



PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)

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FILED

DATE: October 22, 2018

TIME: 9:08 AM

WSR 18-21-155

Agency: Department of Health- Dental Quality Assurance Commission

- Original Notice
 Supplemental Notice to WSR 18-15-056
 Continuance of WSR
 Preproposal Statement of Inquiry was filed as WSR 17-17-140 ; or
 Expedited Rule Making--Proposed notice was filed as WSR ; or
 Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).
 Proposal is exempt under RCW .

Title of rule and other identifying information: (describe subject) Chapter 246-817 WAC. The Dental Quality Assurance Commission (commission) proposes supplemental filing for changes to originally proposed new sections and changes to existing rule that will establish requirements and standards for prescribing opioid drugs by dentists consistent with the directives of Engrossed Substitute House Bill (ESHB) 1427. The commission agreed with stakeholder comments at the September 7, 2018 hearing that substantive changes were necessary before adoption of the rules.

Hearing location(s):			
Date:	Time:	Location: (be specific)	Comment:
12/07/2018	9:35 a.m.	Department of Health Point Plaza East, Room 152/153 310 Israel Rd. SE Tumwater, WA 98501	

Date of intended adoption: 12/07/2018 (Note: This is **NOT** the effective date)

Submit written comments to:

Name: Jennifer Santiago
Address: PO Box 47852
Olympia, WA 98504
Email: <https://fortress.wa.gov/doh/policyreview>
Fax: 360-236-2901
Other:
By (date) 11/30/2018

Assistance for persons with disabilities:

Contact Jennifer Santiago
Phone: 360-236-4893
Fax: 360-236-2901
TTY: (360) 833-6388 or 711
Email: jennifer.santiago@doh.wa.gov
Other:
By (date) 11/30/2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The commission is proposing establishing new sections of rule to implement the provisions of ESHB 1427. The bill directed five boards and commissions to consider the agency medical directors' group and the centers for disease control guidelines, and to work in consultation with the department, the University of Washington, and the professional association of each profession to develop requirements for prescribing opioid drugs. The commission is also proposing amendments to the current pain management rules to assure alignment with the proposed opioid prescribing rules, increase consistent rule application, and reduce duplication between existing and new rules. The proposed rules implement section 3 of ESHB 1427 by creating new rules and amending and reorganizing existing pain management rules to reduce duplication and assure harmonization with the new opioid prescribing requirements. The commission changed the original proposal to add cancer-related pain definition

to WAC 246-817-905, deleted WAC 246-817-912 Patient evaluation and patient record, and changed the query requirement in WAC 246-8174-980 from every prescription to a prescription monitoring program query upon first refill or renewal and transitions of pain phases.

Reasons supporting proposal: The proposed rules are necessary to establish and implement opioid prescribing requirements for dentists. The proposed rules provide a necessary framework and structure for safe, consistent opioid prescribing practice consistent with directives of ESHB 1427. The proposed rules recognize instances where clinical judgement is appropriate by providing practice guidance without being overly prescriptive, and are designed to reduce the risks associated with opioid use in the management of pain, while increasing public health and safety. The goal is to reduce the number of people who inadvertently become addicted to opioids and, consequently, reduce the burden on opioid treatment programs. The supplemental proposal is different from the previous CR102 filed as WSR 18-15-056 on July 16, 2018; the previous CR-102 rules lacked a cancer-related pain definition, had duplicative rules for patient evaluation and patient record which were streamlined, and required changes to the rule for queries related to the prescription monitoring program. These changes were made based upon significant stakeholder concerns expressed during the previous CR-102 hearing.

Statutory authority for adoption: RCW 18.32002, 18.32.0365, and RCW 18.32.800

Statute being implemented: ESHB 1427 (Chapter 297, Laws of 2017), codified in part as RCW 18.32.800

Is rule necessary because of a:

Federal Law?

Yes No

Federal Court Decision?

Yes No

State Court Decision?

Yes No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: (person or organization) Washington State Dental Quality Assurance Commission Private
 Public Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Jennifer Santiago	111 Israel Rd. SE, Tumwater, WA 98501	360-236-4893
Implementation:	Jennifer Santiago	111 Israel Rd. SE, Tumwater, WA 98501	360-236-4893
Enforcement:	Jennifer Santiago	111 Israel Rd. SE, Tumwater, WA 98501	360-236-4893

Is a school district fiscal impact statement required under RCW 28A.305.135? Yes No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:

Address:

Phone:

Fax:

TTY:

Email:

Other:

Is a cost-benefit analysis required under RCW 34.05.328?

Yes: A preliminary cost-benefit analysis may be obtained by contacting:

Name: Jennifer Santiago
Address: PO Box 47852
 Olympia, WA 98504
Phone: 360-236-4893
Fax: 360-236-2901
TTY: (360) 833-6388 or 711
Email: jennifer.santiago@doh.wa.gov
Other:

No: Please explain:

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> RCW 34.05.310 (4)(b)
(Internal government operations) | <input type="checkbox"/> RCW 34.05.310 (4)(e)
(Dictated by statute) |
| <input type="checkbox"/> RCW 34.05.310 (4)(c)
(Incorporation by reference) | <input type="checkbox"/> RCW 34.05.310 (4)(f)
(Set or adjust fees) |
| <input type="checkbox"/> RCW 34.05.310 (4)(d)
(Correct or clarify language) | <input type="checkbox"/> RCW 34.05.310 (4)(g)
((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit) |

This rule proposal, or portions of the proposal, is exempt under RCW .

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

No Briefly summarize the agency's analysis showing how costs were calculated. The proposed rules impact dental clinic businesses if the dentist(s) in the business prescribe opioids for pain management. The proposed rules do not apply to dentists who do not prescribe opioids. The cost calculations and analysis has not changed as a result of this new proposal. The following North American Industrial Classification System (NAICS) six-digit codes, total number of businesses in Washington state in 2013, total combined and average business payroll (rounded to the thousands), and minor cost thresholds have been applied to the proposal:

1. NAICS Code: 621210 Offices of Dentists

Total establishments in Washington: 3,551

Total combined annual payroll: \$1,212,689,000.00

Average annual payroll (total payroll divided by total establishments): \$341,506

Minor Cost threshold (Average payroll multiplied by .01): \$3,415

The commission has analyzed the anticipated costs of compliance for a business at \$29.40 for every patient encounter only when a dentist prescribes opioids, and only if the dentist performs all of the tasks required in the proposed rules. Many of the required tasks in the rules are often performed by other staff (such as dental assistants) at much lower costs. For example, regarding the following tasks required under the proposed rules at every patient encounter when an opioid is prescribed:

-Documenting patient history and physical condition

-Documenting/updating the patient health record

-Completing a prescription monitoring program (PMP) check

A dentist performing these tasks would cost the business an estimated \$20.16*; or

A dental assistant could perform the same task for an estimated \$4.46*.

Depending on the patient's phase of pain management, the business may incur the following additional cost:

a. From \$0 per patient encounter for a patient whose pain level and function meet the expected course of recovery; up to

b. An estimated \$5.88 per patient encounter when the dentist must re-evaluate a patient transitioning to another pain phase.

Based on these anticipated costs, the commission has determined that the proposed rules would not impose more than minor costs for businesses that must comply.

*Based on United States Department of Labor Statistics, Occupational Employment and Wages 2017 for 29-1021 Dentists, General, and 31-9091, Dental Assistants.

Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:

Address:

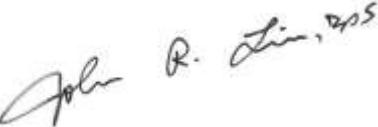
Phone:

Fax:

TTY:

Email:

Other:

Date: 10/22/2018	Signature: 
Name: John R. Liu, DDS	
Title: Dental Quality Assurance Commission Chairperson	

((PAIN MANAGEMENT)) OPIOID PRESCRIBING

Opioid Prescribing—General Provisions

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-901 ((Pain management)) Intent and scope. ((These rules)) WAC 246-817-901 through 246-817-980 govern the ((use)) prescribing of opioids in the treatment of ((patients for chronic non-cancer)) pain.

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-905 Exclusions. ((The rules adopted under)) WAC 246-817-901 through ((246-817-965)) 246-817-980 do not apply to:

(1) The treatment of patients with cancer-related pain. Cancer-related pain means pain that is unpleasant, persistent, subjective sensory and emotional experience associated with actual or potential tissue injury or damage or described in such terms and is related to cancer or cancer treatment that interferes with usual functioning;

(2) The provision of palliative, hospice, or other end-of-life care; ((or

(2) The management of acute pain caused by an injury or surgical procedure.))

(3) The treatment of inpatient hospital patients. Inpatient means a person who has been admitted to the hospital for more than twenty-four hours; or

(4) The provision of procedural medications.

NEW SECTION

WAC 246-817-906 Definitions. The definitions in this section apply to WAC 246-817-901 through 246-817-980 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 renewals, or obtaining prescriptions for the same or similar drugs from more than one dentist or other health care practitioner.

(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 six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of 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) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.

(6) "High dose" means ninety milligram MED or more, per day.

(7) "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.

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

(9) "Hospital" means any institution, place, building, or agency licensed under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 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.

(10) "Low-risk" means a category of patient at low risk of opioid induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than 50 MED.

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

(12) "Moderate-risk" means a category of patient at moderate risk of opioid induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history of substance use disorder or abuse, aberrant behavior, and dose of opioids between 50-90 MED.

(13) "Morphine equivalent dose" or "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 facility that provides comprehensive pain management and includes care provided by multiple available disciplines, practitioners, or treatment modalities.

(15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "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 that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodeone, fentanyl, meperidine, and methadone.

(17) "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.

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

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "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.

(21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

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

(23) "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.

NEW SECTION

WAC 246-817-907 Patient notification, secure storage, and disposal. (1) The dentist shall provide information to the patient educating them of risks associated with the use of opioids. The dentist 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 nonoperative 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 medication including, but not limited to, the availability of recognized drug take-back programs.
- (4) This requirement may be satisfied with a document provided by the department of health.

NEW SECTION

WAC 246-817-908 Use of alternative modalities for pain treatment. The dentist 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.

NEW SECTION

WAC 246-817-909 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, a dentist licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the rules in this chapter. The continuing education must be at least three hours in length.

(2) The dentist shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the dentist'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.

(3) The hours spent completing the training in opioid prescribing under this section count toward meeting applicable continuing education requirements for dentist license renewal.

NEW SECTION

WAC 246-817-911 Diagnosis identified on prescription. The practitioner shall include the diagnosis, indication for use, or the International Classification of Diseases (ICD) code on all opioid prescriptions.

Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain

NEW SECTION

WAC 246-817-913 Treatment plan—Acute nonoperative pain and acute perioperative pain. The dentist shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain or acute perioperative pain and shall document completion of these requirements in the patient record:

(1) The dentist shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-817-908 unless not clinically appropriate.

(2) The dentist, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-817-980 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns in the patient record.

(3) If the dentist prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient;

(b) More than a seven-day supply will rarely be needed;

(c) The dentist shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the dentist 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 dentist shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the dentist 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 nonoperative pain or acute perioperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should a dentist need to prescribe a long-acting opioid for acute pain, the dentist shall document the reason in the patient record.

(7) A dentist shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-817-976.

(8) If the dentist elects to prescribe a combination of opioids with a medication listed in WAC 246-817-975 or to a patient known to be receiving a medication listed in WAC 246-817-975 from another practitioner, such prescribing must be in accordance with WAC 246-817-975.

(9) If the dentist elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain or acute perioperative pain, the dentist shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-817-915 and 246-817-916 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

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-915 Patient evaluation and patient record. The dentist shall ((obtain, evaluate)) comply with the requirements in this section when prescribing opioid analgesics for subacute pain, and shall document completion of these requirements in the ((patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

(1) The patient's health history shall include:

- (a) Current and past treatments for pain;
- (b) Comorbidities; and
- (c) Any substance abuse.

(2) The patient's health history should include:

- (a) A review of any available prescription monitoring program or emergency department-based information exchange; and
- (b) Any relevant information from a pharmacist provided to the dentist.

(3) The initial patient evaluation shall include:

- (a) Physical examination;
- (b) The nature and intensity of the pain;
- (c) The effect of the pain on physical and psychological function;
- (d) Medications including indication(s), date, type, dosage, and quantity prescribed;
- (e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:
 - (i) History of addiction;

- (ii) Abuse or aberrant behavior regarding opioid use;
- (iii) Psychiatric conditions;
- (iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;
- (v) Poorly controlled depression or anxiety;
- (vi) Evidence or risk of significant adverse events, including falls or fractures;
- (vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;
- (viii) Repeated visits to emergency departments seeking opioids;
- (ix) History of sleep apnea or other respiratory risk factors;
- (x) Possible or current pregnancy; and
- (xi) History of allergies or intolerances.
- (4) The initial patient evaluation should include:
- (a) Any available diagnostic, therapeutic, and laboratory results; and
- (b) Any available consultations.
- (5) The health record shall be maintained in an accessible manner, readily available for review, and should include:
- (a) The diagnosis, treatment plan, and objectives;
- (b) Documentation of the presence of one or more recognized indications for the use of pain medication;
- (c) Documentation of any medication prescribed;
- (d) Results of periodic reviews;
- (e) Any written agreements for treatment between the patient and the dentist; and
- (f) The dentist's instructions to the patient record:
- (1) Prior to prescribing an opioid for subacute pain, the dentist shall:
- (a) Conduct an appropriate history and physical examination or review and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;
- (b) Evaluate the nature and intensity of the pain;
- (c) Inquire about other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;
- (d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-817-980 to identify any Schedule II-V medications or drugs of concern received by the patient and document in their review and any concerns;
- (e) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and
- (f) 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 dentist 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 and any concerns the dentist may have;
- (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, nonpharmacological modalities and nonopioid 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 established 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.

NEW SECTION

WAC 246-817-916 Treatment plan—Subacute pain. (1) The dentist shall recognize the progression of a patient from the acute nonoperative 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 dentist shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the dentist shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The dentist 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 dentist prescribes opioids for effective pain control, such prescriptions must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. The dentist 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 dentist elects to prescribe a combination of opioids with a medication listed in WAC 246-817-975 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-817-975 from another practitioner, the dentist shall prescribe in accordance with WAC 246-817-975.

(5) If the dentist elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the dentist shall document in the patient record that the patient is transitioning from subacute

pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-817-919 through 246-817-967, shall apply.

Opioid Prescribing—Chronic Pain Management

NEW SECTION

WAC 246-817-919 Patient evaluation and patient record. The dentist 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 PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-817-980;
 - (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;
 - (i) The dentist should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;
 - (ii) "Risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.
 - (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) Written agreements, as described in WAC 246-817-930, for treatment between the patient and the dentist;
 - (j) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy; and
 - (k) Treatment plan and objectives including:
 - (i) Documentation of any medication prescribed;
 - (ii) Biologic specimen testing ordered; and
 - (iii) Any labs or imaging ordered.
- (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.

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-920 Treatment plan. (1) ((The written)) When the patient enters the chronic pain phase, the dentist shall reevaluate the patient by treating the situation as a new disease.

((2) The chronic pain treatment plan ((shall)) must state the objectives that will be used to determine treatment success and ((shall)) 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.

((+2)) ((3) After treatment begins, the dentist ((should)) shall adjust drug therapy to the individual health needs of the patient. ((The dentist shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The dentist shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.))

((+2)) ((3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.))

((+2)) ((4) The dentist shall complete patient notification in accordance with the provisions of WAC 246-817-907.))

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-930 Written agreement for treatment. ((Chronic non-cancer pain patients should receive all chronic pain management prescriptions from one dentist and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing)) The dentist shall use a written agreement for treatment with the patient ((outlining patient)) who requires long-term opioid therapy for chron-

ic pain that outlines the patient's responsibilities. This written agreement for treatment ((shall)) must include:

(1) The patient's agreement to provide biological samples for ((urine/serum medical level screening)) biological specimen testing when requested by the dentist;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills or renewals. "Refill" or "renewal" 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 246-817-901 through 246-817-980, refills or renewals are subject to the same limitation and requirements as initial prescriptions;

(3) Reasons for which ((drug)) opioid therapy may be discontinued ((e.g.)) such as, but not limited to, violation of agreement((+));

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

(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;

((+5)) (6) The patient's agreement to not abuse ((alcohol or use other medically unauthorized)) substances that can put the patient at risk for adverse outcomes;

((+6)) (7) A written authorization for:

(a) The dentist to release the agreement for treatment to:

(i) Local emergency departments((r));

(ii) Urgent care facilities((r));

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies((; and)).

(b) The dentist to release the agreement to other practitioners ((to) so other practitioners can report violations of the agreement (back)) to the dentist((.))

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

(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;

(9) treating the patient's chronic pain and to the PMP.

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

((+10)) (9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the dentist's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-935 Periodic review. (1) The dentist shall periodically review the course of treatment for chronic ((noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least ev-

~~ery six months. However, for treatment of stable patients with chronic noncancer pain involving non-escalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.~~

~~(1)) pain. The frequency of visits, biological testing, and PMP queries must be determined based on the patient's risk category:~~

- ~~(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 dentist's discretion.~~

~~(2) During the periodic review, the dentist shall determine:~~

~~(a) The patient's compliance with any medication treatment plan;~~
~~(b) If pain, function, or quality of life have improved ((or)), 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 dentist's evaluation of progress towards treatment objectives.~~

~~((2)) (3) Periodic patient evaluations must also include:~~

~~(a) History and physical examination 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 246-817-980 and subsection (1) of this section.~~

~~(4) The dentist 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 dentist shall consider tapering, changing, or discontinuing treatment ((when:~~

- ~~(a) Function or pain does not improve after a trial period;~~
- ~~(b) There is evidence of significant adverse effects;~~
- ~~(c) Other treatment modalities are indicated; or~~
- ~~(d) There is evidence of misuse, addiction, or diversion.~~

~~(3) The dentist should periodically review information from any available prescription monitoring program or emergency department based information exchange.~~

~~(4) The dentist should periodically review any relevant information from a pharmacist provided to the dentist)) in accordance with the provisions of WAC 246-817-966.~~

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-950 Consultation—Recommendations and requirements.

~~(1) The dentist shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic ((noncancer)) pain~~

patients who are under eighteen years of age((r)) or who are ((at risk for medication misuse, abuse, or diversion)) 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 ((for adults)) is one hundred twenty ((milligrams morphine equivalent dose (MED) (oral)). In the event a)) MED. Unless the consultation is exempted under WAC 246-817-955 or 246-817-960, the dentist who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold ((of one hundred twenty milligrams MED (orally) per day, a consultation with a)) shall comply with the pain management specialist ((as)) consultation requirements described in WAC 246-817-965 ((is required, unless the consultation is exempted under WAC 246-817-955 or 246-817-960. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

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

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

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

((iii)) An electronic consultation between the pain management specialist and the dentist; or

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

(d) Other chronic pain evaluation services as approved by the dental quality assurance commission.

((b))) (3) A dentist 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 pain management specialist provides a written record of the consultation to the dentist, the dentist shall maintain it as part of the patient record.

((3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-817-901 through 246-817-965, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.) (4) The dentist shall use great caution when prescribing opioids to children and adolescents with chronic pain, appropriate referral to a specialist is encouraged.

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-955 Consultation—Exemptions for exigent and special circumstances. A dentist is not required to consult with a pain management specialist as described in WAC 246-817-965 when ((he or she)) the dentist has documented adherence to all standards of practice as defined in WAC ((246-817-901 through 246-817-965)) 246-817-919 through 246-817-967 and when ((any)) one or more of the following conditions ((apply)) 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((r)) with expected return to ((or below)) their baseline dosage level or below;
- (3) The dentist documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams ((morphine equivalent dose—()) MED(+) per day without first obtaining a consultation; or
- (4) The dentist documents the patient's pain and function is stable and the patient is on a ((non-escalating)) nonescalating dosage of opioids.

AMENDATORY SECTION (Amending WSR 11-10-061, filed 5/2/11, effective 7/1/11)

WAC 246-817-960 Consultation—Exemptions for the dentist. The dentist is exempt from the consultation requirement in WAC 246-817-950 if one or more of the following qualifications are met:

- (1) The dentist is a pain management specialist ((as described in)) under WAC 246-817-965; ((or))
- (2) The dentist has successfully completed((, within the last two)) every four years((r)) 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 long-acting opioids, to include methadone)) substance use disorders; ((or))
- (3) The dentist is a pain management practitioner working in a multidisciplinary chronic pain treatment center((r)) or a multidisciplinary academic research facility; or
- (4) The dentist has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of ((his or her)) their current practice is the direct provision of pain management care.

WAC 246-817-965 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 physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; 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's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) If a dentist: 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.

(3) If an advanced registered nurse practitioner (ARNP):

((a) A minimum of three years of clinical experience in a chronic pain management care setting;

((b) Credentialed in pain management by a Washington state nursing care quality assurance commission approved national professional association, pain association, or other credentialing entity;

((c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

((d) 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.

(4) 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

((c) Credentialed in pain management by a Washington state podiatric medical board approved national professional association, pain association, or other credentialing entity; and

((d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.)) A dentist

shall be 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.

(2) An allopathic physician shall meet requirements in WAC 246-919-945 and an allopathic physician assistant shall meet requirements in WAC 246-918-895.

(3) An osteopathic physician shall meet requirements in WAC 246-853-750 and an osteopathic physician assistant shall meet requirements in WAC 246-854-330.

(4) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(5) A podiatric physician shall meet requirements in WAC 246-922-750.

NEW SECTION

WAC 246-817-966 Assessment of treatment plan. (1) The dentist 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.

(2) The dentist shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

- (a) The patient requests;
- (b) The patient experiences deterioration in function or pain;
- (c) The patient is noncompliant 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 patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-817-967 Patients with chronic pain, including those on high doses, establishing a relationship with a new dentist. (1) When a patient receiving chronic opioid pain medications changes to a new dentist, it is normally appropriate for the new dentist to initially maintain the patient's current opioid doses. Over time, the dentist may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A dentist's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-817-950 and the tapering requirements of WAC 246-817-966 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 nonescalating;

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

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, in excess of one hundred twenty milligram MED 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 246-817-950 and 246-817-966 shall apply.

Opioid Prescribing—Special Populations

NEW SECTION

WAC 246-817-970 Special populations—Patients twenty-four years of age or under, pregnant patients, and aging populations. (1) Patients twenty-four years of age or under. In the treatment of pain for patients twenty-four years of age or under, the dentist shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly. Eight to twelve tablets supply will often be sufficient. The dentist shall not prescribe beyond twelve tablets without clinical documentation in the patient record to justify the need for such a quantity.

(2) Pregnant patients. A dentist shall not discontinue use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The dentist 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 dentist 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.

NEW SECTION

WAC 246-817-971 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the dentist knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the dentist shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) A dentist providing episodic care to a patient who the dentist knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the dentist shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative 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 dentist 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 dentist shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the episodic care dentist, when practicable.

(5) For the purpose of this section "episodic care" means medical or dental care provided by a practitioner other than the designated primary care practitioner in the acute care setting; for example, urgent care or emergency department.

Opioid Prescribing—Coprescribing

NEW SECTION

WAC 246-817-975 Coprescribing of opioids with certain medications. (1) The dentist shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation of clinical judgment and discussion of risks with patient:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Sleeping medications also known as 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 dentist 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.

NEW SECTION

WAC 246-817-976 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the dentist providing acute nonoperative pain or acute perioperative pain treat-

ment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

(2) A dentist shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so.

(3) A dentist shall not deny necessary operative intervention for use of these medications by a patient.

NEW SECTION

WAC 246-817-977 Coprescribing of naloxone. The dentist shall confirm or provide a current prescription for naloxone or refer the patient to a pharmacist for further counseling and evaluation when opioids are prescribed to a high-risk patient.

Opioid Prescribing—Prescribing Monitoring Program

NEW SECTION

WAC 246-817-980 Prescription monitoring program—Required registration, queries, and documentation. (1) The dentist shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe opioids in Washington state.

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

(3) At a minimum, the dentist shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

(a) Upon the first refill or renewal of an opioid prescription for acute nonoperative 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 dentist 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 must be completed at least quarterly;

(b) For a moderate-risk patient, a PMP must be completed at least semiannually; and

(c) For a low-risk patient, a PMP must be completed at least annually.

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

(6) The dentist shall ensure a PMP query is performed when providing episodic care to a patient whom the dentist knows to be receiving opioids for chronic pain, in accordance with WAC 246-817-971.

(7) If the dentist is using an electronic medical record or EMR that integrates access to the PMP into the workflow of the EMR, the dentist shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-817-975.

(8) 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 dentist or their designee due to a temporary technological or electrical failure.

(9) Pertinent concerns discovered in the PMP must be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-817-910	Definitions.
WAC 246-817-925	Informed consent.
WAC 246-817-940	Long-acting opioids, including methadone.
WAC 246-817-945	Episodic care.