

NEW SECTION

WAC 246-XXX-XXX Pain management – Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

WAC 246-XXX-XXX Exclusions. The rules adopted under this section do not apply:

- (1) To the provision of palliative, hospice, or other end-of-life care; or
- (2) To the management of acute pain caused by an injury or surgical procedure.

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WAC 246-XXX-XXX Definitions. The definitions in this section apply throughout the section unless the context clearly requires otherwise.

- (1) “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. It is generally time-limited, often less than three months in duration, and usually less than six months.
- (2) “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:
 - (a) Impaired control over drug use,
 - (b) Craving,
 - (c) Compulsive use, or
 - (d) Continued use despite harm.
- (3) “Chronic noncancer pain” means a state in which noncancer 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.
- (4) “Comorbidity” means a pre-existing or co-existing physical or psychiatric disease or condition
- (5) “Hospice” 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 freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

- (6) "Palliative" means care that improves the quality of life of patients and their families facing 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.
- (7) "Physical dependence" means a physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence that may be relieved in total or in part by re-administration of the substance.
- (8) "Psychological dependence" means a subjective sense of need for a specific substance, either for its positive effects or to avoid negative effects associated with its abstinence.
- (9) "Tolerance" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

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WAC 246-XXX-XXX Patient evaluation. The (insert profession) shall obtain, evaluate, and document 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 (insert profession).
- (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 (insert profession), and
 - (f) The (insert profession) instructions to the patient.

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WAC 246-XXX-XXX Treatment plan.

- (1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall 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) After treatment begins the (insert profession) should adjust drug therapy to the individual health needs of the patient. (insert profession) shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. (insert profession) shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

- (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.

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WAC 246-XXX-XXX Informed consent. The (insert profession) shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

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WAC 246-XXX-XXX Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one (insert profession) 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 (insert profession) shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

- (1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the (insert profession),
- (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 and dispensed by a single pharmacy,
- (5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances,
- (6) A written authorization for:
 - (a) The (insert profession) to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies, and
 - (b) Other practitioners to report violations of the agreement back to the (insert profession),
- (7) A written authorization that the (insert profession) may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity,

- (8) Acknowledgement that a violation of the agreement may result in a tapering or discontinuation of the prescription,
- (9) Acknowledgement that it is the patient's responsibility to safeguard all medications and keep them in a secure location, and
- (10) Acknowledgement that if the patient violates the terms of the agreement, the violation and the (insert profession)'s response to the violation will be documented, as well as the rationale for changes in the treatment plan.

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WAC 246-XX-XXX Periodic review. The (insert profession) 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 every six months. However, for treatment of stable patients with chronic noncancer pain involving non-escalating daily dosages of 40 milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

- (1) During the periodic review, the (insert profession) shall determine:
 - (a) Patient's compliance with any medication treatment plan,
 - (b) If pain, function, or quality of life have improved or diminished 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 (insert profession)'s evaluation of progress towards treatment objectives.
- (2) The (insert profession) 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 (insert profession) 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 (insert profession) should periodically review information from any available prescription monitoring program or emergency department-based information exchange.
- (4) The (insert profession) should periodically review any relevant information from a pharmacist provided to the (insert profession).

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WAC 246-XX-XXX Long-acting opioids, including methadone.

Long-acting opioids, including methadone, should only be prescribed by a (insert profession) who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. (Insert Profession) prescribing long-acting opioids or methadone should have a one-time completion of at least four hours of continuing education relating to this topic.

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WAC 246-XXX-XXX Episodic Care.

- 1) When evaluating patients for episodic care, such as emergency or urgent care, the (insert profession) should review any available prescription monitoring program, emergency department-based information exchange, or other tracking system.
- 2) Episodic care practitioners should avoid providing opioids for chronic pain management. However, if opioids are provided, the (insert profession) should limit the use of opioids for a chronic noncancer pain patient to the minimum amount necessary to control the pain until the patient can receive care from a primary care practitioner.
- 3) Prescriptions for opioids written by an episodic care practitioner shall include indications for use or the International Classification of Disease Code (ICD) and shall be written to require photo identification of the person picking up the prescription in order to fill.
- 4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under (insert agreement for treatment section XX (6)) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

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WAC 246-XXX-XXX Consultation.

- (1) **Consultation.** The (insert profession) 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 18 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) **Mandatory Consultation at 120 milligrams morphine equivalent dose (MED).** In the event a (insert profession) prescribes a dosage amount that meets or exceeds the consultation threshold of 120 milligrams MED per day, a consultation with a pain management specialist is required, unless the consultation is exempted under section XXX (exigent) or section XXX (exempt practitioner).
- (a) The mandatory consultation shall 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 (insert profession),
 - iii. An electronic consultation between the pain management specialist and the (insert profession), or
 - iv. An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the (insert profession) or a licensed health care practitioner designated by the (insert profession) or the pain management specialist.
 - (b) A (insert profession) 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 (insert profession), the (insert profession) 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 this section, "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.

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WAC 246-XXX-XXX Exigent and special circumstances under which the 120 milligrams MED may be exceeded without consultation with a pain management specialist.

A (insert profession) is not required to consult with a pain management specialist when he or she has documented adherence to all standards of practice as defined in sections X-X of this chapter and when any one or more of the following conditions apply:

- (1) The patient is following a tapering schedule,

- (2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level,
- (3) The (insert profession) documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above 120 milligrams MED per day without first obtaining a consultation, or
- (4) The (insert profession) documents the patient's pain and function is stable and the patient is on a non-escalating dosage of opioids.

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WAC 246-XXX-XXX (insert profession) exempt from consultation requirement.

The (insert profession) is exempt from the consultation requirement in section XXX if one or more of the following qualifications are met:

- (1) The (insert profession) is a pain management specialist under section XXX,
- (2) The (insert profession) has successfully completed, within the last two years, a minimum of 12 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,
- (3) The (insert profession) practitioner is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility, or
- (4) The (insert profession) has a minimum three years of clinical experience in a chronic pain management setting, and at least 30 percent of his or her current practice is the direct provision of pain management care.

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WAC 246-XXX-XXX 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.
- (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 a specialty that includes a focus on chronic noncancer pain management by a Nursing Care Quality Assurance Commission-approved national professional association, pain association, or other credentialing entity,
 - (c) Successful completion of a minimum of at least 18 continuing education hours in pain management during the past two years, and
 - (d) At least 30 percent of the ARNP's current practice is the direct provision of pain management care.
- (4) If a podiatrist:
- (a) A minimum of three years of clinical experience in a chronic pain management care setting,
 - (b) Credentialed in a specialty that includes a focus on chronic noncancer pain management by a Podiatric Medical Board-approved national professional association, pain association, or other credentialing entity, and
 - (c) Successful completion of a minimum of at least 18 hours of continuing education in pain management during the past two years, and at least 30 percent of the podiatrist's current practice is the direct provision of pain management care, or
 - (d) 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 Podiatric Medical Board.