This document is a conceptual rules draft, designed for discussion purposes only

CONCEPTUAL DRAFT VERSION 6.1
OPIOID PRESCRIBING RULES (ESHB 1427)
February 16, 2018

TABLE OF CONTENTS

OPIOID PRESCRIBING – GENERAL PROVISIONS
246-XXX-X01 Intent
246-XXX-X02 Scope and Applicability
246-XXX-X03 Definitions
246-XXX-X04 Exclusions
246-XXX-X05 Patient Notification, Secure Storage, and Disposal
246-XXX-X06 Use of Alternative Modalities for Pain Treatment Encouraged
246-XXX-X07 Diagnosis Identified on Prescriptions

OPIOID PRESCRIBING – ACUTE AND PERIOPERATIVE CARE
246-XXX-X21 Patient evaluation and Patient Record
246-XXX-X22 Treatment Plan – Acute
246-XXX-X23 Treatment Plan – Perioperative

OPIOID PRESCRIBING – SUBACUTE CARE
246-XXX-X31 Subacute Pain Care
246-XXX-X32 Subacute Care – Patient Evaluation and Patient Record

OPIOID PRESCRIBING – CHRONIC NON-CANCER PAIN MANAGEMENT
246-XXX-X41 Initial Patient Evaluation and Patient Record
246-XXX-X42 Treatment Plan
246-XXX-X43 Written Agreement for Treatment
246-XXX-X44 Periodic Review
246-XXX-X45 Consultation—Recommendations and Requirements
246-XXX-X46 Consultation—Exemptions for Exigent and Special Circumstances
246-XXX-X47 Consultation—Exemptions for the Practitioner
246-XXX-X48 Pain Management Specialist
246-XXX-X49 Tapering Requirements
246-XXX-X50 High Dose Patients Establishing a Relationship with a New Practitioner

OPIOID PRESCRIBING – SPECIAL POPULATIONS
246-XXX-X71 Special Populations: Patients Under 25 Years of Age, Pregnant Patients, and Aging Populations
246-XXX-X72 Episodic Care of Chronic Opioid Patients

OPIOID PRESCRIBING – CO-PRESCRIBING AND MEDICATION-ASSISTED TREATMENT
246-XXX-X81 Co-prescribing of Opioids with Certain Medications

246-XXX-X82 Co-prescribing of Opioid Agonists for Medication-Assisted Treatment
246-XXX-X83 Co-prescribing of Naloxone

OPIOID PRESCRIBING – PRESCRIPTION MONITORING PROGRAM

246-XXX-X91 Prescription Monitoring Program – Required Queries
246-XXX-X92 Prescription Monitoring Program – Recommended Queries

NOTE: Numbering for the above sections is for illustration purposes only. We recognize that 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

NOTE TO READERS: The 1427 Task Force has not reviewed Sections X01 and X02 in previous stakeholder meetings. We will ask the Task Force to consider several options on March 14 with respect to these sections. We have presented prior feedback on these sections to the Task Force. You may wish to skip these sections in your review.

246-XXX-X01 Intent

Pursuant to ESHB 1427, chapter 297, sections 2 through 8, Laws of 2017 and Executive Order 16-09, the Dental Quality Assurance Commission, the Nursing Care Quality Assurance Commission, the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, and the Podiatric Medical Board have worked together collaborated to develop and adopt shared professional practice requirements expected of all healthcare practitioners who prescribe opioid analgesics.

The diagnosis and treatment of pain is integral to the practice of (medicine/nursing/osteopathic medicine and surgery/dentistry/podiatric medicine and surgery).

Practitioners should not prescribe opioid analgesics by default. Opioid analgesics may be essential in the treatment of acute or subacute pain due to trauma or surgery; however, use for acute or subacute pain can raise the risk of addiction. Use for chronic pain carries significant patient risk.

Changes from Previous Draft:
• None. • MQAC submission is provided below.
Status:
Deferred at February 9 meeting, review at March meeting needed.
Notes:
• Both WSMA and WSPMA have questioned the purpose of this section and whether it could be deleted. They also point out that this rulemaking is not strictly pursuant to EO 16-09. The key question is whether this section provides important contextual value. It is not generally enforceable and could have an unintended impact on prescribing.

[MQAC submission]:

The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or

inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes non-treatment, under-treatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain, including acute pain, perioperative pain, subacute pain and chronic pain. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, these rules have been developed to clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment as defined in the first paragraph may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to illness, trauma or surgery, subacute pain and chronic pain, whether due to cancer or non-cancer origins. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. Examples of current clinical practice guidelines include AMDG guidelines http://agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf and CDC guidelines for chronic pain https://www.cdc.gov/drugoverdose/prescribing/guideline.html. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a

legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist practitioners in providing appropriate medical care for patients. They are not inflexible rules or rigid practice requirements and are not intended, nor should they be used, to establish a legal standard of care outside the context of the medical quality assurance commission's jurisdiction.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner based on all the circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.
Therefore, it should be recognized that adherence to these rules will not assure an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist practitioners in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

NOTE TO READERS: The 1427 Task Force has not reviewed Sections X01 and X02 in previous stakeholder meetings. We will ask the Task Force to consider several options on March 14 with respect to these sections. We have presented prior feedback on these sections to the Task Force. You may wish to skip these sections in your review.

246-XXX-X02 Scope and Applicability

(1) The variety and complexity of human conditions make it impossible to address in rule all the circumstances the practitioner must consider when treating a patient. As with all health professions regulations, these rules are intended to set minimum standards for professional conduct; these rules do not encompass all of the guidelines recommended by the agency medical directors group, the Bree collaborative, centers for disease control guidelines, or other agencies or organizations.

(2) Where these rules do not address specific issues, the (board/commission) will govern based on nationally accepted and evidence-based standard of care and will refer to current clinical practice guidelines and expert review in considering cases involving management of pain. The practitioner should obtain sufficient education and training on current clinical practice guidelines, on an ongoing basis, to ensure competency in safe prescribing of opioids and other analgesics.

(3) These rules establish enforceable standards for practitioners prescribing opioid analgesics under the (board's/commission's) jurisdiction. Compliance with applicable state or federal law is required. These rules do not establish a legal standard of care outside the context of the (board's/commission's) jurisdiction.

Changes from Previous Draft:
None.
Status:
Deferred at February meeting; needs to be discussed at March meeting.
Notes:

246-XXX-X03 Definitions

The definitions in this section apply throughout sections X01 through section X92 unless the context clearly requires otherwise.

(1) "**Aberrant Behaviors"** means behavior that indicates misuse, diversion or addiction. This includes, but is not limited to, multiple early refills or obtaining prescriptions for the same or similar drugs from more than one clinician 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 (0) to six (6) weeks in duration.

(3) "**Addiction**" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include: impaired control over drug use, craving, compulsive use, or continued use despite harm. Addiction does not mean physical dependence and tolerance that are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"**Addiction**" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:

(a) Impaired control over drug use;
(b) Craving;
(c) Compulsive use; or
(d) Continued use despite harm.

(4) "**Biological specimen test**" or "**biological specimen testing**" means tests including but not limited to urine, hair or other biological samples for various drugs and metabolites to provide objective documentation of adherence to an opioid treatment plan as well as aid in the diagnosis and treatment of addiction or substance use disorders.

"Biological specimen testing" means tests including but not limited to urine, hair or other biological samples for various drugs and metabolites.

(5) "**Chronic non-cancer pain**" means a state in which non-cancer 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.

(6) "**Chronic pain**" means pain caused by various diseases or abnormal conditions that continue longer than twelve weeks.

"**Chronic pain**" means pain caused by various diseases or abnormal conditions that continue longer than twelve weeks.

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

(8) "**Definitive testing**" is biologic specimen testing that is used for any of the following: (1) confirming the results of presumptive (screening) testing, utilizing testing equipment that is more accurate, (2) identifying specific drugs that presumptive testing does not check for, (3) identifying specific drugs by their metabolites, which presumptive testing does not check for, (4) quantifying drug concentrations.

(9) "**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.

(10) "**Functional examination**" means an examination used to describe an individual's ability to perform key daily activities and to evaluate changes in the activities of everyday life. It encompasses physical, social, and psychological domains.

(11) "**High dose**" means ninety (90) milligram MED per day.

(12) "**High-risk**" means a patient at increased propensity for misuse, abuse, stockpiling, diversion, addiction, overdose, or other aberrant behaviors as determined by the patient's history, and/or the risk assessment tool chosen by the practitioner, or other factors identified by the practitioner.

> "**High-risk**" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of addiction or abuse, aberrant behavior, or the use of any central nervous system (CNS) depressant.

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

(14) "**Hospice care**" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life, and patient and family support. Hospice can be provided in the patient's home as well as in freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

(15) "**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.

(16) "**Inpatient**" means a person who has been admitted to a hospital for more than twenty-four hours.

(17) ”**Medication assisted treatment**” or “**MAT**” means the use of FDA-approved opioid agonist and antagonists medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

“**Medication Assisted Treatment (MAT),”** for the purposes of this chapter, means the pharmacologic management of opioid use disorder rather than the more traditional definition that would also include a treatment program that combines behavioral therapy and medications to treat substance use disorders.

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

(19) “**Multidisciplinary pain clinic**" means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines or treatment modalities, for example, medical care through physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, podiatry, dental, advanced registered nurse practitioners, and physical therapy, occupational therapy, or other complementary therapies.

(20) “**Multimodal management of pain**” means the application of non-narcotic relief mechanisms, such as anti-inflammatory medications, acetaminophen, nerve blocks, NMDA agonists, and other medications.

(21) “**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.

(22) “**Opioid Dependence”** means physiologic adaptation that is a natural, non-pathologic result of opioid use. It may result in tolerance as well as withdrawal symptoms if the medication is stopped. This is not the same as addiction.

(23) “**Opioid naïve**” means a patient who has not used opioids for more than seven consecutive days during the previous thirty days.

“**Opioid naïve**” means a patient who has not used opioids in the previous thirty days.

(24) "**Palliative**" means care that maintains or improves the quality of life of patients and their families facing serious illness.

(25) "**Palliative care**" means care that maintains or improves the quality of life for patients facing serious or life-threatening illness through the identification, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.

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

(27) "**Pain management clinic**" means a publicly or privately owned facility for which a majority of patients are receiving chronic pain treatment which may include opioid analgesics or other care provided by multiple available disciplines or treatment modalities.

(28) "**Perioperative pain**" means acute pain that occurs as the result of surgery for which opioid analgesics may be prescribed.

"**Perioperative pain**" means acute pain that occurs as the result of surgery.

(29) "**PMP**" means the Washington prescription monitoring program authorized under chapter 70.225 RCW.

(30) "**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, 18.57, or 18.22 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatrist licensed under chapter 18.22 RCW.

(31) "**Risk assessment tools**" means utilizing a tool appropriate for the patient, such as but not limited to, the Screener and Opioid Assessment for Patients with Pain, Opioid Risk Tool, or Screening, Brief Intervention and Referral to Treatment, which are designed for predicting the likelihood that a patient will abuse or misuse a prescribed controlled substance based on past behavior, genetic predispositions, social or environmental factors, or other risks.

"**Risk assessment tool**" means tools appropriate for identifying high-risk patients. Examples include, but are not limited to, The Screener and Opioid Assessment for Patients with Pain, and Opioid Risk Tool.

(32) "**Subacute pain**" means the symptom or illness has passed the acute episode, but is not yet chronic.

"Subacute Pain" is considered to be a continuation of pain, of 6 weeks to 12 weeks in duration.

Changes from Previous Draft:
• Removed definitions of legacy patient and CMIF as not used in rule. • Renumbered for clarity. MQAC suggestions to definitions have been incorporated in alphabetical order or below the original proposed language in red font.
Status:
Additional review needed at March meeting.
Notes:
• Consider if a definition is needed: "pain management specialist," and time frames associated with phases of care. • If using the MQAC (31) clarify whether tool identifies risk generally, or only high risk.

246-XXX-X04 Exclusions

(1) The rules adopted under WAC 246-XXX-X01 through 246-XXX-X92 do not apply to the following:

(a) Patients with cancer-related pain;
(b) Hospice care and end of life patients;
(c) Inpatient hospital patients; and
(d) Palliative care patients.

246-XXX-X05 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, the patient, and the phase of treatment. The practitioner shall document such notification in the patient's 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 a phase of treatment, as follows:

(i) Acute pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding the safe and secure storage of opioid prescriptions and the proper disposal of unused opioid medications, including but not limited to the availability of recognized drug take-back programs.

246-XXX-X06 Use of Alternative Modalities for Pain Treatment

(1) The practitioner shall consider multimodal pharmacologic and non-pharmacologic therapy for acute, subacute, or perioperative pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based alternatives exist. A practitioner may combine opioids with other medications and treatments, such as but not limited to acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDS), osteopathic manipulative treatment, physical therapy, massage, and sleep hygiene.

246-XXX-X07 Diagnosis Identified on Prescriptions

(1) The practitioner shall include the diagnosis, indications for use, or the International Classification of Diseases (ICD) code on all opioid prescriptions.

OPIOID PRESCRIBING – ACUTE AND PERIOPERATIVE CARE

246-XXX-X21 Acute and Perioperative Care – Patient Evaluation and Patient Record

(1) Prior to writing an opioid prescription for acute or perioperative pain, the practitioner shall:

(a) Conduct an appropriate history and physical examination;
(b) Identify the nature and intensity of the pain; and
(c) Inquire of the patient other medications the patient is prescribed or is taking, including date, type, dosage and quantity prescribed.

(2) The practitioner shall conduct queries of the Washington State PMP in accordance with the provisions of WAC 246-XXX-X91 and WAC 246-XXX-X92 to identify any Class II-IV controlled medications prescribed by other practitioners and document review and concerns prior to renewing an opioid prescription.

(3) The practitioner treating a patient for acute or perioperative 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) Practitioner queries of the PMP;
(c) All medications the patient is known to be prescribed or taking;
(d) An appropriate pain treatment plan, including the consideration of, or attempts to use, non-pharmacological modalities and non-opioid therapy; and
(e) All other required components of the patient record, as set out in rule.

Changes from Previous Draft:
• Previous general provisions records section combined with acute and perioperative patient evaluation section. • Added subsection (e) as some boards and commissions have recordkeeping rules which may be appropriate to reference here. • The previous language and the MQAC suggestion were combined for consideration as a whole. Provisions relating to follow-up visits were previously incorporated into the acute and perioperative treatment planning sections.
Status:
Concept discussed at January 8 meeting, not yet considered in full.
Notes:
• Previous stakeholder key questions: 1) What about emergent situations where there may not be time to do all of this before pain meds are administered; and 2) since PMP is just controlled substances, practitioner may not have access to all other medications. • MQAC subsection (6)(a)-(d) is currently contained in –X22 and –X23, re: the treatment plan.

246-XXX-X22 Treatment Plan - Acute

(1) The practitioner shall comply with the following requirements when prescribing opioid analgesics for acute pain. The practitioner shall document completion of these requirements in the patient record.

(2) The practitioner shall consider prescribing non-opioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-XXX-X06.

(3) The practitioner shall prescribe opioids for effective pain control and 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 a patient who does not follow the normal course of recovery. If significant and documented improvement in functional stability, pain control, pain relief, or increased function 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 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) Long-acting opioids are not indicated for acute and perioperative pain. Should a practitioner need to use a long-acting opioid for acute pain, that reason must be documented in the patient record.

(7) MAT medications shall not be discontinued when treating acute or perioperative pain, consistent with the provisions of WAC 246-XXX-X82.

(8) If the practitioner elects to treat patients with opioids beyond the six week time period of acute pain, the practitioner shall recognize 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.

Changes from Previous Draft:
• Subsection (8) is provided for consideration of MAT language in acute and peri sections. • Subsection (9) models X23(7), discussed at the February 9 meeting, to acknowledge the transition from acute to subacute. It does not provide for exception to the application of subacute rules after the 6 week mark as is provided in X23.
Status:
Discussed at January 8 meeting.
Notes:
•

246-XXX-X23 Treatment Plan - Perioperative

(1) The practitioner shall comply with the following requirements when prescribing opioid analgesics for perioperative pain. The practitioner shall document completion of these requirements in the patient's record.

(2) The practitioner shall consider prescribing non-opioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-XXX-X06.

(3) The practitioner shall prescribe opioids only when clinically appropriate for effective pain control and 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.*

(4) The practitioner shall re-evaluate a patient who does not follow the normal course of recovery. If significant and documented improvement in functional stability, pain control, pain relief, or increased function 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 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 treat patients with opioids beyond the six week time period of perioperative pain, the practitioner shall recognize that the patient is transitioning from perioperative pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-XXX-X31 through WAC 246-XXX-X32, shall be followed unless improvement in functional stability, pain control, pain relief, or increased function is documented and there is documentation of the timing and plan for discontinuation of all opioid medications.

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

***NOTE: The taskforce requested to see how the Bree Collaborative perioperative guidelines could be incorporated into rule as part of (3). That concept is provided below for reference.**

Changes from Previous Draft:
• Revised MQAC suggested language re: transition to subacute pain as (7). • Included a reference to co-prescribing X81 as discussed at February 9 meeting. Inclusion here is not necessary, as X81 applies generally.
Status:

Concept approved (7 member vote) at February 9 meeting.
Notes:
• Inclusion of the below prescribing guidelines would be very detailed and prescriptive for rules. There is concern that any future change in the guidelines would necessitate a corresponding change in rule. Further, recommendations as to a three day prescription and a fourteen day limit with documented exception is already contained in rule. • (8) & (9) are generally applicable as provided in –X81. Recommend removal from here.

(3) The practitioner shall prescribe opioids for effective pain control and 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.

a. Recommended duration of opioid treatment for post-operative pain for selected types of procedures and populations:
    i. Adolescents ≤ 24 years old:
        1. Dental extractions (e.g. third molar, wisdom tooth):
            a. Prescribe NSAID or combination of NSAID and acetaminophen for mild to moderate pain.
            b. Prescribe ≤ 3 days (e.g., 8 to 12 tablets) of immediate release opioids in combination with an NSAID or acetaminophen for severe pain.
    ii. Adults:
        1. Minor procedures:
            a. Dental extractions or simple oral surgery (e.g. graft, implant):
                i. Prescribe NSAID or combination of NSAID and acetaminophen for mild to moderate pain.
                ii. Prescribe ≤ 3 days (e.g., 8 to 12 tablets) of immediate release opioids in combination with an NSAID or acetaminophen for severe pain.
            b. Minor surgery (e.g. hernia repair, laparoscopic appendectomy, carpal tunnel release, laparoscopic cholecystectomy, biopsy, meniscectomy):
                i. Prescribe non-opioid analgesics (e.g. NSAIDs, acetaminophen) and non-pharmacologic therapies.
                ii. Prescribe ≤ 3 days (e.g., 8 to 12 tablets) of immediate release opioids for severe pain.
        2. Moderate procedures:

   a. Moderate surgery (e.g. ACL repair, rotator cuff repair, discectomy, laminectomy):
      i. Prescribe non-opioid analgesics (e.g. NSAIDs, acetaminophen) and non-pharmacologic therapies
      ii. Prescribe ≤ 7 days (e.g., up to 42 tablets) of immediate release opioids for severe pain. Continued opioid use requires appropriate re-evaluation by the surgeon.

3. Major procedures:
   a. Major surgery (e.g. lumbar fusion, knee replacement, hip replacement):
      i. Prescribe non-opioid analgesics (e.g. NSAIDs, acetaminophen) and non-pharmacologic therapies.
      ii. Prescribe the lowest effective dose and shortest duration of immediate release opioids.
      iii. Do not discharge with more than a 14-day supply of opioids. Continued opioid use requires appropriate re-evaluation by the surgeon.
      iv. Taper off opioids within 6 weeks after surgery.
4. Patients on Chronic Opioid Therapy:
   a. Elective major surgery in patients on chronic opioid therapy:
      i. Prescribe non-opioid analgesics (e.g. NSAIDs, acetaminophen) and non-pharmacologic therapies.
      ii. Prescribe the lowest effective dose of immediate release opioids for acute pain.
      iii. Resume chronic regimen if patients are expected to continue postoperatively.
      iv. Taper opioids to preoperative doses or lower within 6 weeks after surgery.

OPIOID PRESCRIBING – SUBACUTE CARE

246-XXX-X31 Subacute Pain Care

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

(2) The goal in this phase is to taper opioids. If tapering has not begun prior to the subacute phase, the practitioner shall have observed a patient with significant and documented improvement in functional stability, pain control, pain relief, or increased function in order to have a legitimate basis to continue prescribing opioids beyond the acute pain episode. The practitioner shall make reasonable attempts to discontinue the use of opioids by no later than the conclusion of the subacute phase.

(3) The practitioner shall prescribe opioids for effective pain control and in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The practitioner shall not prescribe beyond a ten 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 Schedule II-IV medication listed in WAC 246-XXX-X81 or prescribes opioids to a patient known to be receiving a Schedule II-IV 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 patients with opioids beyond the subacute phase, the practitioner should recognize that the patient is progressing from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-XXX-X41 through WAC 246-XXX-X50, shall apply.

[MQAC submission, additional language]: **Progression from subacute to Chronic Pain**

The progression of subacute to chronic pain is a continuum and must be recognized by the practitioner. Chronic pain treatment should be a deliberate decision that takes into considerations the risks and benefits of chronic pain treatment for the patient. The practitioner shall comply with the following requirements, in addition to the requirements identified in Section 11, when providing chronic pain treatment for a patient. Chronic pain treatment is for pain lasting greater than twelve weeks. The practitioner shall document completion of these requirements in the patient's healthcare records.

The practitioner shall prescribe opioids for chronic pain treatment only if function and/or pain control is maintained or if there is sustained meaningful improvement in function and/or pain control, and no serious adverse outcomes or contraindications. The practitioner shall periodically review the course of treatment for chronic pain, the patient's state of health, and any new information about the etiology of the pain. See subsequent periodic review section to determine frequency of review.

CONCEPTUAL DRAFT VERSION 6.1
SUBACUTE CARE

Changes from Previous Draft:
• Section preciously created based on January meeting was restructured and streamlined with X32. • Subsection (6) created, modeling the language of X23(7), regarding the transition from subacute to chronic to incorporate the provided MQAC suggestion. • MQAC suggests language to address the transition from subacute care to chronic, provided in red font.
Status:
Concept discussed at January 8 meeting, further review needed.
Notes:

246-XXX-X32 Subacute Care – Patient Evaluation and 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 or perioperative phase;

(b) Identify 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 queries of the Washington State PMP in accordance with the provisions of WAC 246-XXX-X91 and WAC 246-XXX-X92;

(e) Screen and document the patient's level of risk for aberrant behavior and adverse events related to opioid therapy. If determined 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;

(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 functional stability, pain control, pain relief, or increased function forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) Practitioner 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 evaluations of function and pain using validated instruments;

(g) Results of any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;

(h) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery, including but not limited to depression or anxiety;

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

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

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

(3) Follow-up visits 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.

Changes from Previous Draft:
• Section previously created based on January meeting based on -X31 and- X91 PMP requirements. Task force consideration of patient evaluation and record requirements needed.
Status:
Created per January 8 meeting, content not yet discussed.
Notes:
•

OPIOID PRESCRIBING – CHRONIC PAIN MANAGEMENT

246-XXX-X41 Initial Patient Evaluation and Patient Record

The practitioner shall obtain, 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 initial patient evaluation must include:
- (a) Appropriate physical examination;
- (b) Chronic pain treatment with opioids must take into consideration the risks and benefits of chronic pain treatment for the patient;
- (c) Medications the patient is taking including indication(s), date, type, dosage, and quantity prescribed, and as related to treatment of the pain, efficacy of medications tried;
- (d) Review of the Washington state PMP to identify schedule II-V or other drugs of concern received by the patient in accordance with the provisions of WAC 246-XXX-X91 and WAC 246-XXX-X92.
- (e) Any available diagnostic, therapeutic, and laboratory results;
- (f) Use of a risk assessment tool and assign patient to a high, medium or low risk category. The practitioner should use caution and monitor 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 "pain contract") for treatment between the patient and the practitioner; and
- (k) Documentation of Informed Consent, including 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 the above as well as all other required components of the patient record, as set out in rule.

246-XXX-X42 Treatment Plan

(1) When the patient enters the chronic stage the patient must 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; and

(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 advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

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 drug therapy may be discontinued (e.g., violation of agreement);

(4) The requirement that all chronic pain management prescriptions are provided by a single prescriber, a single clinic, or a multidisciplinary pain clinic;

(5) The requirement that all pain management prescriptions are to be dispensed by a single pharmacy, pharmacy system, or pharmacy benefits manager 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 local emergency departments, urgent care facilities, other practitioners caring for the patient who might prescribe pain medications, and pharmacies; and

(b) Other practitioners to report violations of the agreement to the practitioner treating the patient's chronic pain and to the PMP;

(8) A written authorization that the practitioner may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;

(9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(10) 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

The practitioner shall periodically review the course of treatment for chronic pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews must take place at least every six months. However, for treatment of stable patients involving non-escalating daily dosages, the practitioner shall determine the periodic review schedule and document the rationale in the patient record.

(1) 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, considering any available information from family members or other caregivers; 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.

(2) Periodic or subsequent patient evaluations must 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;
- (c) Review of the Washington State PMP to identify schedule II-V or other drugs of concern received by the patient at a frequency determined by the patient's risk category, in accordance with the provisions of WAC 246-XXX-X91 and WAC 246-XXX-X92;
- (d) Administering a biological specimen test at the frequency determined by the patient's risk category, as follows:
  - (i) For a high risk-patient, at least quarterly;
  - (ii) For a medium-risk patient, at least semiannually;
  - (iii) For a low-risk patient, at least annually; and
  - (iv) Immediately upon indication of aberrant behavior.

(3) 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.

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 at risk for medication misuse, abuse, or diversion. 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 for adults is one hundred twenty milligrams morphine equivalent dose (MED). In the event 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. Great caution should be used when prescribing opioids to children with chronic pain, and appropriate referral to a specialist is encouraged.

(a) The mandatory consultation must consist of at least one of the following:

(i) An office visit with the patient and the pain management specialist;

(ii) A telephone consultation between the pain management specialist and the practitioner;

(iii) An electronic consultation between the pain management specialist and the prescribing practitioner; ~~or~~

(iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the prescribing practitioner or with a licensed health care practitioner designated by the prescribing practitioner or the pain management specialist; or

(v) Other chronic pain evaluation services as approved by the regulatory authority.

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

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 they have documented adherence to all standards of practice as defined in WAC 246-XXX-X41 through 246-XXX-X50 and when any one or more of the following conditions apply:

(1) The patient is following a tapering schedule; or

(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; or

(3) The practitioner documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty ones 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; or

(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 addiction medicine; or

(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 a 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 a 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 certified registered nurse anesthetist (CRNA) with current certification for anesthesia and/or non-surgical pain management; 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 nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity; 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 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.

Changes from Previous Draft:
• Original chronic rules amended per February 9 meeting.
Status:
Task force approved at February 9 meeting.
Notes:
• Unclear from February meeting if task force intended to use "or" in (4)(b), which would mean that an ARNP would need to meet only one criteria (CRNA or 3 years of experience or credentialed in pain management or 18 hours of CE or 30% of practice); this would deviate from the criteria applicable to other professions and the current rule. The text above maintains the criteria of the current rule. • Unclear from February meeting if task force intended to strike the criteria for a podiatric physician meeting the requirements of (5)(b) (3 years of experience, credentialed in pain management, etc.) as is permitted for other professions. • Consider adding Pharmacists. • Consider providing cross-reference to other profession WACs to describe a pain management specialist rather than list the other professions' qualifications.

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, or discontinuing treatment 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; or
(e) There is evidence of misuse, abuse addiction, or diversion.
(f) There is evidence of significant adverse effects;
(g) Severe adverse event or overdose; or
(h) Escalating doses.
(i) When the opioid dose continues to escalate with no improvement in pain, function or quality of life

246-XXX-X50 High Dose Pain Patients Establishing a Relationship with a New Practitioner

(1) When a patient is already on a high dose of opioid pain medications and changes to a new practitioner, it is normally appropriate for that practitioner to maintain their current opioid doses initially. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) To ensure a safe transfer of care the following requirements must be met:

(a) The patient's dose is stable and non-escalating;

(b) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements; and

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

Changes from Previous Draft:
• There was extensive discussion on this section at the February 9 meeting. Multiple edits were discussed, however discussion was tabled without a final resolution due to time constraints. • An alternative suggestion is proved below for consideration by the task force.
Status:
Discussed at February meeting, further work is required.
Notes:
• Clarity needed re: which provisions a high dose patient is exempt from (consultation, tapering, etc.) and for how long.

(1) A practitioner's treatment of a 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:

i. Was already being treated with a dosage of opioids in excess of one hundred twenty milligram MED for chronic pain immediately prior to the adoption of this chapter; or

ii. 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 with another practitioner immediately prior to changing to the new practitioner for continuing treatment of the same chronic condition; and

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

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements; and

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

(2) As applied to the treatment of a new patient, this exemption is granted for the first six months of that new care, after which the requirements of WAC 246-XXX-X45 and WAC 246-XXX-X49 shall apply.

OPIOID PRESCRIBING – SPECIAL POPULATIONS

NOTE TO READERS: The provisions of the prior version's sections X71, X72, and X73 have been condensed into one section. The Task Force will need to consider this approach in its discussions on March 14 and whether the current version of X71 is appropriate for rule, or if it is better suited for guidelines or educational outreach efforts.

246-XXX-X71 Special Populations: Patients Under 25 Years of Age, Pregnant Patients, and Aging Populations

(1) **Patients 25 years of age or under**: In the treatment of pain for patients 25 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.

(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 65 years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

Changes from Previous Draft:
• Combined the three special populations into one section.
Status:
Task force approved of these three special populations at the February 9 meeting.
Notes:
• Reference to the AMDG guidelines was removed due to concern that any change in name or content of the guidelines could necessitate a change in rule. Rather than explicitly refer to these sources in rule, it is recommended that these be provided to practitioners as educational materials. • Much of the information related to special populations should be retained and be part of an education and outreach campaign by the five B/Cs.

246-XXX-X72 Episodic Care of Chronic Opioid Patients

(1) When providing episodic care for patients being treated with opioids for chronic pain, such as for emergency or urgent care, the practitioner shall review the Washington state PMP to identify schedule II-V or other drugs of concern received by the patient.

(2) A practitioner providing episodic care to a patient being treated with opioids for chronic pain should avoid providing additional opioids. However, if opioids are provided, the practitioner shall limit the use of opioids for a chronic pain patient to the minimum amount necessary to control the acute, perioperative, or similar breakthrough 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 treatment practitioner when practicable.

Changes from Previous Draft:
• Amended per February 9 meeting. • Removed provision to include indications of use on prescriptions as that is a general provision under X07. • Provision requiring a check of other states' PMPs moved for consideration as part of X91.
Status:
Task force approved (8 member vote) at February 9 meeting.
Notes:
• Resolve whether subsection (2) will be "shall" or "should."

OPIOID PRESCRIBING – CO-PRESCRIBING AND MEDICATION-ASSISTED TREATMENT

246-XXX-X81 Co-prescribing with Certain Medications

(1) A practitioner shall not prescribe a combination of opioids 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 concurrently prescribed one or more of the medications listed in subsection (1), the opioid prescribing practitioner shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently.

246-XXX-X82 Co-prescribing of Opioid Agonists for Medication-Assisted Treatment

(1) If a practitioner prescribes opioids to a patient known to be engaged in medication-assisted treatment (MAT) for events such as an acute or perioperative episode, the opioid-prescribing practitioner shall coordinate their prescribing with the MAT practitioner. This coordination must occur as soon as is practicable to appropriately treat episodic pain while maintaining the patient's MAT. [MQAC submission]: Where practicable, clinicians providing care to acute pain or perioperative pain patients shall prescribe pain relief either in consultation with a pain specialist or with the prescribing clinician.

(2) Medication assisted treatment (MAT) medications shall not be discontinued when treating acute or perioperative pain without clear and convincing documentation of the necessity to do so, nor shall use of these medications be used to deny necessary operative intervention.

Changes from Previous Draft:
• Slight changes to language of section for clarity. • MQAC suggested language included in red font.
Status:
Discussed at January 8 meeting, Review of MQAC suggestions needed.
Notes:
• Does the task force want to require that those performing MAT have a buprenorphine waiver from SAMHSA? • Does the task force want to establish any special education/training requirements for those performing MAT? • As noted in –X22 Treatment Plan – Acute, further discussion of this section is needed. Suggested language in –X22 was: "MAT medications should not be discontinued when treating acute or perioperative pain without clear and convincing documentation of the necessity to do so, nor should use of these medications be used to deny necessary operative intervention. Whenever possible, clinicians providing care to acute pain or perioperative pain patients should prescribe pain relief either in consultation with a pain specialist or with the prescribing clinician."

246-XXX-X83 Co-prescribing of Naloxone

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

OPIOID PRESCRIBING – PRESCRIPTION MONITORING PROGRAM

246-XXX-X91 Prescription Monitoring Program – Required Queries

(1) The practitioner shall ensure a PMP query is performed prior to the prescription of an opioid or sedative hypnotic at the following times:

(a) Upon the third refill renewal of an acute opioid prescription;

(b) The time of transition from acute to subacute pain; and

(c) The time of transition from subacute to chronic pain.

(2) For chronic opioid therapy, 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 medium 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.

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

(4) The practitioner shall ensure a PMP query is performed in conjunction with episodic care, in accordance with WAC 246-XXX-X72.

(5) A practitioner treating a patient likely or known to be concurrently receiving care outside of Washington State shall also review any other appropriate, available prescription monitoring program.

Changes from Previous Draft and Follow-ups:
• Amended per February 9 meeting. Recommended queries in following section. • Subsection (5) was created from a MQAC suggestion to X72. It was moved to this section for consideration as a general requirement of PMP checks.
Status:
Task force reached consensus (8 member vote) on the content of this section at February 9 meeting. Agreement that these requirements are the floor and each B/C may add additional requirements.
Notes:
• Consider whether the PMP check at any indication of aberrant behavior applies to all patients, not just chronic.

246-XXX-X92 Prescription Monitoring Program – Recommended Queries

(1) For acute, perioperative, and subacute care, it is strongly recommended that a PMP query be performed prior to any prescription for an opioid or sedative hypnotic to identify schedule II-V or other drugs of concern received by the patient.

(2) For chronic pain management, it is strongly recommended that a PMP query be performed quarterly, prior to prescribing any opioid or sedative hypnotic to identify schedule II-V or other drugs of concern received by the patient.