the physicians.
AnneMario?	: annemario@earthlink.net		Get out of our profession. Get all of the foreign physicians out as well as these atrocities called nurse practitioners and PA's. We are physicians, not providers or health care professionals! WE WANT OUR PROFESSION BACK AND GOVERNMENT INTRUSION out!!!!! We were once the best in the world almost 100 years ago and you are what happened. I can't even get a hard copy of my license for my money and what is that about. I need an unconstitutional drivers license to drive but God forbid I have one to show that I am a physician!
steven Hayden,MD	HAYDENS@ccf.org		I recommend that the board of medicine continue to press physicians especially in emergency rooms and urgent care centers to have systems in place to limit the prescription of opiates for acute pain and to help standardize the systems across as wide a range of facilities as possible.
Jerry Smidebush, MD	gsmidebush@gmail.com		I am in agreement with the proposed changes.
Susan Colburn, MD	mailto:paradox45701@aol.com		Doctors went to medical school and should be allowed their judgement. You are restricting the practice of medicine to much
John Schoettmer, MD	mailto:f16docshot@hotmail.com		These are fine as guidelines, but would be horrible as law. As usual, you cannot make a law that will apply in every case and I can think of many exceptions to these rules. You are going to give doctors the choice of providing poor patient care vs being a criminal and losing their medical license. At the very least you will just be adding a pile of documentation requirements that accomplish nothing except making our jobs harder.
Yadwinder Singh, MD	yadimd1@gmail.com		Please consider opioids prescription for skilled nursing facilities, Long term care and Assisted Livings . These patients are in controlled settings . They have osteoporotic compression fractures, Spinal stenosis, Advanced kidney disease . And are not good candidates for surgery or interventional therapies We should check Oarrs report in them . They have chronic non cancer and non hospice musculoskeletal pain
Stephen Choflet, MD	schoflet@hvhs.org		This is absolutely ridiculous how far the pendulum has swung on pain management. To say that you should not prescribe narcotics for more than a certain amount of time, obviously has never has an episode of severe acutely pain. Is it possible to leave any discretion to the physicians?
Andew Reid, MD	reidca@aol.com	Findlay Ear, Nose and Throat	the tonsillectomy (and UPPP) in adults is still a very painful operation that requires pain control to maintain fluid intake to avoid dehydration and ER visits for that problem.

Anthony Cavalieri, MD	Anthony.Cavalieri@cchmc.org		I would suggest making it clear instead of "scheduled" medicines, that opiates is put in place. As a prescriber for children with ADHD, the amount of extra monitoring makes no sense as these medications are lumped with opiates.
William Drew, mD	ahradllc@gmail.com		Why accept the use of opioid analgesia as first line treatment? With the risks and dangers we have seen resulting from prescribing these high power drugs with high potential for addiction, even with very few doses, why not require the use of non opioid analgesia as primary treatment? Then require explaination from those not following those rules.
Scott Weiner, MD	WeinerSD@summahealth.org	Summa Health Orthopedic	always having a 7 day limit but make the process for giving the patient an additional script easier. Currently the patient or family needs to physically come to a site to get a script. Many of my orthopaedic oncology patients live quite a distance away so that is a major inconvenience. Often, we will have the local PCP write a script but that doesn't sound like a good option with the new rule for the PCP. If there is an electronic way to send additional limited opioid for these special cases would be appreciated. I don't think narcotics for non-surgical pain should be greater than 5 days for anyone. If the emergency room gives a 7 day script, will the doctor be able to do an additional script in the office? What type of documentation for additional drugs is not clear. Will it be a simple dot phrase or more? I also think we as a society cater to addicts but that is another topic. There should be more access to 'comprehensive pain management
Karl Ulicny, MD	karlulicny@gmail.com		While I applaud the efforts being undertaken here, and agree that too liberal dispensing has caused the current opioid epidemic, I caution about two things.First, there is no provision in the language for patients undergoing major surgery, such as in my case Cardiac Surgery. Why we are providing such medication and quantities exceeding three days, typically 80 Percocet upon discharge 4 to 6 days post-procedure, is self-evident. The requirement to document places yet another burden upon the physician already overburdened with documentation, and risks penalty if our NP's or PA's fail to do so.Secondly, this attempt to crack down on over-prescribing will undoubtedly lead to an overreaction by prescribers. We have already seen this in Northern Kentucky. Unfortunately, this has led to an explosion in Heroin usage which is now more accessible and cheaper and which frankly has cost more in lives and dollars than prescription narcotics.
Eric Fryxell, MD	eefryxell@hotmail.com		They look fine, mostly common sense good practice.
Reginald Reginella, MD.	rlreginella@yahoo.com		As an emergency medicine physician we see the affects of opiate abuse. The bottom line is addicts are going to get their drugs wherever and whenever they need and want. These new rules running rampant across our Country are nothing more than reactionary rulings rather than proactive measures.Most physicians are good stewards of opiates. Go after the drug mill doctors. You can find these docs in 2 minutes by running a prescription report. Shut them down and you "doctor" problem goes away.This is not a doctor problem. This is an addict problem. Just as an addict or more importantly a recovering addict. They only care about the drug.
Jim Klosterman, MD	jklost@aol.com		As an orthopedic surgeon, it is typical to write narcotics for post operative pain management. Example: After total knee replacement, narcotics are typical for the 90 day global. We see patients at 30 days post op, and again at 3 months. The new rules will require seeing these patients weekly (not logistically possible)
Judith Varnau, MD	drvarnau@bcwh.org		For post-op pain meds for major surgery. This should be included in the Hospice, addiction therapy. Allow at least 30 days for major surgery and then longer if documented in the medical record.
Matthew Kauffman, MD	drmjk73@hotmail.com		management or both? What are our options if the patient cannot take NSAIDS to assist in acute pain management and the 30 MED is not sufficient to manage the post operative pain? Our options get limited quickly when insurance covers limited medications (example would be Lidoderm patches which help postoperative pain but is only indicated for Herpes Zoster) other than Opiods and NSAIDS.I do think that the definition of acute pain needs to be more clearly defined. Also, management of chronic pain for non cancer patients are not defined. Can we please clarify this matter further.
Carrie Sanan, MD	carriesanan@gmail.com		I suggest that the requirement to educate and notify and explicitly document talking about the addictive potential of the opiate medication with the parents of minors medication is misguided. in some cases it is appropriate for the docs to do this, but in many cases, the way in which it is done can leave the minor with supoptimal pain control while their parent denies them their meds for fear of getting them addicted. allowing the physician to judge what to say is part of the responsible practice of medicine and anything else is micromanagement of physician practice and will be to the detriment of patient care. also would undoubtedly add unnecessary burden of documentation to the physician.
Melanie Carlson, MD	Melanie.Carlson@UHhospitals.org		expected of us with regards to what conditions apply and don't apply.#2. I think nursing home patients should be excluded and rehab patients (There is NO way we can limit hip surgery patients to 7 d of narcotics). #3. I think tramadol should be removed from the list. The Board is contradicting itself. The schedule IV classification states" of low abuse potential" so why include this medication ? It is a very useful low abuse potential medication, especially helpful in patients that can't take NSAIDS.#4. There is no verbiage on chronic pain included in this legislation, how do they fit into this? How do we document, determine chronic versus acute, again referencing #1 .#5. Some of the wording states the first prescription, does that mean if they are still in pain and we think it is necessary that they need more meds we can then prescribe again?
Nancy Flickinger, MD	nflickinger@summahealth.org		I am concerned that we use EPIC for prescribing and there is little allowance to add the dx to the script. The system we use Is not open to adjustments. We are hostages of the EMR system that we use. We have basically eliminated paper scripts.
Wendy Melick, Practice Administrator	wmelick@wpiobgyn.com		I am concerned with the fact it appears a patient could easily tell their provider they had an allergic reaction and be given a different form of opioid (or multiple forms if they have a reaction to more than one prescription) for up to an additional 7 days trusting the individual will dispose of the prior prescription with education on how to do so.
Anthony Krebs, MD	adkrebs@yahoo.com		For the third rule (4731-11-13), education on possible addiction would be more suited to be accomplished at the point where the prescription is dispensed.
Rae Bunyak, PA	Rae.Bunyak@osumc.edu		This does not take into consideration post- operative patients and the need for pain control.

Jim Bean, MD	entjwb@aol.com		I'm wondering why the physician risks criminal charges by your rules and if I remember right, the Pharmacy Board rules states the pharmacist who fills the prescription is blameless. I have had patients on Suboxone undergo surgery. The surgeon wrote prescription for opiate. A relative took the prescriptions given to the same pharmacy where the patient had Suboxone filled and they filled the opiate. To me that is totally wrong. I was told that was only the surgeon who was responsible. The patient brought the medication to me and we witnessed the destruction of the medication.
Todd Mages, MD	drmages@yahoo.com		I support it.
Mark Swift, MD	mailto:doctorx@zoominternet.net]	Trumbel Memorial Hospital, ED	I am all for this and even tougher parameters. We had a reported 179 ODs in Trumbull county alone with 26 deaths in March of 2017. April has been just as bad. I am on the front lines and anything to help is appreciated especially when we are dealing with these patient populations who are allergic to NSAIDS. Also I wish attending physicians would not sent their patients to the ED for pain management. This in and of itself is a real problem to say the least.
David Joffe, MD	drcdave@yahoo.com		Agree. Appropriate.
Michael Finamore, MD	:michaelfinamore12@gmail.com		I am a cardiothoracic anesthesiologist.There is data out there suggesting the use of methadone in cardiac surgery actually decreases post operative narcotic usage. The language of not using long acting opioids for acute pain contradicts this special scenario. I am also in the process of trying to see if that initial study by Murphy works in the community hospital setting I currently work out. The study may also demonstrate a similar effect to other types of surgeries particularly longer duration back surgeries.I would personally make an exemption for intraoperative opioid use. I cannot comment in other fields of practice, but regarding surgical patients I believe long acting opioids certainly can reduce opioid consumption.
Daniel Cain, DO	drcain.online@gmail.com		While it is understandable that something must be done to correct the narcotic-addiction problem in our nation, the place to begin is not to make it harder for acute-pain patients to be adequately treated. To limit patients to a predetermined number of pain medications in the immediate post-operative period is not "almost" absurd -- it is ludicrous. To use a counter argument that all the surgeon needs to do is jump through more paperwork hoops is just as ludicrous.
Gary Oliver, MD	sfdermpath@gmail.com		1. The people making these decisions should only be physicians that have at least several years experience in pain management and addiction management. 2. Bureaucrats, people with any agenda (such as saving money, making money for a company etc. should be excluded) and people who are not unbiased experts should be excluded in the decision process.3. In general it is widely known that there are far too many agenda driven government rules for physicians that are destroying health care.
Thomas Gibbs, DO	DrTomGibbs@questrs.org	CommQuest Services, Inc. , Community Services of Stark County , Quest Recovery and Prevention Services	This all looks good to me
Robert Gill, MD	mailto:rgill@JTDMH.org	Auglaize/Mercer County Drug Coalition	I agree with your proposal. However if your proposal does not include “Medical Marijuana” you are being hypocritical in your endeavor.
Roxanne Cech, MD	cech@ohio.edu		I am at the university practice where we have been actively weaning people down off their opiates, but not all are stopped. My comment pertaining to the rule is that these individuals might need longer than 7 days and might already be on a higher than 30meq dose before having surgery. Recently one of my patients had pilonidal cyst surgery and needed a full 2 weeks of increasing his short acting opiate. Please consider the idea of Increasing the current dose by 30 meq a day and a longer time period for those already on chronic medication.
David Fedders, MD	dfedders@zoomtown.com		The proposed amendments are too restrictive of doctors. The policy has a cookie cutter quality. This will restrict appropriate treatment for those who might be outliers. This is exactly the flexibility that the practice of medicine needs for creative treatment. Restriction of supply of drugs, is too global an approach. It would be better to regulate the offending prescribers in a more focused manner, rather than a one size fits all. There will be losses of healing capacity with this. Other “enablers” like the drug companies might be let off the hook, and the medical profession might be scapegoated because of its honesty.More appropriate approaches to the demand might be better pain management, more access to more appropriate substance abuse treatment, better access to and better effectiveness of mental health treatment, vocational rehabilitation, educational rehabilitation, increases in physical therapy insurance coverage, prison reform which would include in house drug treatment with better preparation for success upon release, better health care coverage in general with less of a co-pay, and regulation of the pharmaceutical industry's ability to charge prices which have little relationship to costs.
Paul Conover, mD	pconover@sbcglobal.ne		As a practicing colorectal surgeon in Ohio I think this ruling would be a great disservice to patients and their families. I can tell you from sad experience over the past 20 years that five days of analgesics is not enough for patients recovering from anorectal procedures such as hemorrhoidectomy, sphincteroplasty or fistulotomy. [illegible] system. This recent barrage of negative news insinuating physicians as the cause for addiction and deaths with our citizens is casting stones on the wrong individual. This is a typical political ploy done by our government to make the public feel that they care and are doing something to protect citizens. I do not recall one patient of mine who has turned to heroin or became a dealer on the street. This law, as written, could be interpreted in such a way as to be injurious to a physician unjustly. Take the General Provisions, section B. A physician cannot control all possibilities once a patient leaves his office. A gun dealer cannot predict the use of a gun once purchased legally. To use this law as justification for the current opioid problem is like putting a band aid on a leaking hoover dam !!! Pills, amphetamines, heroin, fentanyl are supplied by drug dealers within the country and Mexican cartels. You are always going to have 15 % of the population addicted or dependent on something. There are always bad eggs in every profession, but we already have record keeping at pharmacies and doctor offices in place. Thank you for your email. Please feel free to forward this to our governor. In conclusion, this bill is poorly thought out and not needed in view of our present pharmaceutical record keeping system.
Craig Harris, MD	giharr@yahoo.com		I think ED physicians should be excluded from writing a diagnosis on the prescription. ED physicians should also be limited to only a 3 day supply for both minor and adult patients. Patients should be able to follow up with their family physician in that time frame if opioid analgesics are still needed.
Chontelle Degler, DO	cjmmwu@gmail.com		

Rosalind J. Batley MD	Rosalind.Batley@nationwidechildrens.org		I am concerned about legislating medical treatment. I fear that the Congress and appointed officials , who know nothing about medicine and make decisions based upon lobbyists opinions, will decide what is appropriate treatment in multiple situations.
Robert Cromley, MD	mailto:robertcromley@hotmail.com		these are the guidelines physicians should have been following all along.
Linda Bond, MD	Linda.Bond@va.gov	Cleveland VA	Limits should be 10 days for both children and adults in keeping realistically with clinical practice.
Suzanne Marques, PharmD	smarques@mercy.com	St. Rita's Hospital	I am a pharmacist practicing in a hospital. We frequently see trauma and surgical patients who require more than 30 MED/day of opioid pain medication. I am all in favor of ensuring patients do not receive more narcotic than they need, however, this amount of narcotic may not be sufficient for all patients (eg; Percocet 5/325 2 tabs q4h prn exceeds the MED as listed). According to the proposed rule, it appears that the Rx can be written for a longer duration, but not a higher amount. If this is not the case, then I believe the wording should be modified. In addition, providing a diagnosis and reason for the qty/length of therapy should be added to the medical record for all patients and should mitigate some of the concerns over excessive prscribing. I am concerned that with severely restricting opioids in this manner, we will be doing harm to some of our patients by not adequately relieving their acute pain, especially in surgical patients.
Theodore Parran, MD	tvp@case.edu		First, change "education of" to "education on." Shouldn't in the exclusions it say that this does not apply to the management of chronic pain also? Third, A3c is confusing - and concerning if I am reading it right. Does it mean that NEVER can more than 30 MS equivalents/day be prescribed for acute pain? That means that patients sent home with acute sickle cell crisis pain on Dilaudid can not have more than 4-6 mg total in a 24 hour period. Or more than 20 mg Oxycodone in a 24 hour period. Even if they have had such pain before and have some experience with and tolerance to opioids. I think that 30 Mg EQ MS is too low ... 50 probably OK .
Mark Hurst, MD		ODMHAS	They are quite well-written and I appreciate it.
Steven Shell, DO	sandyfoot@comcast.net		The proposed changes fail to address the fundamental driving force of the problem: demand. You are attempting to limit the supply side of the issue by controlling how doctor's practice medicine. Not only is that insulting to physicians, it allows non-medical bureaucrats to decide how best to treat the patient.Focus more on the demand side and less on the supply side.
Will Sawyer, MD	dr.will@henrythehand.com		For acute trauma it can be difficult to predict the length of time a patient needs "pain relief" for sleeping and functioning in ADLs. Particularly those older than 50y.o. Because NSAIDs can be a problem in the elderly. And they may only take the med bid not q4h. And the generally resist coming back in 7 days. I am little concerned about providing Dx to the pharmacies and confidentiallity issues. What is the purpose of the Dx on the script??
Stan Stoler, MD	mailto:shstoler@gmail.com		I highly commend the Ohio State Medical Board for taking this action which hopefully will pass
Mark Komar, MD	komarmd@sbcglobal.net		There should be none of these rules good physicians should be allowed to practice medicine the state board should identify the small number of outliers and discipline the outliers
Joel Salon, DDS, MD	ddsmd2@sbcglobal.net		I am an oral surgeon with a dental and medical license. My only concern regarding the proposed rules deals with the definition of a minor. For some of my procedures my teenage patients need adult doses of pain medication and 5 days will not be enough. They need 7 days of medication.I believe you need to define minor
Daniel Beaver, MD	mailto:administrator@imnorocketsurgeon.com]		There is no differentiation of in-patient vs. out-patient use. Therefore one can assume that premature newborns in the Newborn Intensive Care Units: are at risk for addiction, should have their parents counselled for the same, and have a higher risk for addiction (5 days treatment vs. 7 days for adults).
Michael Huges, MD	hughesm@summahealth.org		I do have one comment Rule 4731-11-01 Section C-2. I believe should specify if a phone consultation is considered an “interaction” or is a face to face encounter required.
Shelli Powell, MD	shelli.powell.md@gmail.com		I am an orthopedic trauma surgeon and have concerns that the proposed rules will cause significant pain management issues with multiple trauma orthopedic patients. Their injuries frequently require longer than one month periods of opioids and I think they should be one of the "exceptions" listed.
Amy Richardson, MD	amyrichar@gmail.com		Well Done! Congratulations. Please enforce these rules strictly.
Daniel Raymond, MD	RAYMOND3@ccf.org		I am a thoracic surgeon managing patients after challenging and painful chest operations. The implications for pain control are rather severe in our specialty as pain control is related to coughing effectiveness, pulmonary hygiene and prevention of pneumonia. Patients undergoing thoracotomy for lung cancer, for instance, frequently require several weeks of narcotic pain medication. Secondly, non-narcotic pain medicines receive a lot of positive press, however, they typically are not potent enough for post-surgical pain. a very realistic means to limit the amount of narcotic released upon the street would be to allow patients to receive small volume prescriptions with limited refills. In patients with severe postop pain, a combination of extended release and immediate release meds is often the most effective means of pain control. It would be prefereable to see these restrictions encourage the use of Pain Specialists and Addiction Specialists for patients with challenging pain control problems and increase funding for those Specialties.
John Rees, MD	mailto:k100rt@aol.com		I AGREE WITH THE PROPOSED RULE CHANGES

Jeffrey Pruitt, MD	JAPruitt@mercy.com	Why 7 days? What is magic about this time period?
P. Kesav, MD	mailto:pkesav@hotmail.com	I think these rules are counter productive and promote illegal drug trafficking.
Robert Segraves, MD	rsegraves3@hotmail.com	At this point is there any evidence that Ohio physicians are still overprescribing opiates? Probably all this will accomplish is to make it harder for individuals in severe pain (ie after orthopedic surgery) to obtain necessary medication to benefit from rehabilitation therapy. 2nd comments: restricting opiate prescriptions has already driven many ohio citizens to heroin and their deaths because heroin is unregulated and laced with fentanyl
Ashish Rungta, MD	ashtme@gmail.com	All 3 changes seem very reasonable
Magdelina Kerschner, MD	drk@apsiwellness.com	I am in total agreement with the new rules for treatment of acute pain. Limit of seven days and limit of MED of 30 is great.
John Kean, MD	John.Kean@nationwidechildrens.org	Opioids have been long over prescribed, especially in children. They rarely need more than Tylenol for pain for anything. It's a shame sensible prescribing needs to be legislated. Even worse, these rules won't lower the death rate from narcotics in Ohio.
Milton Sanchez-Parodi, MD	:msanchezparodi@yahoo.com	Consider the proposed changes beneficial for all and Agree with the Proposed changes 4731-11-1, 2 and 13
fred Broniak, DO	fbroniak@aol.com	As a practicing, board certified Emergency Physician licensed in Michigan, Ohio, and Florida, I view with concern the trend for central governmental authorities to supplant their judgement for the judgement of the physician actually attending to the patient.
Stephen Carp, MD	mailto:info@carpcosmetic.com	As a surgeon, the implementation of rule 4731-11-13 would place undue burden on the surgeon and patient. Many procedures require more the 7 days of pain management. The need to document repeatedly will not improve patient care, it will only discharge physicians from proper pain management, to lessen the work load.
Michael Swanson, DO	mailto:mjs@mindspring.com	What are opiod treatment options?Is this purposely vague?
Jason Chao, MD	:jason.chao@case.edu	Our EMR currently does not have the capability to print the diagnosis on the prescription, even though the doctor has already linked the prescription to a diagnosis. It will require a major change in our EMR, that will likely take many months to implement.
Douglas Sherlock MD	mailto:Douglas.Sherlock@UHhospitals.org	The proposed rule will eliminate the use of chronic opioid use for non-palliative care or cancer use.
Carrie Baker, MD	dr.carrie.baker@gmail.com	will not be able to achieve pain control with only 30 morphine equivalents per day in the acute phase. If post-op pain is not controlled, they will come to the ED for evaluation and treatment. This will require a CT to look for infection, labs and other tests to make sure they do not have bleeding or infection.
R Jurdi, MD	shontin@aol.com	New limit ok for acute but not for chronic pain . Patients with multiple previous surgeries as back fixation hardware with neuropathy , severe debilitating arthritis, collapsed vertebrae with nerve impingement ... need opioids . There is no way such patients can survive with such pains...
Gayle Herrington, MD	gayle_herrington770@msn.com	limited to seven days. This is certainly inadequate for bilateral knee replacement in many patients. I think it should be to the surgeon discretion based on the individual patient as to whether they feel more than a seven day course is warranted.
Carl Otten, MD	carl.otten@icloud.com	I am concerned that this new rule will prevent my excellent and long term physician from continuing my treatment for chronic pain associated with spondylosis and peripheral neuropathy. I have failed lumbar facet injections, physical therapy, massage, and acupuncture
Matthew Kauffman, MD	mailto:drmjk73@hotmail.com]	medications for Ohio, is the state medical board planning on offering any type of educational lectures/meetings or is there a special video that you can post that reviews all of the current changes? definite concerns on management of patients postoperative pain with the limitations of 30 MED/day - orthopedic surgeries.
Michael Banks, MD	orthowest@mac.com	steer very clear of requiring diagnosis codes/descriptions as they will NOT be helpful for you. Hyper-regulatory policies at all levels of government are destroying the practice of medicine and be vigilant of that problem as we are driving very good experience MDs out of practice
Virginia Woodrow, MD	Virginia.Woodrow@mha.ohio.gov	30 MED may not be enough for patients who are currently addicted to opiates though not yet in treatment. Refusing to adequately treat their pain if they are in an accident, having surgery, etc. would be cruel.

Carolyn Winkler, MT	email4cdw@gmail.com	Speaking as both a victim of chronic pain and a current license holder, please allow me to speak on the behalf of chronic pain victims. We are not addicts look at the statistics, I believe chronic pain victims only make up 7% of addicts.
Shamsi Lashgari-Saegh, M.D.	shamsi@saegh.com	I reviewed the amendments and in agreement with them.
Cheryl P., LMT	cherylp31@aol.com	To limit the ability to stop a persons pain is terrible. The only people that would do something like that are those without empathy or compassion. data use. Shouldn't it be mined so the DEA and police can investigate to stop the big players in drug abuse?Thanks for anything you can do to help stop the deaths, it is so sad. "These rules are for acute pain only. Rules for chronic pain are in 4371-21 of the Administrative Code "
Terry Sanor, MD	Teri Sanor <tlsanor@gmail.com>	If one writes a diagnosis on the prescription form, is one not guilty of a HIPPA violation?
William E. Feeman, JR., MD	William Feeman Jr. MD <bgs43402@yahoo.com>	Regarding the above rule which limits the daily opiate dose to 30 MED/day: That corresponds to approximately 20 mg oxycodone and 30 mg hydrocodone. These doses are not adequate in many adults for initial treatment of pain from many surgical procedures, e.g. knee replacement, complex spine surgery, major vascular procedures to name a few. A higher limit at least for the first Rx would make sense to me
Gilbert Templeton MD	Pat/Gil <pgtemp@sbcglobal.net>	Forcing physicians to add a diagnosis on all narcotic prescriptions will add additional administrative time to an already busy day by having to add additional information on the prescriptions. This seems unnecessary and excessively burdensome for physicians.
Matthew Douglas Russell, M.D.	Russell, Matthew D. <Matthew.Russell@ohiohealth.com>	The idea of prescribing a 5 day supply to one group of patients while a 7 day supply to another group is confusing at the very least. Then, with prn prescriptions, how does one compute a 5 day or 7 day supply? I suppose physicians who don't compute correctly will be disciplined. Yes, the criminalization continues. The complexity escalates.
Kenneth Christman, MD	kscdchristman@aol.com	Perhaps the Board should consider broadening the rule so that medication dispensed at an inpatient facility, or prescribed to the patient at an inpatient facility prior to discharge, are exempt from the rule?
Dan Zinsmaster	Daniel.Zinsmaster@DINSMORE.COM	burden which I question for its debatable value in reducing over-prescribing and also who receives this information. diagnoses should not be public knowledge. all the this repressive behaviour by the above authorities is chilling; many of us may simply discontinue prescribing pain medications entirely.
Russell Lee-Wood,MD	rleewo1o@yahoo.com	I am not in favor of new proposed rule.It should be left to physician descretion.
Rajnikant Kothari, MD	rajnikantkothari@icloud.com	adults who have a tonsillectomy ROUTINELY have severe pain for 7 - 10 days after their procedure, in my experience. Since the most frequent complication of tonsillectomy is bleeding, which tends to occur either in the first few days after surgery or around 7 - 10 days later, I personally do not want my patients to take NSAIDs for pain control, as they increase bleeding time should bleeding occur. Consequently, these patients more often than not are on opioids longer than 7 days.
David Stepnick, MD	dstepnick@metrohealth.org	also encourage patient to seek alternate medical therapy that is efficient to control the pains and work together, such as acupuncture
Li Sparks, AC	nkyacupuncture@gmail.com	RX's must include the patient's diagnosis: provide no true benefit and take way too much time. Looking up the ICD-10 codes is a pain in the butt. This is unreimbursed time. The present EMR systems would have to be changed if the diagnosis and ICD-10 code are to be printed on each Rx we give the pt.
Lisa Gennari, MD	lgennari@aiwhcincinnati.com	
Naren, Saraswathy B., VHACIN	Saraswathy.Naren@va.gov	I prefer guidelines to rules and believe that education and monitoring of prescribing patterns contributes significant value. the reason why opiate medications have existed and gained a longstanding place in modern medicine is because they can be beneficial tools in providing high-quality patient-centered medical care when utilized appropriately. Within the context of a healthy doctor-patient relationship we need to respect the role of physician judgment in determining how best to treat an individual.
Jonathon Leizman, MD	jleiz@aol.com	
Marylou Sayre, MD	maryloujoe@hotmail.com	I agree with the 7 day rule. There should be more regulation of prescribing for chronic pain.
Robert N. Steensen, MD	rsteensen@gmail.com	In orthopedic surgery we have a large number of patients who have major surgeries, such as a knee replacement or hip replacement, or who have suffered severe injuries from trauma such as motor vehicle accidents. These patients routinely have significant pain after these injuries/surgeries that require pain medication for longer than seven days. This is a common situation in orthopedic surgery. il is not the exception, it is the norm. My recommendation is thirty days.

Mark Tornero, MD	Mark.Tornero@osumc.edu		Shouldn't there be a 5th provision excluding patients who are being discharged from the hospital who were hospitalized for significant issues requiring significant dosages of pain meds (i.e. your poly trauma patient, or spinal cord injury patient, or some other condition where part of their hospital recovery required management of uncontrollable pain that you know is going to last more than 7 days – you can't expect them to be weaned off pain meds in such a short period of time and when they get discharged from the hospital and you prescribe a 30 day supply of high dose pain meds, when the pharmacy gets this prescription are they going to contact the board saying "hey we're getting a lot of scripts from this doctor treating acute pain for greater than 7 days"
Jonathan B. Feibel, M.D.	doctorduke91@aol.com	President, Ohio Orthopedic Society	7 day period and should not exceed 30 MED's daily. This is much too short a period of time and much too low a MED in the post-operative/post-fracture period
Gary Pennington, MD	gpennington@CrystalClinic.com		EMR's are unable to place a diagnosis code on prescriptions, will you be discuss this with the EMR corporations? Have you considered an exemption for early postop patients? I work at the Crystal Clinic a large orthopedic and plastic surgery center. We frequently operate on patients that live 1 to 2 hours away from our office. We are currently unable to e-prescribe opioids due to difficulties with Centricity. A 2 week exemption for postsurgery would be helpful.
Erin Breese, MD	Erin.Breese@cchmc.org		It makes no sense to have a different length of time (5 days vs 7 days) for children and adults. For any given procedure, do you think children will have 2 days less of pain than an adult in the same situation?
Ryan Kauffman, MD	ASpicer@ohioafp.org	President, Ohio Academy of Family Physicians	condition that the controlled substance is being used to treat, violates patient confidentiality. Will investigations be opened and/or disciplinary actions be taken against prescribers based on this diagnosis code information?electronic medical record systems do not readily allow diagnosis codes and duration of treatment information to be printed on the script. This is a complicated and expensive requirement to implement. Object to the 30 MED limit.
David Rollins, MD	DRollins@neo-vascular.com		the proposed seven day restriction should be modified for surgical practices to a minimum of two to three weeks. If we are going to modify and modernize our acute pain management practices, then additional information and training are required. To my knowledge, there are few, if any, Medical Society or State Board sponsored opportunities to retrain physicians in acute pain management. Perhaps the Board would consider helping with educational needs?
Elaine Beed, MD	ebeedmd@aol.com		As a physician of 40 years I have found these new rules very distressing and worrisome.
Joseph Burick, DO	jpburickdo@gmail.com		The word acute in medicine is less than 6 months.
Laurie Bankston, MD	lbankstonmd@gmail.com		My practice uses EPIC. It will take months to change the way our prescriptions print in order to add a diagnosis code for pain to the script.The stringency of these rules will serve largely to reduce access to pain medication for those who are ill and injured. The administrative burdens of this are excessive. What about protected health information? The MED is arbitrarily set. What about trauma patients discharged with acute pain who will likely have chronic issues? Let's expand treatment resources. And law enforcement. And patient education. And end the "patient satisfaction" scores
David Hill, MD	dbhill@dbhill.net		I object to these proposed rules as there is no evidence that the implementation of these rules will make any changes for the better regarding iatrogenic drug addiction, but have a high probability of preventing adequate pain control for many patients.
Michael McCrea, MD	amanda@gov-advantage.com	President, Ohio- American College of Emergency Physicians	Limits are in line with present ER practices. Educaiton should be given at the pharmacy. Recommend that the Medical Board develop a pamphet to be used in ED and other settings on additive nature of controlled substances so that consistent info is given.; Also sent copy of letter to PHarmacy Bd, concerning burden of determining the ICD-10 code and cost to upgrade EHR systems.
Michelle Pohl, MD	Michelle.Pohl@lakehealth.org		Agrees with the proposed rules.
Kenneth Goldschneider, MD	Kenneth.Goldschneider@cchmc.org		A spinal fusion in a teenager will hurt just as much as for an adult.Parents have already given consent to treat when they undergo whatever treatment was provided that led to needing opioids for pain control. the morphine equivalents allowed per day (MED) is wholly inadequate for all but the smallest patient. mandate (with appropriate funding) adequate and accessible disposal mechanisms. Adding ICD-10 codes does not add safety.
Jamesetta Lewis, DO	Jamesetta.Lewis@Cantonmercy.org		If a chronic pain patient needs surgery or any other acute intervention , do these rules apply to this patient population? 2. If a chronic pain patient needs a short acting opiate temporarily for an acute flare-up of pain will I have to still follow the acute opiate guidelines?3. What evidence do you have that supports only using a 30 MED per day range for acute pain?
Traci Brodie, patient	birmanluv0831@gmail.com		Physicians are applying the proposed rule to chronic pain.
Roma Amin, MD	roma.p.amin@gmail.com		My first concern is that the rules only apply to primary care doctors and dentists.Majority of my patients on long-term opioids were started in the emergency room or post-operatively by a surgeon. Many of our community's patients go to primary care doctors who as a blanket rule don't prescribe opioids due to the increasing legislature and fear for reprimand. Emergency physicians have significant monetary rewards for high Press-Ganey scores. these rules do not truly help stop our patients from becoming addicted and that it will further disengage patients from continuity of care and send more of them to the urgenct care/emergency rooms throughout the community.
Michael Reed, DO	Michael.Reed2@ohiohealth.com		why mention hospice and palliative care but not other non-terminal, chronic pain conditions as being exempted?

Jeff Lycan	jlycan@hospicealliianceofohio.org	Ohio Hospice Alliance	No comments on the rules.
Rodney Miller, MD	rrmiller96@embarqmail.com		I support Dr Feibel's statement re opiods use by orthopedic surgeons
Sergio Ulloa, MD	<sergio_ulloa@yahoo.com>		postoperatively 5 Percocet are not adequate for acute pain in all of my patients.
Robert Erickson, MD	rce2md@neo.rr.com		Support comments submitted by Dr. Feibel
Raymond Boniface, MD	rjboniface@zoominternet.net		Support comments submitted by Dr. Feibel
Matt Heckler, DO	mheckler@oaswo.com		Support comments submitted by Dr. Feibel. to make a generalization and expectation that all post-op total knee patients are allowed 4 pain pills daily and need to come to my office for monitoring every 7 days jeopardizes the quality of care. Supports Dr. Feibel's statement. I agree with the proposal of amending the rule to allow exception for the first 60 days of the post-op/post-fracture period.
Jeremy Mathis, MD	<jermathis02@gmail.com>		
Joe Assenmacher, MD	<jassenmacher@yahoo.com>		Support Dr. Feibel's letter. 30 MED translates to 4 5/325 Percocets per day which in my opinion and many other orthopedists, outright cruel and abusive to patients that have just undergone joint replacement or significant trauma surgery.
Stephen Yoder, MD	<steveyoder@icloud.com>		The proposed guidelines are much too restrictive and impractical for Orthopedic surgeons and their patients. Please note that I support other provisions of the prescribing policies and have advocated limited narcotic prescriptions since I started practicing most of my foot and ankle surgical patients would suffer and fail to be able to cope with surgery. Without proper pain control patients will be sent to a local ED or readmitted for unwarranted recovery that could be avoided or possibly cannot get a needed surgery.
Adam Miller, MD	<amiller@beaconortho.com>		
Andrew Glassman, MD	Andrew.Glassman@osumc.edu>		suggest amending the proposed rule to allow exception for the first 60 days of the post-operative/post-fracture period, with narcotics to be prescribed only by the operative physician or his/her designee (i.e. PA/NP/partner/pain management specialist). supportive of the other parts of the rule
John Urse, MD	jurse@oaswo.com>		Please consider not placing even more restrictions on our role as physicuans to prescribe opioids.
Kort Gronbach, MD	kmgronbach@hotmail.com	Serves on Governor Kasich's GOCAT Initiatives	proposed rules will create undue hardships on the the patients injured the most and have the most difficult time getting to their doctors, the elderly and disabled. , if passed, would undermine our previous work on ED visits for opioids. Should be prescription accountability through pharmacy mandatory bring back and accounted for on OARRS with proper disposal of drugs.
Christopher Iobst, MD	Christopher.Iobst@nationwidechildrens.org>		limb lengthening and limb reconstruction; Patients see a behavioral health specialist to learn pain management strategies but many still require pain medication for greater than 7 days and more than 30 MED's daily
John Gallagher, MD	JMGallagher@mercy.com>		agree with Dr. Feibel's letter. However I would like to amend Dr. Feibel's suggestion by shortening the carve out period to 4 weeks.
MIchele Huffman, orthopedic nurse	MIchele.Huffman@mchs.com		Suggests exemption for post-surgical care
Dr. Raymond Duffett	rduffett@southwoodshealth.com		Agree with Dr. Feibel.
Richard Freiberg, MD	raf@cinci.rr.com>		Agree with goal, but with modification to 14 days, with exceptions only for end stage neoplasm and terminal illness. Doctors won't comply with the rule as drafted.

Fred Jorgensen, MD		Academy of Medicine of Cleveland and Northern Ohio	Requiring ICD-9 violates patient privacy and some EMRs are unable to do this; Use of long-acting drugs should be left to physician discretion; If documentation required to exceed the limit, Med Bd rule should clearly define the documentation requirements; It is unclear whether the subsequent physician is bound by the 7 day script written by the original physician; 30 MED limit does not consider chronic pain patient who has acute pain situation; Will the MD BD investigate all physicians who exceed the limit? GOCAT guidelines working well.
Susan Stedje, MD	sstedje@woh.rr.com	Ohio Osteopathic Association	Agrees with comments of the Academy of Family Physicians Definition of "pallative care" needs to mirror hospice care without the 6 month time period. Suggests joint MD BD/Pharmacy BD study committee for outliers before reaches discipline; use of ICD-10 code: patient privacy and will complicate script writing; 30 MED not reasonable for chronic pain patient with acute pain situation and for severe acute pain. REcommend 30 - 50 MED with quick taper to 30, especially for the elderly.
Sean Stiltner, DO			
John Naveau, MD	jjn@coldwatermedical.com		EMR doesn't allow ICD-10 code to be printed; The limitations of days will make it more difficult for covering physicians on weekends and for nursing home physicians when patients have surgery because surgeons will only prescribe when the patient comes to office.
Kenneth Doolittle, MD	Kenneth.Doolittle@kch.org>		orthopedists, outright cruel and abusive to patients that have just undergone joint replacement or significant trauma surgery. Add exception for post-surgical and allow 60 days as prescribed by the physician of record, operative physician, or physicians designee (NP/PA).
Stephen Helper, MD	shelper@ameritech.net>		Letter is the same as Dr. Freibel's.
Jeffery McMath, MD	<jambonedoc@gmail.com>		Agree with Dr. Freibel proposed.
Richard Fischer, MD	dfische1@columbus.rr.com>		
Maria Stromer, RN	<mstromer@zangcenter.com>		Should not exempt cancer/hospice/pallitive patients. Medications are diverted. Patients no longer being treated for cancer should seek other forms of relief.
Ellin Gafford, MD, Director	Huma.Ansari@osumc.edu>	OSU, Division of Pallative Medicine	Should be evidenced based, and none for 30 MED limit; Physician should use medical judgment; Should have period risk assessments for patients; Proposed rules will make primary care physicians fearly of providing pallative care.
David Mungo, MD	<dmsjmungo@aol.com>		Not evidence based, Go after the problem prescribers, this will make it less attractive to practice in Ohio.
Kevin Pugh, MD	kjportho@mac.com>		Same basic letter as Dr. Freibel, only suggests a 90 day period for post-surgical/fracture/trauma care.
Christopher Kaeding, MD	Christopher.Kaeding@osumc.edu>		Agree with Dr. Freibel
Brian Davison, MD	bdavison@orthopedicone.com>		Agree with Dr. Freiber; Exemptions should include immediate post-operative and post- fracture period, defined by 60 or at most 90 days.
Robert Turner, MD	doct1984@aol.com		disappointed that there is little similarity between the GOCAT guidelines and these rule; 30 MED and 7 days is not sufficient for orthopedic surgeries; The rules will make physicians targets of the Pharmacy Board.
James Davidson, MD	jdavidsonmd@gmail.com>		Supports Dr. Freibel's letter.
James Harwood, MD	jharwood@ftmc.com>		Oppose putting ICD-10 code on script as is release of confidential information and EMRs can't do it. Limitations don't allow modification for individual patients. Will contribute to shortage of primary care physicians.
Precious Barnes, DO	preciousba@pcom.edu>		substance abuse clinics and expanding the usage of nonopioid related options to treat pain. The medical board should assist physicians in expanding their resources not limiting them. Physicians spend years training in how to deal with complex medical conditions and are put through rigorous testing proving that they are clinically capable of dealing with such complexities and should not be limited in the treatment of patient care.

			No more than 30 MED is not the standard of care for post-operative patients and those with acute fractures. Only 7 day script is unrealistic and will impose hardship on patients. Suggest allow exception for the first 90 days (to coincide with a standard global period for surgeries and fractures in general) in the post-operative and post-fracture periods. During that time period, the operative or treating physician or his/her designee (CNP/PA/partner in practice/pain management specialist) would be the only individuals allowed to prescribe opioids for the patient.
Steven Gaines, MD	gainesst@gmail.com>		Requiring ICD-10 code violates patient confidentiality and is more work for physician and pharmacist without any clear benefit. The 7 day and 30 MED limits do not comport with the carefully constructed GCOAT guidelines. Amount of opioids prescribed and dispensed has decreased in each of 4 years. PRoblem is more than physicain prescribing.
Donald Mack, MD	Donald.Mack@osumc.edu>		Agree with Dr. Freibel. In addition, patients may have medical or pharmacologic contraindications to some non-narcotic analgesics. Concern that extending script beyond 7 days will lead to regulatory discipline. Elderly and frail patients particularly at risk if pain not appropriately treated. See letter for specific suggestions for ways to improve langauge regarding how many days the script may be for.
Anne C. Sullivan, MD	Anne.Sullivan@osumc.edu>		
Kenneth Patric, MD	tennbc@aol.com		Limit should be 5 days for both adult and minor. Concerns re HIPAA for placing diagnosis on script. Some states have tried and abandoned the diagnosis on script concept.
Julie Y Bishop, MD	Julie.Bishop@osumc.edu>		Supports Dr. Freibel's letter.
Robyn Chatman, MD, President	jhayhurst@osma.org>	OSMA	report de-identified information. Suggests language for re-write of (A)(1) to allow physician discretion of use of extended release or long-acting drug. Limit on days should reflect practice specialty, especially for post-operative and fracture situations. Unclear when "First" acute pain prescription starts -- upon release from hospital? Applicable to subsequent physician treating for post-surgical/fracture pain? No consideratiaon of chronic pain patient with acute pain. Board should develop form for risks/benefits but use at discretion of physician. DOsage should be at discretion of physician: suggests language for re-write. Board must have clear data collection parameters and detail how will be used.
Lisa Yerian, M.D., Vice-Chair of Staff Affairs	barnhab@ccf.org>	Cleveland Clinic	"Acute pain" needs to be more specifically defined as it is on the Cleveland Clinic website. 30 MED not sufficient for patients who are not narcotic naïve. Clarify and/or limit the number of prescriptions that can be provided for a given patient and the limits for any additional or subsequent prescriptions. For minors, should not have to get written consent. Provides listing of types of conditions where should be exemptiion to time and/or MED limits. Need to clarify who is covered by exemption for in-patient.
John Ryan, MD	John.ryan@osumc.edu>		Supports Dr. Freibel's letter. Does not believe that the rules for acute pain prescription as outlined are reflective of current standard of care / best practice for pain management of patients with acute postop pain or post injury / post trauma pain and I think this would lead to poor care for this patient population.
James Natalie, MD			Negative impact on legitmate care. 2. Cost of care will go up with repeated office visits for scripts. 3. Undue hardship on providers who will develop ways to CYA. The rule, and the pending accumulation of data by the state, will shift the burden of proof from innocent until proven guilty to guilty until you prove that didn't break the rule. Should educate patients on dangers of medications. Problem is far more than physician prescribing.
William Annable, M.D., Chief Medical Officer	Daniel.Bucci@UHhospitals.org>	University Hospitals, Cleveland	Need to clarify how the 30 MED will apply to patient who is not narcotic naïve. Provide guidance as to level of detail required to support extending beyond 7 day limit. EMRs not capable of putting diagnosis on script. Concerns for privacy of confidential health information.
Daniel F. Grum, MD, MBA OSA President	willa@tompappas.com>	Ohio Society of Anesthestiologists	Standards are arbitrary and not based on science. Privacy risks for putting diagnosis on script; insurers should provide de-identified data. Same letter basically as the OSMA letter.
Sean McGlone, Senior VP and General Counsel	Sean.McGlone@ohiohospitals.org>	OHA	Remove the 3-day presumption langauge as is confusing. Inconsistency in usage of whom can give consent for minor and should allow just documentation of consent. Longer than 7 days should be based on clinical judgment. Board should develop form for informed consent. Allow exception to the 30 MED limit when physician determines in medically necessary.
Payal Desai, MD, plus 6 other physicians	Payal.Desai@osumc.edu>	Childrens Hospitals in Ohio	consider the diagnoses of Sickle Cell Disease and Hemophilia, like cancer, as an explicit exception because the chronic conditions have acute instances
Walter Cha, MD, President	dhurley@capitol-consulting.net>	OH Chptr, American College of Surgeons	Requiring diagnosis on script poses technological and privacy concerns. Should be able to prescribe extended and long acting narcotic with reason documented. Remove the reference to 3 day supply. Allow refill with reason documented. Delete requirement to document why non-opioid being used. Allow greater than 30 MED with documentation.
Carl S. Wehri, M. D.	cswehri@outlook.com>		Diagnosis code on scripts is an administrative burden with no value.only permitting a seven day pain med Rx is arbitrary and capricious
Nisha Hammel, Dir. Of Advocacy	nhammel@leadingageohio.org>	LeadingAge Ohio	Has no outstanding concerns.

Sydney Stone, Jr., MD	stone450@gmail.com	Agree Dr. Feibel.
David Robie, MD	drobie@orthopedicone.com>	Comments are consistent with Dr. Feibel. Limiting narcotics in the post-operative period can have devastating effects on the outcome of orthopedic surgery. Proposed regulations may drive even more patients to illicit drugs, alcohol, or despair.