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Conceptual Draft Version 7.1
Opioid Prescribing Rules (ESHB 1427)
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NOTE: Numbering for the above sections is for illustration purposes only. Actual numbering will need to take into account existing chronic non-cancer pain rules, which have different section numbers, depending on the chapter.
Opioid Prescribing – General Provisions

246-XXX-X01 Intent and scope
These rules govern the prescribing of opioids in the treatment of pain.
246-XXX-X02 Definitions
The following definitions apply to WAC 246-XXX-X01 through 246-XXX-X91 unless the context clearly requires otherwise:

(1) “Aberrant behavior” means behavior that indicates misuse, diversion or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions for the same or similar drugs from more than one practitioner or other health care provider.

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. Acute pain is considered to be of zero to six weeks in duration.

(3) “Biological specimen test” or “biological specimen testing” means tests of biological specimen including, but not limited to, urine, hair or other biological samples for various drugs and metabolites.

(4) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process, that causes continuous or intermittent pain over months or years. Chronic pain includes pain resulting from the treatment of cancer or the residual effects of a previous cancer tumor of a patient who has completed treatment, is cured or in full clinical remission with no current evidence of disease, or is under cancer surveillance only.

(5) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.

(6) “Episodic care” means medical care provided by a practitioner other than the designated primary care practitioner in the acute care setting, for example, urgent care or emergency department.

(7) “High dose” means ninety milligram MED, or more, per day.

(8) “High-risk” is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high dose opioid prescription, or the use of any central nervous system depressant.

(9) “Hospice” means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less.

(10) “Hospital” means any institution, place, building, or agency licensed by the department under chapters 70.41 or 71.12 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.
(11) “Inpatient” means a person who has been admitted to a hospital for more than twenty-four hours.

(12) “Medication assisted treatment (MAT)” means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

(13) “Morphine equivalent dose (MED)” means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(14) “Multidisciplinary pain clinic” means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines, practitioners, or treatment modalities.

(15) “Multimodal management of pain” means the application of non-opioid analgesic mechanisms, such as, but not limited to, anti-depressants, anticonvulsants, anti-inflammatory medications, acetaminophen, interventional procedures, or any nonpharmacological pain treatments.

(16) “Non-operative pain” means acute pain which does not occur as a result of surgery.

(17) “Opioid analgesic” or “opioid” means a drug that is used to alleviate moderate to severe pain that is either an opiate (derived from the opium poppy) or opiate-like (semi-synthetic or synthetic drugs). Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(18) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(19) “Pain” means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(20) “Pain management clinic” means a publicly or privately owned facility for which a majority of patients are receiving chronic pain treatment.

(21) “Perioperative pain” means acute pain that occurs as the result of surgery.

(22) “Prescription monitoring program” or “PMP” means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(23) “Practitioner” means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.
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(24) “Refill” means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-XXX-X01 through WAC 246-XXX-X91, refills are subject to the same limitations and requirements as initial prescriptions.

(25) “Risk assessment tools” means professionally-developed, clinically accepted questionnaires appropriate for identifying a patient’s level of risk for substance abuse or misuse.

(26) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(27) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.
246-XXX-X03 Exclusions
WAC 246-XXX-X01 through 246-XXX-X91 do not apply to:
(1) The treatment of patients with cancer-related pain;
(2) The provision of palliative, hospice, or other end-of-life care;
(3) The treatment of inpatient hospital patients; or
(4) The provision of procedural pre-medications.
246-XXX-X04 Patient notification, secure storage, and disposal

(1) The practitioner shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The practitioner shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:
   (a) The first issuance of a prescription for an opioid; and
   (b) The transition between phase of treatment, as follows:
      (i) Acute non-operative pain or acute perioperative pain to subacute pain; and
      (ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:
   (a) The safe and secure storage of opioid prescriptions; and
   (b) The proper disposal of unused opioid medications, including but not limited to the availability of recognized drug take-back programs.
246-XXX-X05 Use of alternative modalities for pain treatment
The practitioner shall consider multimodal pharmacologic and non-pharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. A practitioner may combine opioids with other medications and treatments, including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDS), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.
246-XXX-X06 Continuing education requirements for opioid prescribing

(1) In order to prescribe an opioid in Washington state, a practitioner licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids. The continuing education must be at least one hour in length.

(2) The practitioner shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the practitioner’s first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.
Opioid Prescribing – Acute Non-Operative Pain and Acute Perioperative Pain

Prior to writing an opioid prescription for acute non-operative pain or acute perioperative pain, the practitioner shall:

1. Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;
2. Evaluate the nature and intensity of the pain or anticipated pain following surgery; and
3. Inquire about any other medications the patient is prescribed or is taking, including date, type, dosage and quantity prescribed.
246-XXX-X22 Treatment plan – Acute non-operative pain

The practitioner shall comply with the requirements in this section when prescribing opioid analgesics for acute non-operative pain and shall document completion of these requirements in the patient record:

1. The practitioner shall consider prescribing non-opioid analgesics as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-XXX-X05.

2. The practitioner, or his or her designee, shall conduct queries of the Washington state prescription monitoring program in accordance with the provisions of WAC 246-XXX-X91 to identify any schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

3. If the practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. A three day supply or less will often be sufficient; more than a seven day supply will rarely be needed. The practitioner shall not prescribe beyond a seven day supply without clinical documentation in the patient record to justify the need for such a quantity.

4. The practitioner shall re-evaluate the patient who does not follow the normal course of recovery. If significant and documented improvement in function or pain control has not occurred, the practitioner shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

5. Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
   a. Change in pain level;
   b. Change in physical function;
   c. Change in psychosocial function; and
   d. Additional planned diagnostic evaluations to investigate causes of continued acute non-operative pain or other treatments.

6. Long-acting or extended release opioids are not indicated for acute non-operative pain. Should a practitioner need to prescribe a long-acting opioid for acute pain, that reason must be documented in the patient record.

7. Medication assisted treatment medications shall not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-XXX-X82.

8. If the practitioner elects to treat a patient with opioids beyond the six week time period of acute non-operative pain, the practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-XXX-X31 through WAC 246-XXX-X32, shall apply.
246-XXX-X23 Treatment plan - Acute perioperative pain

The practitioner shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient’s record:

1. The practitioner shall consider prescribing non-opioid analgesics as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-XXX-X05.

2. The practitioner, or his or her designee, shall conduct queries of the Washington state prescription monitoring program in accordance with the provisions of WAC 246-XXX-X91 to identify any schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

3. If the practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. A three day supply or less will often be sufficient; more than a fourteen day supply will rarely be needed for perioperative pain. The practitioner shall not prescribe beyond a fourteen day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the practitioner may refer to clinical practice guidelines including, but not limited to, those produced by the Agency Medical Directors’ Group, the Centers for Disease Control and Prevention, or The Bree Collaborative.

4. The practitioner shall re-evaluate a patient who does not follow the normal course of recovery. If significant and documented improvement in function or pain control has not occurred, the practitioner shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

5. Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
   a. Change in pain level;
   b. Change in physical function;
   c. Change in psychosocial function; and
   d. Additional planned diagnostic evaluations or other treatments.

6. If the practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-XXX-X81 or to a patient known to be receiving a medication listed in WAC 246-XXX-X81 from another practitioner, such prescribing must be in accordance with WAC 246-XXX-X81.

7. If the practitioner elects to treat a patient with opioids beyond the six week time period of acute perioperative pain, the practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-XXX-X31 through WAC 246-XXX-X32, shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.
Opioid Prescribing – Subacute Pain

246-XXX-X31 Patient evaluation and patient record

The practitioner shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record:

(1) Prior to writing an opioid prescription for subacute pain, the practitioner shall:
   (a) Conduct an appropriate history and physical examination or review and update the patient’s existing history and examination taken during the acute non-operative or acute perioperative phase;
   (b) Evaluate the nature and intensity of the pain;
   (c) Inquire regarding other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;
   (d) Conduct, or cause his or her designee to conduct, a query of the Washington state prescription monitoring program (PMP) in accordance with the provisions of WAC 246-XXX-X91 to identify any schedule II-V medications or drugs of concern received by the patient and document their review and any concerns;
   (e) Screen and document the patient’s potential for high-risk behavior and adverse events related to opioid therapy. If the practitioner determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone.
   (f) Obtain a biological specimen test if the patient’s function is deteriorating or if pain is escalating; and
   (g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery, including but not limited to depression or anxiety.

(2) The practitioner treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:
   (a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;
   (b) The observed significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;
   (c) The result of any queries of the PMP;
   (d) All medications the patient is known to be prescribed or taking;
   (e) An appropriate pain treatment plan, including the consideration of, or attempts to use, non-pharmacological modalities and non-opioid therapy;
   (f) Results of any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;
(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

(h) Results of screening for the patient’s level of risk for aberrant behavior and adverse events related to opioid therapy;

(i) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable; and

(j) All other required components of the patient record, as set out in statute or rule.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;
(b) Change in physical function;
(c) Change in psychosocial function; and
(d) Additional planned diagnostic evaluations or other treatments.
246-XXX-X32 Treatment plan – Subacute pain

(1) The practitioner shall recognize the progression of a patient from the acute non-operative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six to twelve week subacute phase, the practitioner shall re-evaluate the patient who does not follow the normal course of recovery. If significant and documented improvement in function or pain control has not occurred, the practitioner shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The practitioner shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve week conclusion of the subacute phase.

(3) If the practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The practitioner shall not prescribe beyond a fourteen day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-XXX-X81 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-XXX-X81 from another practitioner, such prescribing must be in accordance with WAC 246-XXX-X81.

(5) If the practitioner elects to treat a patient with opioids beyond the six to twelve week subacute phase, the practitioner shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-XXX-X41 through WAC 246-XXX-X50, shall apply.
Opioid Prescribing – Chronic Pain Management

246-XXX-X41 Patient evaluation and patient record

The practitioner shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(1) History: The patient's health history must include:
   (a) The nature and intensity of the pain;
   (b) The effect of pain on physical and psychosocial function;
   (c) Current and past treatments for pain, including medications and their efficacy;
   (d) Review of any significant comorbidities;
   (e) Any current or historical substance use disorder;
   (f) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and
   (g) Medication allergies.

(2) Evaluation: The patient evaluation prior to opioid prescribing must include:
   (a) Appropriate physical examination;
   (b) Consideration of the risks and benefits of chronic pain treatment for the patient;
   (c) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;
   (d) Review of the Washington state prescription monitoring program to identify any schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-XXX-X91.
   (e) Any available diagnostic, therapeutic, and laboratory results;
   (f) Use of a risk assessment tool and assignment of the patient to a high, moderate or low risk category. The practitioner should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;
   (g) Any available consultations, particularly as related to the patient’s pain;
   (h) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
   (i) Treatment plan and objectives including:
      (i) Documentation of any medication prescribed;
      (ii) Biologic specimen testing (urine or other drug screen) ordered; and
      (iii) Any labs or imaging ordered;
   (j) Written agreements, also known as a “pain contract,” for treatment between the patient and the practitioner; and
   (k) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.
(3) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in subsections (1) and (2) of this section, as well as all other required components of the patient record, as set out in statute or rule.
246-XXX-X42 Treatment plan

(1) When the patient enters the chronic pain phase, the patient shall be reevaluated by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include, at a minimum:
   (a) Any change in pain relief;
   (b) Any change in physical and psychosocial function; or
   (c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the practitioner shall adjust drug therapy to the individual health needs of the patient.

(4) The practitioner shall complete patient notification in accordance with the provisions of WAC 246-XXX-X04.
246-XXX-X43 Written agreement for treatment
The practitioner shall use a written agreement for treatment with the patient who requires long
term opioid therapy for chronic pain that outlines the patient’s responsibilities. This written
agreement for treatment must include:

(1) The patient's agreement to provide biological samples for biological specimen testing
    when requested by the practitioner;
(2) The patient's agreement to take medications at the dose and frequency prescribed with
    a specific protocol for lost prescriptions and early refills;
(3) Reasons for which opioid therapy may be discontinued (e.g., violation of agreement);
(4) The requirement that all chronic opioid prescriptions are provided by a single
    prescriber, a single clinic, or a multidisciplinary pain clinic;
(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single
    pharmacy or pharmacy system whenever possible;
(6) The patient's agreement to not abuse substances that can put the patient at risk for
    adverse outcomes;
(7) A written authorization for:
    (a) The practitioner to release the agreement for treatment to:
        (i) Local emergency departments;
        (ii) Urgent care facilities;
        (iii) Other practitioners caring for the patient who might prescribe pain
            medications; and
        (iv) Pharmacies; and
    (b) Other practitioners to report violations of the agreement to the practitioner
        treating the patient’s chronic pain and to the prescription monitoring program;
(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and
    keep them in a secure location; and
(9) Acknowledgment that if the patient violates the terms of the agreement, the violation
    and the practitioner’s response to the violation will be documented, as well as the rationale for
    changes in the treatment plan.
246-XXX-X44 Periodic review

(1) The practitioner shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and prescription monitoring program (PMP) queries shall be determined based on the patient’s risk category, as follows:

(a) For a high-risk patient, at least quarterly;
(b) For a moderate-risk patient, at least semiannually;
(c) For a low-risk patient, at least annually;
(d) Immediately upon indication of concerning aberrant behavior; and
(e) More frequently at the practitioner’s discretion.

(2) During the periodic review, the practitioner shall determine:

(a) The patient’s compliance with any medication treatment plan;
(b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
(c) If continuation or modification of medications for pain management treatment is necessary based on the practitioner’s evaluation of progress towards treatment objectives.

(3) Periodic or subsequent patient evaluations must also include:

(a) History and physical exam related to the pain;
(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and
(c) Review of the Washington state PMP to identify any schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient’s risk category, and otherwise in accordance with the provisions of WAC 246-XXX-X91 and section (1) of this section.

(4) The practitioner shall assess the appropriateness of continued use of the current treatment plan if the patient’s progress or compliance with current treatment plan is unsatisfactory. The practitioner shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-XXX-X49.
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CHRONIC PAIN MANAGEMENT

246-XXX-X45 Consultation—Recommendations and requirements

(1) The practitioner shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams morphine equivalent dose (MED). In the event that the practitioner prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED per day, a consultation with a pain management specialist as described in WAC 246-XXX-X48 is required, unless the consultation is exempted under WAC 246-XXX-X46 or 246-XXX-X47. The mandatory consultation must consist of at least one of the following:

   (a) An office visit with the patient and the pain management specialist;
   (b) A consultation between the pain management specialist and the practitioner;
   (c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the practitioner or with a licensed health care practitioner designated by the practitioner or the pain management specialist; or
   (d) Other chronic pain evaluation services as approved by the regulatory authority.

(3) The practitioner shall document each consultation with the pain management specialist. Any written record of a consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the pain management specialist provides a written record of the consultation to the practitioner, the practitioner shall maintain it as part of the patient record.

(4) The practitioner shall use great caution when prescribing opioids to children and adolescents with chronic pain; appropriate referral to a specialist is encouraged.
246-XXX-X46 Consultation—Exemptions for exigent and special circumstances
A practitioner is not required to consult with a pain management specialist as defined in WAC 246-XXX-X48 when the practitioner has documented adherence to all standards of practice as defined in WAC 246-XXX-X41 through 246-XXX-X50 and when one or more of the following conditions are met:

1. The patient is following a tapering schedule;
2. The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage with expected return to their baseline dosage level or below;
3. The practitioner documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty morphine equivalent dose (MED) per day without first obtaining a consultation; or
4. The practitioner documents the patient's pain and function is stable and the patient is on a non-escalating dosage of opioids.
246-XXX-X47 Consultation—Exemptions for the practitioner
A practitioner is exempt from the consultation requirement in WAC 246-XXX-X45 if one or more of the following qualifications are met:

1. The practitioner is a pain management specialist under WAC 246-XXX-X48;
2. The practitioner has successfully completed, every four years, a minimum of twelve continuing education hours on chronic pain management approved by the profession’s continuing education accrediting organization, with at least two of these hours dedicated to substance use disorders;
3. The practitioner is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or
4. The practitioner has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.
246-XXX-X48 Pain management specialist

A pain management specialist shall meet one or more of the following qualifications:

1. If an allopathic physician or osteopathic physician:
   a. Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or
   b. Has a subspecialty certificate in pain medicine by an ABMS-approved board; or
   c. Has a certification of added qualification in pain management by the AOA; or
   d. A minimum of three years of clinical experience in a chronic pain management care setting; and
      i. Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for a physician or the Washington state board of osteopathic medicine and surgery for an osteopathic physician; and
      ii. Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for a physician or three years for an osteopathic physician; and
      iii. At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

2. If an allopathic physician assistant or osteopathic physician assistant who has a delegation agreement with a physician or osteopathic physician pain management specialist and meets educational requirements and practice requirements listed below:
   a. A minimum of three years of clinical experience in a chronic pain management care setting; and
      i. Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for a physician assistant or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant; and
      ii. Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and
      iii. At least thirty percent of the physician assistant or osteopathic physician assistant’s current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

3. If a dentist:
   a. Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.

4. If an advanced registered nurse practitioner (ARNP):
   a. A minimum of three years of clinical experience in a chronic pain management care setting; or
(b) Credentialed in pain management by a Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity; or
(c) Meets both of the following:
   (i) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and
   (ii) At least thirty percent of the ARNP’s current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(5) If a podiatric physician:
(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or
(b) A minimum of three years of clinical experience in a chronic pain management care setting; and
   (i) Credentialed in pain management by a Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity; and
   (ii) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years; and
   (iii) At least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.
246-XXX-X49 Tapering requirements

(1) The practitioner shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment plan is unsatisfactory. The practitioner shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests tapering;
(b) The patient experiences a deterioration in function or pain;
(c) The patient is non-compliant with the written agreement;
(d) Other treatment modalities are indicated;
(e) There is evidence of misuse, abuse, substance use disorder, or diversion;
(f) The patient experiences a severe adverse event or overdose;
(g) There is unauthorized escalation of doses; or
(h) The opioid dose continues to escalate with no improvement in pain, function or quality of life.
Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner

(1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient’s current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A practitioner’s treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-XXX-X45 and the tapering requirements of WAC 246-XXX-X49 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligram MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient’s dose is stable and non-escalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as documented by medical records and prescription monitoring program queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, at the exceptional dose.

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-XXX-X45 and WAC 246-XXX-X49 shall apply.
Opioid Prescribing – Special Populations

246-XXX-X71 Special populations – Patients twenty-five years of age or under, pregnant patients, and aging populations

(1) Patients twenty-five years of age or under: In the treatment of pain for patients twenty-five years of age or under, the practitioner shall treat pain in a manner commensurate with that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients: Use of medication assisted treatment (MAT) opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The practitioner shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations: As people age, their tolerance and metabolizing of opioids may change. The practitioner shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.
246-XXX-X72 Episodic care of chronic opioid patients

(1) When providing episodic care for a patient who the practitioner knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the practitioner shall review the Washington state prescription monitoring program to identify any schedule II-V or drugs of concern received by the patient and document their review and any concerns.

(2) A practitioner providing episodic care to a patient who the practitioner knows is being treated with opioids for chronic pain should provide additional opioids to be commensurate with the severity of the acute pain. If opioids are provided, the practitioner shall limit the use of opioids to the minimum amount necessary to control the acute non-operative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient’s chronic pain treatment.

(3) The episodic care practitioner shall report known violations of the patient’s written agreement to the patient’s treatment practitioner who provided the agreement for treatment.

(4) The episodic care practitioner shall coordinate care with the patient’s chronic pain treatment practitioner if that person is known to the episodic care practitioner, when practicable.
Opioid Prescribing – Co-Prescribing

246-XXX-X81 Co-prescribing with certain medications

(1) The practitioner shall not knowingly prescribe opioids in combination with the following schedule II-IV medications without documentation of clinical judgment:
   (a) Benzodiazepines;
   (b) Barbiturates;
   (c) Sedatives;
   (d) Carisoprodol; or
   (e) Sleeping medications (Z drugs).

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the practitioner prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.
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CO-PRESCRIBING

246-XXX-X82 Co-prescribing of opioids for patients receiving medication assisted treatment

(1) Where practicable, the practitioner providing acute non-operative pain or acute perioperative pain treatment to a patient known to be receiving medication assisted treatment (MAT) shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

(2) MAT medications shall not be discontinued when treating acute non-operative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary operative intervention.
CO-PRESCRIBING

246-XXX-X83 Co-prescribing of naloxone

(1) The practitioner shall confirm or provide a current prescription for naloxone when high dose opioids are prescribed to a high-risk patient.

(2) The practitioner should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.
Opioid Prescribing – Prescription Monitoring Program

246-XXX-X91 Prescription monitoring program – Required registration, queries, and documentation

(1) The practitioner shall register to access the prescription monitoring program (PMP) or demonstrate proof of having registered to access the PMP if he or she prescribes opioids in Washington state.

(2) The practitioner is permitted to delegate performance of a required PMP query to an authorized designee.

(3) At a minimum, the practitioner shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-XXX-X81 at the following times:
   (a) Upon the second refill of an opioid prescription for acute non-operative pain or acute perioperative pain;
   (b) The time of transition from acute to subacute pain; and
   (c) The time of transition from subacute to chronic pain.

(4) For chronic pain management, the practitioner shall ensure a PMP query is performed at a minimum frequency determined by the patient’s risk assessment, as follows:
   (a) For a high-risk patient, a PMP query shall be completed at least quarterly.
   (b) For a moderate risk patient, a PMP query shall be completed at least semiannually.
   (c) For a low risk patient, a PMP query shall be completed at least annually.

(5) The practitioner shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.

(6) The practitioner shall ensure a PMP query is performed when providing episodic care to a patient who the practitioner knows to be receiving opioids for chronic pain, in accordance with WAC 246-XXX-X72.

(7) If the practitioner is working in a practice, group, or institution that integrates access to the PMP into the workflow of the electronic medical record (EMR), the practitioner shall ensure a PMP query is performed for all prescriptions of opioids and sedative hypnotics for acute pain. For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the EMR cannot be accessed by the practitioner due to a temporary technological or electrical failure.

(8) Pertinent concerns discovered in the PMP shall be documented in the patient record.