

**APPENDIX: WASHINGTON STATE OPIOID PRESCRIBING RULES**

The following excerpt is reprinted from the Washington Administrative Code. Available online at <http://apps.leg.wa.gov/WAC/default.aspx?cite=246>. The rules outlined are effective January 1, 2019.

**BOARD OF NURSING RULES****WAC 246-840-460 Pain management—Intent.**

WAC 246-840-460 through 246-840-4990 govern the use of opioids in the treatment of pain in the acute, perioperative, subacute, and chronic phases. Treatment modalities including opioid use 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 undertreatment or inappropriate treatment of pain. For the purpose of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. In addition to these rules, the nursing commission recommends practitioners adhere to applicable state agency medical directors' group (AMDG) and federal Centers for Disease Control and Prevention (CDC) guidelines for the treatment of pain in all phases.

**WAC 246-840-463 Exclusions.**

WAC 246-840-460 through 246-840-4990 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients; or
- (4) Procedural premedications.

**WAC 246-840-4651 Patient notification, secure storage, and disposal.**

- (1) The practitioner shall provide information to the patient educating them of:
  - (a) Risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment;
  - (b) The safe and secure storage of opioid prescriptions; and
  - (c) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.
- (2) The practitioner shall document such notification in the patient record.
- (3) 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 phases of treatment, as follows:
    - (i) Acute nonoperative pain or acute perioperative pain to subacute pain; and
    - (ii) Subacute pain to chronic pain.

**WAC 246-840-4653 Use of alternative modalities for pain treatment.**

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

**WAC 246-840-4655 Continuing education requirements for opioid prescribing.**

- (1) In order to prescribe an opioid in Washington state, an advanced registered nurse practitioner licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids. Additionally, a chronic pain management specialist must meet the continuing education requirements in WAC 246-840-493. The continuing education must be at least four hours in length.
- (2) The advanced registered nurse practitioner shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the advanced registered nurse practitioner's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later. The four hour course may count toward any NCQAC required continuing education.

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### **WAC 246-840-4657 Diagnosis identified on prescriptions.**

The advanced registered nurse practitioner shall include the diagnosis or the International Classification of Diseases (ICD) code on all opioid prescriptions.

### **WAC 246-840-4659 Patient evaluation and patient record—Acute.**

Prior to prescribing an opioid for acute nonoperative pain or acute perioperative pain, the advanced registered nurse practitioner shall:

- (1) Conduct and document an appropriate history and physical examination including screening for risk factors for overdose and severe postoperative pain;
- (2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and
- (3) Inquire about any other medications the patient is prescribed or is taking including type, dosage, and quantity prescribed.

### **WAC 246-840-4661 Treatment plan—Acute nonoperative pain.**

The advanced registered nurse practitioner shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record.

- (1) The advanced registered nurse practitioner shall consider recommending or prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.
- (2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 to identify any Schedule II-V medications or drugs of concern received by the patient, and document their review and any concerns.
- (3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription must not be in 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 advanced registered nurse 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 advanced registered nurse practitioner 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 advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.
- (6) Long-acting or extended release opioids are not typically indicated for acute nonoperative pain. Should an advanced registered nurse practitioner need to prescribe a long-acting opioid for acute pain, that reason must be documented in the patient record.
- (7) Medication assisted treatment (MAT) medications shall not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-840-4970.
- (8) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, shall apply.

### **WAC 246-840-4663 Treatment plan—Acute perioperative pain.**

The advanced registered nurse practitioner shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient's record.

- (1) The advanced registered nurse practitioner shall consider prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.
- (2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 to identify any Schedule II-V medications or drugs of concern received by the patient, and document in the patient record their review and any concerns.
- (3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a fourteen-day supply will rarely be needed for perioperative pain. The advanced registered nurse practitioner shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the advanced registered nurse practitioner may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group (AMDG), the Centers for Disease Control and Prevention (CDC), or the Bree Collaborative.

- (4) The advanced registered nurse practitioner shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional planned diagnostic evaluations or other treatments.
- (6) If the advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.
- (7) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, 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.

**WAC 246-840-4665 Patient evaluation and patient record—Subacute pain.**

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

- (1) Prior to prescribing an opioid for subacute pain, the advanced registered nurse 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 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 type, dosage, and quantity prescribed;
  - (d) Conduct, or cause the practitioner's authorized designee as defined in WAC 246-470-050 to conduct, a query of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990, to identify any Schedule II-V medications or drugs of concern received by the patient, and document their review and any concerns;
  - (e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the advanced registered nurse practitioner determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;
  - (f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and
  - (g) Screen or refer the patient for further consultation for psychosocial factors that may be impairing recovery including, but not limited to, depression or anxiety.
- (2) The advanced registered nurse practitioner treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:
  - (a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;
  - (b) The observed significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;
  - (c) The result of any queries of the PMP;
  - (d) All medications the patient is known to be prescribed or taking;
  - (e) An appropriate pain treatment plan, including the consideration of, or attempts to use, 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 that 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.

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- (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.

### WAC 246-840-4667 Treatment plan—Subacute pain.

- (1) The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated. The advanced registered nurse practitioner shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.
- (3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The advanced registered nurse practitioner shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.
- (4) If the advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.
- (5) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-840-467 through 246-840-4940, shall apply.

### WAC 246-840-467 Patient evaluation and patient record.

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

- (1) The patient's health history shall 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) 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), type, dosage, quantity prescribed, and as related to treatment of the pain, efficacy of medications tried;
  - (d) Review of the prescription monitoring program (PMP) to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-840-4990;
  - (e) Any available diagnostic, therapeutic, and laboratory results;
  - (f) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low risk category. The advanced registered nurse practitioner should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high risk;
  - (g) Any available consultations, particularly as related to the patient's pain;
  - (h) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
  - (i) Written agreements, as described in WAC 246-840-475 for treatment between the patient and the advanced registered nurse practitioner;

- (j) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy;
- (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, and all other required components of the patient record, as set out in statute or rule.

**WAC 246-840-470 Treatment plan.**

- (1) When the patient enters the chronic pain phase, the advanced registered nurse shall reevaluate the patient 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 advanced registered nurse practitioner shall adjust drug therapy to the individual health needs of the patient.
- (4) The advanced registered nurse practitioners shall complete patient notification in accordance with the provisions of WAC 246-840-4651.

**WAC 246-840-475 Written agreement for treatment.**

The advanced registered nurse 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 advanced registered nurse 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 or renewals;
- (3) Reasons for which opioid therapy may be discontinued;
- (4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, a single clinic, or a multidisciplinary pain clinic;
- (5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;
- (6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;
- (7) A written authorization for:
  - (a) The advanced registered nurse practitioner to release the agreement for treatment to:
    - (i) Local emergency departments;
    - (ii) Urgent care facilities;
    - (iii) Other practitioners caring for the patient who might prescribe pain medications; and
    - (iv) Pharmacies.
  - (b) Other practitioners to report violations of the agreement to the advanced registered nurse practitioner treating the patient's chronic pain and to the prescription monitoring program (PMP).
- (8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and
- (9) Acknowledgment that, if the patient violates the terms of the agreement, the violation and the advanced registered nurse practitioner's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

**WAC 246-840-4935 Assessment of treatment plan.**

The advanced registered nurse 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 advanced registered nurse practitioner shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

- (1) The patient requests;
- (2) The patient experiences a deterioration in function or pain;
- (3) The patient is noncompliant with the written agreement;
- (4) Other treatment modalities are indicated;

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- (5) There is evidence of misuse, abuse, substance use disorder, or diversion;
- (6) The patient experiences a severe adverse event or overdose;
- (7) There is unauthorized escalation of doses; or
- (8) There is continued dose escalation with no improvement in pain, function, or quality of life.

### **WAC 246-840-4940 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner.**

- (1) When a patient receiving chronic opioid pain medication(s) changes to a new advanced registered nurse practitioner, the advanced registered nurse practitioner shall query the prescription monitoring program (PMP). It is normally appropriate for the new advanced registered nurse practitioner to initially maintain the patient's current opioid doses. Over time, the advanced registered nurse practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
- (2) An advanced registered nurse practitioner's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-840-485 and the tapering requirements of WAC 246-840-4935 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, at the dose in excess to one hundred twenty milligram MED.
- (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 246-840-485 and 246-840-4935 shall apply.

### **WAC 246-840-4950 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations.**

- (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the advanced registered nurse practitioner shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.
- (2) Pregnant patients. Use of medication assisted treatment (MAT) opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The advanced registered nurse practitioner shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.
- (3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The advanced registered nurse practitioner shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

### **WAC 246-840-4955 Episodic care of chronic opioid patients.**

- (1) When providing episodic care for a patient who the advanced registered nurse practitioner knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the advanced registered nurse practitioner shall review the prescription monitoring program (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) An advanced registered nurse practitioner providing episodic care to a patient who the advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 advanced registered nurse 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 advanced registered nurse practitioner shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the episodic care advanced registered nurse practitioner, when practicable.

### **WAC 246-840-4960 Coprescribing with certain medications.**

- (1) The advanced registered nurse practitioner shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment and discussion of risks with the patient:
  - (a) Benzodiazepines;
  - (b) Barbiturates;
  - (c) Sedatives;
  - (d) Carisoprodol; or
  - (e) Nonbenzodiazepine hypnotics 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 advanced registered nurse practitioner prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

**WAC 246-840-4970 Coprescribing of opioids for patients receiving medication assisted treatment (MAT).**

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

(2) The advanced registered nurse practitioner shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary operative intervention.

**WAC 246-840-4980 Coprescribing of naloxone.**

(1) The advanced registered nurse practitioner shall confirm or provide a current prescription for naloxone when fifty milligrams MED or above, or when prescribed to a high-risk patient.

(2) The advanced registered nurse practitioner should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

**WAC 246-840-4990 Prescription monitoring program—Required registration, queries, and documentation.**

(1) The advanced registered nurse practitioner shall register to access the prescription monitoring program (PMP) or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The advanced registered nurse practitioner is permitted to delegate performance of a required PMP query to an authorized designee, as defined in WAC 246-470-050.

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

- (a) First opioid prescription for acute pain unless clinical exception is documented; such exceptions should be rare, occurring in less than ten percent of the first prescriptions;
- (b) First refill for acute pain if not checked with initial prescription due to documented clinical exception;
- (c) Time of transition from acute to subacute pain;
- (d) Time of transition from subacute to chronic pain; and
- (e) Time of preoperative assessment for any elective surgery or prior to discharge for nonelective surgery.

(4) For chronic pain management, the advanced registered nurse practitioner shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

- (a) For a high-risk patient, a PMP query shall be completed at least quarterly.
- (b) For a moderate-risk patient, a PMP query shall be completed at least semiannually.
- (c) For a low-risk patient, a PMP query shall be completed at least annually.

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

(6) The advanced registered nurse practitioner shall ensure a PMP query is performed when providing episodic care to a patient who the advanced registered nurse practitioner knows to be receiving opioids for chronic pain, in accordance with WAC 246-840-4955.

(7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the advanced registered nurse practitioner due to a temporary technological or electrical failure. The query shall be completed as soon as technically feasible.

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

**OSTEOPATHIC MEDICINE AND SURGERY RULES**

**Opioid Prescribing—General Provisions**

**WAC 246-853-660 Intent and scope.**

WAC 246-853-660 through 246-853-790 govern the prescribing of opioids in the treatment of pain.

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### WAC 246-853-661 Exclusions.

WAC 246-853-660 through 246-853-790 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients. As used in this section, “inpatient” means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

### WAC 246-853-675 Patient notification, secure storage, and disposal.

- (1) The osteopathic physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician 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 phases 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 medications including, but not limited to, the availability of recognized drug take-back programs.

### WAC 246-853-680 Use of alternative modalities for pain treatment.

The osteopathic physician shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

### WAC 246-853-685 Continuing education requirements for opioid prescribing.

- (1) In order to prescribe an opioid in Washington state, an osteopathic physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.
- (2) The osteopathic physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic physician’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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

### Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain

#### WAC 246-853-690 Patient evaluation and patient record.

Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic physician shall:

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

#### WAC 246-853-695 Treatment plan—Acute nonoperative pain.

The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

- (1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.
- (2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.
- (3) If the osteopathic physician 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 osteopathic physician 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 osteopathic physician 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 osteopathic physician 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;
    - (d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.
  - (6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician need to prescribe a long-acting opioid for acute pain, the osteopathic physician must document the reason in the patient record.
  - (7) An osteopathic physician shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-853-780.
  - (8) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic physician 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 246-853-705 and 246-853-710 shall apply.

**WAC 246-853-700 Treatment plan—Acute perioperative pain.**

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

- (1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.
- (2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II–V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.
- (3) If the osteopathic physician prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  - (a) A three-day supply or less will often be sufficient.
  - (b) More than a fourteen-day supply will rarely be needed for perioperative pain.
  - (c) The osteopathic physician shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the osteopathic physician may refer to clinical practice guidelines.
- (4) The osteopathic physician shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional planned diagnostic evaluations or other treatments.
- (6) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician must prescribe in accordance with WAC 246-853-775.
- (7) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-853-705 and 246-853-710 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**

**WAC 246-853-705 Patient evaluation and patient record.**

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

- (1) Prior to prescribing opioids for subacute pain, the osteopathic physician 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 246-853-790 to identify any Schedule II–V medications or drugs of concern received by the patient and document the review for any concerns;
  - (e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;
  - (f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and
  - (g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.
- (2) The osteopathic physician 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 osteopathic physician 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 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.

**WAC 246-853-710 Treatment plan—Subacute pain.**

- (1) The osteopathic physician 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 osteopathic physician 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 osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician 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 osteopathic physician 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. The osteopathic physician 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 osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician shall prescribe in accordance with WAC 246-853-775.
- (5) If the osteopathic physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic physician 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 246-853-715 through 246-853-760 shall apply.

**Opioid Prescribing—Chronic Pain Management**

**WAC 246-853-715 Patient evaluation and patient record.**

- (1) For the purposes of this section, “risk assessment tool” means professionally developed, clinically accepted questionnaires appropriate for identifying a patient’s level of risk for substance abuse or misuse.
- (2) The osteopathic physician shall evaluate and document the patient’s health history and physical examination in the patient record prior to treating for chronic pain.
  - (a) History. The patient’s health history must include:
    - (i) The nature and intensity of the pain;
    - (ii) The effect of pain on physical and psychosocial function;
    - (iii) Current and past treatments for pain, including medications and their efficacy;
    - (iv) Review of any significant comorbidities;
    - (v) Any current or historical substance use disorder;
    - (vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and
    - (vii) Medication allergies.
  - (b) Evaluation. The patient evaluation prior to opioid prescribing must include:
    - (i) Appropriate physical examination;
    - (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
    - (iii) 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;
    - (iv) 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 246-853-790;
    - (v) Any available diagnostic, therapeutic, and laboratory results;
    - (vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The osteopathic physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk.
    - (vii) Any available consultations, particularly as related to the patient’s pain;
    - (viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
    - (ix) Treatment plan and objectives including:
      - (A) Documentation of any medication prescribed;
      - (B) Biologic specimen testing ordered; and
      - (C) Any labs or imaging ordered;
    - (x) Written agreements, also known as a “pain contract,” for treatment between the patient and the osteopathic physician; and
    - (xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

**WAC 246-853-720 Treatment plan.**

- (1) When the patient enters the chronic pain phase, the osteopathic physician shall reevaluate the patient 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:
  - (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 osteopathic physician shall adjust drug therapy to the individual health needs of the patient.
- (4) The osteopathic physician shall complete patient notification in accordance with the provisions of WAC 246-853-675.

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### **WAC 246-853-725 Written agreement for treatment.**

The osteopathic physician 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 osteopathic physician;
- (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;
- (3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;
- (4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;
- (5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;
- (6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;
- (7) A written authorization for:
  - (a) The osteopathic physician to release the agreement for treatment to:
    - (i) Local emergency departments;
    - (ii) Urgent care facilities;
    - (iii) Other practitioners caring for the patient who might prescribe pain medications; and
    - (iv) Pharmacies.
  - (b) The osteopathic physician to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician 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
- (9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-853-660 through 246-853-790, refills are subject to the same limitations and requirements as initial prescriptions.

### **WAC 246-853-730 Periodic review.**

- (1) The osteopathic physician shall periodically review the course of treatment for chronic pain. The osteopathic physician shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-853-790 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 or aberrant behavior; and
  - (e) More frequently at the osteopathic physician's discretion.
- (2) During the periodic review, the osteopathic physician shall determine:
  - (a) The patient's compliance with any medication treatment plan;
  - (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
  - (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician's evaluation of progress towards treatment objectives.
- (3) Periodic patient evaluations must also include:
  - (a) History and physical exam related to the pain;
  - (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and
  - (c) Review of the 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 246-853-790 and subsection (1) of this section.
- (4) The osteopathic physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-853-755.

**WAC 246-853-735 Consultation—Recommendations and requirements.**

- (1) The osteopathic physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.
- (2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-853-740 or 246-853-745, an osteopathic physician who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-853-750. The mandatory consultation must consist of at least one of the following:
  - (a) An office visit with the patient and the pain management specialist;
  - (b) A consultation between the pain management specialist and the osteopathic physician;
  - (c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the osteopathic physician or with a licensed health care practitioner designated by the osteopathic physician or the pain management specialist; or
  - (d) Other chronic pain evaluation services as approved by the board.
- (3) The osteopathic physician shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician, the osteopathic physician shall maintain it as part of the patient record.
- (4) The osteopathic physician shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

**WAC 246-853-740 Consultation—Exemptions for exigent and special circumstances.**

An osteopathic physician is not required to consult with a pain management specialist as defined in WAC 246-853-750 when the osteopathic physician has documented adherence to all standards of practice as defined in WAC 246-853-715 through 246-853-760, and when one or more of the following conditions are met:

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

**WAC 246-853-745 Consultation—Exemptions for the osteopathic physician.**

An osteopathic physician is exempt from the consultation requirement in WAC 246-853-735 if one or more of the following qualifications are met:

- (1) The osteopathic physician is a pain management specialist under WAC 246-853-750;
- (2) The osteopathic physician 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 organizations. At least two of these hours must be in substance use disorders;
- (3) The osteopathic physician is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or
- (4) The osteopathic physician 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.

**WAC 246-853-750 Pain management specialist.**

- (1) A pain management specialist shall meet one or more of the following qualifications:
  - (a) An osteopathic physician shall be 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;
  - (b) Have a subspecialty certificate in pain medicine by an ABMS-approved board;
  - (c) Have a certification of added qualification in pain management by the AOA;
  - (d) Be credentialed in pain management by an entity approved by the board; or
  - (e) Have a minimum of three years of clinical experience in a chronic pain management care setting including:

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- (i) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past three years for an osteopathic physician; and
  - (ii) At least thirty percent of the osteopathic physician's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.
- (2) An osteopathic physician assistant shall meet requirements in WAC 246-854-330.
  - (3) An allopathic physician shall meet requirements in WAC 246-919-945.
  - (4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.
  - (5) A dentist shall meet requirements in WAC 246-817-965.
  - (6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.
  - (7) A podiatric physician shall meet requirements in WAC 246-922-750.

### **WAC 246-853-755 Tapering requirements.**

- (1) The osteopathic physician 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 is unsatisfactory.
- (2) The osteopathic physician shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:
  - (a) The patient requests;
  - (b) The patient experiences a 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 or doses; or
  - (h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

### **WAC 246-853-760 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner.**

- (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
- (2) An osteopathic physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-853-735 and the tapering requirements of WAC 246-853-755 if:
  - (a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams 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, at the dose in excess of one hundred twenty milligrams MED.
- (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 246-853-735 and 246-853-755 shall apply.

### **Opioid Prescribing—Special Populations**

#### **WAC 246-853-765 Special populations—Patients twenty-five years of age or under, pregnant patient, and aging populations.**

- (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.
- (2) Pregnant patients. The osteopathic physician shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician 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 osteopathic physician 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.

**WAC 246-853-770 Episodic care of chronic opioid patients.**

- (1) When providing episodic care for a patient who the osteopathic physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician 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) An osteopathic physician providing episodic care to a patient who the osteopathic physician 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 osteopathic physician 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 osteopathic physician providing episodic care shall report known violations of the patient’s written agreement to the patient’s treatment practitioner who provided the agreement for treatment, when reasonable.
- (4) The osteopathic physician providing episodic care shall coordinate care with the patient’s chronic pain treatment practitioner if that person is known to the osteopathic physician providing episodic care, when reasonable.
- (5) For the purposes of this section, “episodic care” means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

**Opioid Prescribing—Coprescribing**

**WAC 246-853-775 Coprescribing of opioids with certain medications.**

- (1) The osteopathic physician must not knowingly prescribe opioids in combination with the following Schedule II–IV medications without documentation in the patient record of clinical judgment:
  - (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 osteopathic physician 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.

**WAC 246-853-780 Coprescribing of opioids for patients receiving medication assisted treatment.**

- (1) Where practicable, the osteopathic physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.
- (2) The osteopathic physician shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

**WAC 246-853-785 Coprescribing of naloxone.**

- (1) The osteopathic physician shall confirm or provide a current prescription for naloxone when high dose opioids are prescribed.
- (2) The osteopathic physician should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

**Opioid Prescribing—Prescription Monitoring Program**

**WAC 246-853-790 Prescription monitoring program—Required registration, queries, and documentation.**

- (1) The osteopathic physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.
- (2) The osteopathic physician may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.
- (3) At a minimum, the osteopathic physician shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or of a benzodiazepine.
- (4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician or their authorized designee due to a temporary technological or electrical failure.
- (5) In cases of technical or electrical failure, the osteopathic physician shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.
- (6) Pertinent concerns discovered in the PMP shall be documented in the patient record.

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### WAC 246-853-990 Osteopathic fees and renewal cycle.

- (1) Licenses must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2, except postgraduate training limited licenses.
- (2) Postgraduate training limited licenses must be renewed every year to correspond to program dates.
- (3) The following nonrefundable fees will be charged for osteopathic physicians:

Title of Fee	Fee
<b>Original application</b>	
Endorsement application	\$375.00
UW online access fee (HEAL-WA)	\$16.00
<b>Active license renewal</b>	
Renewal	\$375.00
Late renewal penalty	\$190.00
Expired license reissuance	\$250.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
<b>Inactive license renewal</b>	
Renewal	\$310.00
Expired license reissuance	\$225.00
Late renewal penalty	\$155.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
<b>Retired active license renewal</b>	
Renewal	\$195.00
Late renewal penalty	\$100.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
Endorsement/state exam application	\$500.00
Reexam	\$100.00
Verification of license	\$50.00
<b>Limited license</b>	
Application	\$285.00
Renewal	\$265.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
Temporary permit application	\$70.00
Duplicate certificate	\$20.00



(4) The following nonrefundable fees will be charged for osteopathic physician assistants:

Title of Fee	Fee
<b>Original application</b>	
Application	\$220.00
UW online access fee (HEAL-WA)	\$16.00
<b>Active license renewal</b>	
Renewal	\$220.00
Late renewal penalty	\$110.00
Expired license reissuance	\$100.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
<b>Retired active license renewal</b>	
Renewal	\$120.00
Late renewal penalty	\$60.00
UW online access fee (HEAL-WA)	\$16.00
Substance abuse monitoring surcharge	\$50.00
Verification of license	\$30.00
Interim permit	\$200.00
License after exam	\$100.00
Duplicate certificate	\$20.00

## OSTEOPATHIC PHYSICIANS' ASSISTANTS RULES

### WAC 246-854-240 Intent and scope.

WAC 246-854-240 through 246-854-370 govern the prescribing of opioids in the treatment of pain. Nothing in these rules in any way restricts the current scope of practice of osteopathic physician assistants as set forth in chapters 18.57 and 18.57A RCW and the working agreements between the osteopathic physician and the osteopathic physician assistant, which may include pain management.

### WAC 246-854-241 Exclusions.

WAC 246-854-240 through 246-854-370 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

### WAC 246-854-242 Definitions.

The definitions in this section apply to WAC 246-854-240 through 246-854-370 unless the context clearly requires otherwise.

- (1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician 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) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years postcompletion of curative anticancer treatment with current evidence of disease.

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- (5) “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 may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anticancer treatment with no current evidence of disease.
- (6) “High-dose” means ninety milligrams, 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 a life expectancy of six months or less.
- (9) “Hospital” means any institution, place, building, or agency licensed by the department 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, 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 a fifty milligram morphine equivalent dose.
- (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 a 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 fifty and ninety milligram morphine equivalent doses.
- (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 either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.
- (17) “Palliative” means care that 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) “Prescription monitoring program” or “PMP” means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.
- (21) “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.
- (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 characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

### **WAC 246-854-255 Patient notification, secure storage, and disposal.**

- (1) The osteopathic physician assistant shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician assistant 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 phases 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 medications including, but not limited to, the availability of recognized drug take-back programs.

**WAC 246-854-260 Use of alternative modalities for pain treatment.**

The osteopathic physician assistant shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician assistant may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

**WAC 246-854-265 Continuing education requirements for opioid prescribing.**

- (1) In order to prescribe an opioid in Washington state, an osteopathic physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.
- (2) The osteopathic physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic physician assistant'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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

**Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain**

**WAC 246-854-270 Patient evaluation and patient record.**

Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic physician assistant shall:

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

**WAC 246-854-275 Treatment plan—Acute nonoperative pain.**

The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

- (1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.
- (2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.
- (3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in a quantity greater 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 osteopathic physician assistant 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 osteopathic physician assistant 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 osteopathic physician assistant 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 other treatments.
- (6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician assistant need to prescribe a long-acting opioid for acute pain, the osteopathic physician assistant must document the reason in the patient record.
- (7) An osteopathic physician assistant shall not discontinue medication assistant treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-854-360.

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- (8) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic physician assistant 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 246-854-285 and 246-854-290 shall apply.

### **WAC 246-854-280 Treatment plan—Acute perioperative pain.**

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

- (1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.
- (2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II–V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.
- (3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  - (a) A three-day supply or less will often be sufficient.
  - (b) More than a fourteen-day supply will rarely be needed for perioperative pain.
  - (c) The osteopathic physician assistant shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the osteopathic physician assistant may refer to clinical practice guidelines.
- (4) The osteopathic physician assistant shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional planned diagnostic evaluations or other treatments.
- (6) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant must prescribe in accordance with WAC 246-854-355.
- (7) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-854-285 and 246-854-290 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**

#### **WAC 246-854-285 Patient evaluation and patient record.**

The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

- (1) Prior to prescribing opioids for subacute pain, the osteopathic physician assistant 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 regarding 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 246-854-370 to identify any Schedule II–V medications or drugs of concern received by the patient and document the review for any concerns;
  - (e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician assistant determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;
  - (f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and
  - (g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

- (2) The osteopathic physician assistant 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 results of any queries of the PMP and any concerns the osteopathic physician assistant has;
  - (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 non-opioid therapy;
  - (f) Results of any aberrant biological specimen testing 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.

**WAC 246-854-290 Treatment plan—Subacute pain.**

- (1) The osteopathic physician assistant 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 osteopathic physician assistant 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 osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician assistant 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 osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The osteopathic physician assistant 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 osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant shall prescribe in accordance with WAC 246-854-355.
- (5) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic physician assistant 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 246-854-295 through 246-854-340, shall apply.

**Opioid Prescribing—Chronic Pain Management**

**WAC 246-854-295 Patient evaluation and patient record.**

- (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.
- (2) The osteopathic physician assistant shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.
  - (a) History. The patient's health history must include:
    - (i) The nature and intensity of the pain;
    - (ii) The effect of pain on physical and psychosocial function;
    - (iii) Current and past treatments for pain, including medications and their efficacy;
    - (iv) Review of any significant comorbidities;
    - (v) Any current or historical substance use disorder;
    - (vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and
    - (vii) Medication allergies.

- (b) Evaluation. The patient evaluation prior to opioid prescribing must include:
  - (i) Appropriate physical examination;
  - (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
  - (iii) 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;
  - (iv) 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 246-854-370;
  - (v) Any available diagnostic, therapeutic, and laboratory results;
  - (vi) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low-risk category. The osteopathic physician assistant should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;
  - (vii) Any available consultations, particularly as related to the patient's pain;
  - (viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
  - (ix) Treatment plan and objectives including:
    - (A) Documentation of any medication prescribed;
    - (B) Biologic specimen testing ordered; and
    - (C) Any labs or imaging ordered.
  - (x) Written agreements, also known as a “pain contract,” for treatment between the patient and the osteopathic physician assistant; and
  - (xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

**WAC 246-854-300 Treatment plan.**

- (1) When the patient enters the chronic pain phase, the osteopathic physician assistant shall reevaluate the patient 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 osteopathic physician assistant shall adjust drug therapy to the individual health needs of the patient.
- (4) The osteopathic physician assistant shall complete patient notification in accordance with the provisions of WAC 246-854-255.

**WAC 246-854-305 Written agreement for treatment.**

The osteopathic physician assistant 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 osteopathic physician assistant;
- (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;
- (3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;
- (4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;
- (5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;
- (6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;
- (7) A written authorization for:
  - (a) The osteopathic physician assistant to release the agreement for treatment to:
    - (i) Local emergency departments;
    - (ii) Urgent care facilities;
    - (iii) Other practitioners caring for the patient who might prescribe pain medications; and
    - (iv) Pharmacies.
  - (b) The osteopathic physician assistant to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician assistant 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
- (9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-854-240 through 246-854-370, refills are subject to the same limitations and requirements as initial prescriptions.

**WAC 246-854-310 Periodic review.**

- (1) The osteopathic physician assistant shall periodically review the course of treatment for chronic pain. The osteopathic physician assistant shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-854-370 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 or aberrant behavior; and
  - (e) More frequently at the osteopathic physician assistant's discretion.
- (2) During the periodic review, the osteopathic physician assistant shall determine:
  - (a) The patient's compliance with any medication treatment plan;
  - (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
  - (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician assistant's evaluation of progress towards treatment objectives.
- (3) Periodic patient evaluations must also include:
  - (a) History and physical exam related to the pain;
  - (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and
  - (c) Review the 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 246-854-370 and subsection (1) of this section.
- (4) The osteopathic physician assistant shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician assistant shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-854-335.

**WAC 246-854-315 Consultation—Recommendations and requirements.**

- (1) The osteopathic physician assistant shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.
- (2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-854-320 or 246-854-325, an osteopathic physician assistant who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-854-330. The mandatory consultation must consist of at least one of the following:
  - (a) An office visit with the patient and the pain management specialist;
  - (b) A consultation between the pain management specialist and the osteopathic physician assistant;
  - (c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the osteopathic physician assistant or with a licensed health care practitioner designated by the osteopathic physician assistant or the pain management specialist; or
  - (d) Other chronic pain evaluation services as approved by the board.
- (3) The osteopathic physician assistant shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician assistant, the osteopathic physician assistant shall maintain it as part of the patient record.
- (4) The osteopathic physician assistant shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

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### WAC 246-854-320 Consultation—Exemptions for exigent and special circumstances.

An osteopathic physician assistant is not required to consult with a pain management specialist as defined in WAC 246-854-330 when the osteopathic physician assistant has documented adherence to all standards of practice as defined in WAC 246-854-295 through 246-854-340, and when one or more of the following conditions are met:

- (1) The patient is following a tapering schedule;
- (2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage with expected return to their baseline dosage level or below;
- (3) The osteopathic physician assistant documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty MED per day without first obtaining a consultation; or
- (4) The osteopathic physician assistant documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

### WAC 246-854-325 Consultation—Exemptions for the osteopathic physician assistant.

An osteopathic physician assistant is exempt from the consultation requirement in WAC 246-854-315 if one or more of the following qualifications are met:

- (1) The osteopathic physician assistant is a pain management specialist under WAC 246-854-330;
- (2) The osteopathic physician assistant 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 organizations. At least two of these hours must be in substance use disorders;
- (3) The osteopathic physician assistant is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or
- (4) The osteopathic physician assistant has a minimum of three years 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.

### WAC 246-854-330 Pain management specialist.

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

- (1) An osteopathic physician assistant shall have a delegation agreement with a physician pain management specialist and meet all of the following educational requirements and practice requirements:
  - (a) A minimum of three years clinical experience in a chronic pain management care setting;
  - (b) Credentialed in pain management by an entity approved by the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;
  - (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 osteopathic physician assistant's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.
- (2) An osteopathic physician shall meet requirements in WAC 246-853-750.
- (3) An allopathic physician shall meet requirements in WAC 246-919-945.
- (4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.
- (5) A dentist shall meet requirements in WAC 246-817-965.
- (6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.
- (7) A podiatric physician shall meet requirements in WAC 246-922-750.

### WAC 246-854-335 Tapering requirements.

- (1) The osteopathic physician assistant 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 is unsatisfactory.
- (2) The osteopathic physician assistant shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:
  - (a) The patient requests;
  - (b) The patient experiences a 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 or doses; or
- (h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

**WAC 246-854-340 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner.**

- (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
- (2) An osteopathic physician assistant's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-854-315 and the tapering requirements of WAC 246-854-335 if:
  - (a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams 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, at the dose in excess of one hundred twenty milligrams MED.
- (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 246-854-315 and 246-854-335 shall apply.

**Opioid Prescribing—Special Populations**

**WAC 246-854-345 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations.**

- (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician assistant shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.
- (2) Pregnant patients. The osteopathic physician assistant shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician assistant 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 osteopathic physician assistant 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.

**WAC 246-854-350 Episodic care of chronic opioid patients.**

- (1) When providing episodic care for a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician assistant 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) An osteopathic physician assistant providing episodic care to a patient who the osteopathic physician assistant 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 osteopathic physician assistant 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 osteopathic physician assistant providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.
- (4) The osteopathic physician assistant providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician assistant providing episodic care, when reasonable.
- (5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

**Opioid Prescribing—Coprescribing**

**WAC 246-854-355 Coprescribing of opioids with certain medications.**

- (1) The osteopathic physician assistant must not knowingly prescribe opioids in combination with the following Schedule II–IV medications without documentation in the patient record of clinical judgment:
  - (a) Benzodiazepines;
  - (b) Barbiturates;
  - (c) Sedatives;
  - (d) Carisoprodol; or
  - (e) Sleeping medications, also known as Z drugs.

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- (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 osteopathic physician assistant 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.

### WAC 246-854-360 Coprescribing of opioids for patients receiving medication assisted treatment.

- (1) Where practicable, the osteopathic physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.
- (2) The osteopathic physician assistant shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

### WAC 246-854-365 Coprescribing of naloxone.

- (1) The osteopathic physician assistant shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed.
- (2) The osteopathic physician assistant should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

### Opioid Prescribing—Prescription Monitoring Program

#### WAC 246-854-370 Prescription monitoring program—Required registration, queries, and documentation.

- (1) The osteopathic physician assistant shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.
- (2) The osteopathic physician assistant may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.
- (3) At a minimum, the osteopathic physician assistant shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or a benzodiazepine.
- (4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician assistant or their authorized designee due to a temporary technical or electrical failure.
- (5) In cases of technical or electrical failure, the osteopathic physician assistant shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.
- (6) Pertinent concerns discovered in the PMP shall be documented in the patient record.

## DENTAL QUALITY ASSURANCE COMMISSION RULES

### WAC 246-817-901 Pain management—Intent.

These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

### WAC 246-817-905 Exclusions.

The rules adopted under WAC 246-817-901 through 246-817-965 do not apply to:

- (1) 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.

### WAC 246-817-910 Definitions.

The definitions in this section apply in WAC 246-817-901 through 246-817-965 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 preexisting or coexisting physical or psychiatric disease or condition.
- (5) “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.
- (6) “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.
- (7) “Morphine equivalent dose” means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.
- (8) “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, advanced registered nurse practitioners, and physical therapy, occupational therapy, or other complementary therapies.
- (9) “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.

**WAC 246-817-915 Patient evaluation.**

The dentist 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 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;

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- (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.

### **WAC 246-817-920 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 dentist should 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.
- (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.

### **WAC 246-817-925 Informed consent.**

The dentist 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.

### **WAC 246-817-930 Written agreement for treatment.**

Chronic noncancer 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 dentist 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 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;
- (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 or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;
- (5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
- (6) A written authorization for:
  - (a) The dentist 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 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) 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 dentist's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

### **WAC 246-817-935 Periodic review.**

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 every 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) During the periodic review, the dentist 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 dentist's evaluation of progress towards treatment objectives.
- (2) 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.

**WAC 246-817-940 Long-acting opioids, including methadone.**

Long-acting opioids, including methadone, should only be prescribed by a dentist 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. Dentists prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.

**WAC 246-817-945 Episodic care.**

- (1) When evaluating patients for episodic care, such as emergency or urgent care, the dentist 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 practitioner 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 Diseases (ICD) code 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 WAC 246-817-930(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.

**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, 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) (oral). In the event a dentist prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as 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 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 dentist;
    - (iii) An electronic consultation between the pain management specialist and the dentist; or
    - (iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the dentist or a licensed health care practitioner designated by the dentist or the pain management specialist.
  - (b) 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 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.

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### **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 has documented adherence to all standards of practice as defined in WAC 246-817-901 through 246-817-965 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 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 dosage of opioids.

### **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 WAC 246-817-965; or
- (2) The dentist has successfully completed, within the last two 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 long-acting opioids, to include methadone; or
- (3) The dentist is a pain management practitioner working in a multidisciplinary chronic pain treatment center, 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 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.

## WASHINGTON MEDICAL COMMISSION RULES FOR PHYSICIANS

### Opioid Prescribing—General Provisions

#### WAC 246-919-850 Intent and scope.

The rules in WAC 246-919-850 through 246-919-985 govern the prescribing of opioids in the treatment of pain.

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, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, 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, perioperative, subacute, and chronic pain. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids including co-occurring prescriptions. Accordingly, these rules 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 may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or 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 opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic 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, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

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 opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, 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 opioids, 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 physicians in providing appropriate medical care for patients.

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 guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist physicians 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.

For more specific best practices, the physician 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.

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### WAC 246-919-851 Exclusions.

WAC 246-919-850 through 246-919-985 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients who are patients who have been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural medications.

### WAC 246-919-852 Definitions.

The following definitions apply to WAC 246-919-850 through 246-919-985 unless the context clearly requires otherwise.

- (1) "Aberrant behavior" means behavior that indicates current misuse, diversion, unauthorized use of alcohol or other controlled substances, or multiple early refills (renewals).
- (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 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) "Cancer-related pain" means pain that is an 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.
- (5) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or which 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 is considered to be pain that persists for more than twelve weeks.
- (6) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.
- (7) "Designee" means a licensed health care practitioner authorized by a prescriber to request and receive prescription monitoring program (PMP) data on their behalf.
- (8) "Episodic care" means noncontinuing medical or dental care provided by a physician other than the designated primary prescriber for a patient with chronic pain.
- (9) "High dose" means a ninety milligram morphine equivalent dose (MED), or more, per day.
- (10) "High-risk" is a category of patient at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or abuse, aberrant behavior, dose of opioids, or the use of any concurrent central nervous system depressant.
- (11) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less.
- (12) "Hospital" means any health care institution licensed pursuant to chapters 70.41 and 71.12 RCW, and RCW 72.23.020.
- (13) "Low-risk" is 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 a fifty milligram morphine equivalent dose per day.
- (14) "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.
- (15) "Moderate-risk" is 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 fifty to ninety milligram morphine equivalent doses per day.
- (16) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose using the agency medical directors' group or other conversion table approved by the commission. MED is considered the same as morphine milligram equivalent or MME.
- (17) "Multidisciplinary pain clinic" means a health care delivery facility staffed by physicians of different specialties and other nonphysician health care providers who specialize in the diagnosis and management of patients with chronic pain.
- (18) "Opioid" means a drug that is either an opiate that is derived from the opium poppy or opiate-like that is a semisynthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone when used to treat pain.
- (19) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness.
- (20) "Perioperative pain" means acute pain that occurs surrounding the performance of surgery.
- (21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW. Other jurisdictions may refer to this as the prescription drug monitoring program or "PDMP."



- (22) “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.
- (23) “Refill” or “renewal” means a second or subsequent filling of a previously issued prescription.
- (24) “Subacute pain” is considered to be a continuation of pain that is six- to twelve-weeks in duration.
- (25) “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 is a normal physiological consequence 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.

**WAC 246-919-865 Patient notification, secure storage, and disposal.**

- (1) The physician shall ensure the patient is provided the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic:
  - a) Risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment;
  - b) The safe and secure storage of opioid prescriptions; and
  - c) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.
- (2) This requirement may be satisfied with a document provided by the department of health.

**WAC 246-919-870 Use of alternative modalities for pain treatment.**

The physician shall exercise their professional judgment in selecting appropriate treatment modalities for acute nonoperative, acute perioperative, subacute, or chronic pain including the use of multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist.

**WAC 246-919-875 Continuing education requirements for opioid prescribing.**

- (1) To prescribe an opioid in Washington state, a physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.
- (2) The physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the physician’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 training in prescribing of opioids count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

**Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain**

**WAC 246-919-880 Patient evaluation and patient record—Acute nonoperative pain.**

Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the physician shall:

- (1) Conduct and document an appropriate history and physical examination including screening for risk factors for overdose and severe postoperative pain;
- (2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and
- (3) Inquire about any other medications the patient is prescribed or is taking.

**WAC 246-919-885 Treatment plan—acute nonoperative pain.**

The physician shall comply with the requirements in this section when prescribing opioids for acute nonoperative pain.

- (1) The physician should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-919-870.
- (2) The physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-919-985.
- (3) If the physician 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 three-day supply or less will often be sufficient. The physician 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 physician shall reevaluate the patient who does not follow the expected course of recovery, and 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 may include:
  - (a) Change in pain level;
  - (b) Change in physical function;

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- (c) Change in psychosocial function; and
- (d) Additional indicated diagnostic evaluations.
- (6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.
- (7) Long-acting or extended release opioids are not indicated for acute nonoperative pain.
- (8) Medication assisted treatment medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-919-975.
- (9) If the physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician 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 246-919-895 and 246-919-900 shall apply.

### WAC 246-919-890 Treatment plan—Acute perioperative pain.

The physician shall comply with the requirements in this section when prescribing opioids for perioperative pain.

- (1) The physician should consider prescribing nonopioids as the first line of pain control in patients, unless not clinically appropriate, in accordance with the provisions of WAC 246-919-870.
- (2) The physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-919-985.
- (3) If the physician 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 three-day supply or less will often be sufficient. The physician 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 physician shall reevaluate a patient who does not follow the expected course of recovery and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional indicated diagnostic evaluations or other treatments.
- (6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.
- (7) Long-acting or extended release opioids are not indicated for acute perioperative pain.
- (8) Medication assisted treatment medications must not be discontinued when treating acute perioperative pain except as consistent with the provisions of WAC 246-919-975.
- (9) If the physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-919-895 and 246-919-900 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

#### WAC 246-919-895 Patient evaluation and patient record—Subacute pain.

The physician shall comply with the requirements in this section when prescribing opioids for subacute pain.

- (1) Prior to issuing an opioid prescription for subacute pain, the physician shall assess the rationale for continuing opioid therapy as follows:
  - (a) Conduct an appropriate history and physical examination;
  - (b) Reevaluate the nature and intensity of the pain;
  - (c) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-919-985;
  - (d) Screen the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;
  - (e) Obtain a biological specimen test if the patient's functional status is deteriorating or if pain is escalating; and
  - (f) Screen or refer the patient for further consultation for psychosocial factors if the patient's functional status is deteriorating or if pain is escalating.
- (2) The physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following is 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 or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode;

- (c) Pertinent concerns discovered in the PMP;
  - (d) An appropriate pain treatment plan including the consideration of, or attempts to use, nonpharmacological modalities and non-opioid therapy;
  - (e) The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;
  - (f) Results of psychosocial screening or consultation;
  - (g) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies; and
  - (h) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable.
- (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 indicated diagnostic evaluations or other treatments.

**WAC 246-919-900 Treatment plan—Subacute pain.**

The physician, having recognized the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase shall develop an opioid treatment plan.

- (1) If tapering has not begun prior to the six- to twelve-week subacute phase, the physician shall reevaluate the patient. Based on effect on function or pain control, the physician shall consider whether opioids will be continued, tapered, or discontinued.
- (2) If the physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain that is severe enough to require opioids. During the subacute phase the physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.
- (3) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.
- (4) If the physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the physician shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-919-905 through 246-919-955, shall apply.

**Opioid Prescribing—Chronic Pain Management****WAC 246-919-905 Patient evaluation and patient record—Chronic pain.**

When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician shall include in the patient's record:

- (1) An appropriate history including:
  - (a) The nature and intensity of the pain;
  - (b) The effect of pain on physical and psychosocial function;
  - (c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and
  - (d) Review of comorbidities with particular attention to psychiatric and substance use.
- (2) Appropriate physical examination.
- (3) Ancillary information and tools to include:
  - (a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;
  - (b) Any pertinent diagnostic, therapeutic, and laboratory results;
  - (c) Pertinent consultations; and
  - (d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.
- (4) Assessment. The physician must document medical decision making to include:
  - (a) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
  - (b) Consideration of the risks and benefits of chronic opioid treatment for the patient;
  - (c) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids; and
  - (d) Pertinent concerns discovered in the PMP.
- (5) Treatment plan as provided in WAC 246-919-910.

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### **WAC 246-919-910 Treatment plan—Chronic pain.**

The physician, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop an opioid treatment plan as follows:

- (1) Treatment plan and objectives including:
  - (a) Documentation of any medication prescribed;
  - (b) Biologic specimen testing ordered;
  - (c) Any labs, diagnostic evaluations, referrals, or imaging ordered;
  - (d) Other planned treatments; and
  - (e) Written agreement for treatment as provided in WAC 246-919-915.
- (2) The physician shall complete patient notification in accordance with the provisions of WAC 246-919-865 or provide this information in the written agreement.

### **WAC 246-919-915 Written agreement for treatment—Chronic pain.**

The physician shall use a written agreement that outlines the patient's responsibilities for opioid therapy. This written agreement for treatment must include the following provisions:

- (1) The patient's agreement to provide samples for biological specimen testing when requested by the physician;
- (2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
- (3) Reasons for which opioid therapy may be discontinued;
- (4) The requirement that all opioid prescriptions for chronic pain are provided by a single prescriber or a single clinic, except as provided in WAC 246-919-965 for episodic care;
- (5) The requirement that all opioid prescriptions for chronic pain are to be dispensed by a single pharmacy or pharmacy system whenever possible;
- (6) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
- (7) A violation of the agreement may result in a tapering or discontinuation of the prescription; and
- (8) The patient's responsibility to safeguard all medications and keep them in a secure location.

### **WAC 246-919-920 Periodic review—Chronic pain.**

- (1) The physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-919-985, 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 physician's discretion.
- (2) During the periodic review, the physician shall determine:
  - (a) The patient's compliance with any medication treatment plan;
  - (b) If pain, function, and quality of life have improved, diminished, or are maintained; and
  - (c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.
- (3) Periodic patient evaluations must also include:
  - (a) History and physical examination related to the pain;
  - (b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and
  - (c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-919-985 and subsection (1) of this section.
- (4) If the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

### **WAC 246-919-925 Long-acting opioids—Chronic pain.**

Long-acting opioids should only be prescribed by a physician 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. The physician prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.

**WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain.**

- (1) The physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.
- (2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician 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 246-919-945 is required, unless the consultation is exempted under WAC 246-919-935 or 246-919-940.
- (3) The mandatory consultation must consist of at least one of the following:
  - (a) An office visit with the patient and the pain management specialist;
  - (b) A telephone, electronic, or in-person consultation between the pain management specialist and the physician;
  - (c) An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist; or
  - (d) Other chronic pain evaluation services as approved by the commission.
- (4) A physician shall document each consultation with the pain management specialist.

**WAC 246-919-935 Consultation—Exemptions for exigent and special circumstances—Chronic pain.**

A physician is not required to consult with a pain management specialist as defined in WAC 246-919-945 when the physician has documented adherence to all standards of practice as defined in WAC 246-919-905 through 246-919-925, and when one or more of the following conditions are met:

- (1) The patient is following a tapering schedule;
- (2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with an expected return to their baseline dosage level or below;
- (3) The physician 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 physician documents the patient's pain and function are stable and the patient is on a nonescalating dosage of opioids.

**WAC 246-919-940 Consultation—Exemptions for the physician—Chronic pain.**

The physician is exempt from the consultation requirement in WAC 246-919-930 if one or more of the following qualifications is met:

- (1) The physician is a pain management specialist under WAC 246-919-945;
- (2) The physician has successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders;
- (3) The physician is a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or
- (4) The physician has a minimum of 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.

**WAC 246-919-945 Pain management specialist—Chronic pain.**

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

- (1) If an allopathic physician or osteopathic physician:
  - (a) Is 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, neurology, rheumatology, or anesthesiology;
  - (b) Has a subspecialty certificate in pain medicine by an ABMS-approved board;
  - (c) Has a certification of added qualification in pain management by the AOA;
  - (d) Is credentialed in pain management by an entity approved by the commission for an allopathic physician or the Washington state board of osteopathic medicine and surgery for an osteopathic physician;
  - (e) Has a minimum of three years of clinical experience in a chronic pain management care setting; and
    - (i) Has successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for an allopathic physician or three years for an osteopathic physician; and
    - (ii) Has at least thirty percent of the allopathic 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 an allopathic physician assistant, in accordance with WAC 246-918-895.
- (3) If an osteopathic physician assistant, in accordance with WAC 246-854-330.

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- (4) If a dentist, in accordance with WAC 246-817-965.
- (5) If a podiatric physician, in accordance with WAC 246-922-750.
- (6) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

### **WAC 246-919-950 Tapering considerations—Chronic pain.**

The physician shall consider tapering or referral for a substance use disorder evaluation when:

- (1) The patient requests;
- (2) The patient experiences a deterioration in function or pain;
- (3) The patient is noncompliant with the written agreement;
- (4) Other treatment modalities are indicated;
- (5) There is evidence of misuse, abuse, substance use disorder, or diversion;
- (6) The patient experiences a severe adverse event or overdose;
- (7) There is unauthorized escalation of doses; or
- (8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

### **WAC 246-919-955 Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician.**

- (1) When a patient receiving chronic opioid pain medications changes to a new physician, it is normally appropriate for the new physician to initially maintain the patient's current opioid doses. Over time, the physician may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
- (2) A physician's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-919-930 if:
  - (a) The patient was previously being treated with a dosage of opioids in excess of a 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 history of compliance with treatment plans and written agreements documented by medical records and PMP queries; and
  - (d) The patient has documented functional stability, pain control, or improvements in function or pain control at the presenting opioid 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 246-919-930 shall apply.

### **Opioid Prescribing—Special Populations**

#### **WAC 246-919-960 Special populations—Children or adolescent patients, pregnant patients, and aging populations.**

- (1) Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.
- (2) Pregnant patients. The physician shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment for opioids, such as methadone or buprenorphine, must not be discontinued during pregnancy without consultation with a MAT prescribing practitioner.
- (3) Aging populations. As people age, their sensitivities to and metabolizing of opioids may change. The physician 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.

#### **WAC 246-919-965 Episodic care of chronic opioid patients.**

- (1) When providing episodic care for a patient who the physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the physician or their designee, shall review the PMP and document their review and any concerns.
- (2) A physician providing episodic care to a patient who the physician knows is being treated with opioids for chronic pain should provide additional analgesics, including opioids when appropriate, to adequately treat acute pain. If opioids are provided, the physician shall limit the use of opioids to the minimum amount necessary to control the acute pain until the patient can receive care from the practitioner who is managing the patient's chronic pain.
- (3) The episodic care physician shall coordinate care with the patient's chronic pain treatment practitioner, if possible.

**Opioid Prescribing—Coprescribing**

**WAC 246-919-970 Coprescribing of opioids with certain medications.**

- (1) The physician shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:
  - (a) Benzodiazepines;
  - (b) Barbiturates;
  - (c) Sedatives;
  - (d) Carisoprodol; or
  - (e) Nonbenzodiazepine hypnotics.
- (2) If, because of a prior prescription by another provider, a prescription written by a physician results in a combination of opioids and medications described in subsection (1) of this section, the physician issuing the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care.

**WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment.**

- (1) Where practicable, the physician providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.
- (2) The physician providing acute nonoperative pain or acute perioperative pain treatment shall not discontinue MAT medications without documentation of the reason for doing so, nor shall the use of these medications be used to deny necessary operative intervention.

**WAC 246-919-980 Coprescribing of naloxone.**

The opioid prescribing physician shall confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.

**Opioid Prescribing—Prescription Monitoring Program**

**WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation.**

- (1) The physician shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe Schedule II-V medications in Washington state.
- (2) The physician is permitted to delegate performance of a required PMP query to an authorized designee.
- (3) At a minimum, the physician shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-919-970 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 physician shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:
  - (a) For a high-risk patient, a PMP query shall be completed at least quarterly;
  - (b) For a moderate-risk patient, a PMP query shall be completed at least semiannually; and
  - (c) For a low-risk patient, a PMP query shall be completed at least annually.
- (5) The physician shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.
- (6) The physician shall ensure a PMP query is performed when providing episodic care to a patient who the physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-919-965.
- (7) If the physician is using an electronic medical record (EMR) that integrates access to the PMP into the workflow of the EMR, the physician shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-919-970.
- (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 physician or their designee due to a temporary technological or electrical failure.
- (9) Pertinent concerns discovered in the PMP shall be documented in the patient record.

**WASHINGTON MEDICAL COMMISSION RULES FOR PHYSICIAN ASSISTANTS**

**Opioid Prescribing—General Provisions**

**WAC 246-918-800 Intent and scope.**

The rules in WAC 246-918-800 through 246-918-935 govern the prescribing of opioids in the treatment of pain.

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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, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

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

Inappropriate pain treatment may result from a physician assistant's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician assistant'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 opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma, or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician assistant. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physician assistants should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

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 opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physician assistants incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physician assistants should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, 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 assistant-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 assistant'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 physician assistants in providing appropriate medical care for patients.

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 guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist physician assistants 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.

For more specific best practices, the physician assistant 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.

### **WAC 246-918-801 Exclusions.**

WAC 246-918-800 through 246-918-935 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients who are patients who have been admitted to a hospital for more than twenty-four hours;  
or
- (4) The provision of procedural medications.



**WAC 246-918-802 Definitions.**

The definitions apply to WAC 246-918-800 through 246-918-935 unless the context clearly requires otherwise.

- (1) “Aberrant behavior” means behavior that indicates current misuse, diversion, unauthorized use of alcohol or other controlled substances, or multiple early refills (renewals).
- (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 of 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) “Cancer-related pain” means pain that is an 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.
- (5) “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 is considered to be pain that persists for more than twelve weeks.
- (6) “Comorbidities” means a preexisting or coexisting physical or psychiatric disease or condition.
- (7) “Designee” means a licensed health care practitioner authorized by a prescriber to request and receive prescription monitoring program (PMP) data on their behalf.
- (8) “Episodic care” means noncontinuing medical or dental care provided by a physician assistant other than the designated primary prescriber for a patient with chronic pain.
- (9) “High dose” means a ninety milligram morphine equivalent dose (MED), or more, per day.
- (10) “High-risk” is a category of patient at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or abuse, aberrant behavior, dose of opioids, or the use of any concurrent central nervous system depressant.
- (11) “Hospice” means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less.
- (12) “Hospital” as defined in chapters 70.41, 71.12 RCW, and RCW 72.23.020.
- (13) “Low-risk” is 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 a fifty milligram morphine equivalent dose per day.
- (14) “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.
- (15) “Moderate-risk” is 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 fifty to ninety milligram morphine equivalent doses per day.
- (16) “Morphine equivalent dose” or “MED” means a conversion of various opioids to a morphine equivalent dose using the agency medical directors group or other conversion table approved by the commission. MED is considered the same as morphine milligram equivalent or MME.
- (17) “Multidisciplinary pain clinic” means a health care delivery facility staffed by physicians of different specialties and other nonphysician health care providers who specialize in the diagnosis and management of patients with chronic pain.
- (18) “Opioid” means a drug that is either an opiate that is derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone when used to treat pain.
- (19) “Palliative care” means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness.
- (20) “Perioperative pain” means acute pain that occurs surrounding the performance of surgery.
- (21) “Prescription monitoring program” or “PMP” means the Washington state prescription monitoring program authorized under chapter 70.225 RCW. Other jurisdictions may refer to this as the prescription drug monitoring program or PDMP.
- (22) “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.
- (23) “Refill” or “renewal” means a second or subsequent filling of a previously issued prescription.
- (24) “Subacute pain” is considered to be a continuation of pain that is six to twelve weeks in duration.
- (25) “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 is a normal physiological consequence 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.

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### **WAC 246-918-815 Patient notification, secure storage, and disposal.**

- (1) The physician assistant shall ensure the patient is provided the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic:
  - (a) Risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment;
  - (b) The safe and secure storage of opioid prescriptions; and
  - (c) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.
- (2) This requirement may be satisfied with a document provided by the department of health.

### **WAC 246-918-820 Use of alternative modalities for pain treatment.**

The physician assistant shall exercise their professional judgment in selecting appropriate treatment modalities for acute nonoperative, acute perioperative, subacute, or chronic pain including the use of multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist.

### **WAC 246-918-825 Continuing education requirements for opioid prescribing.**

- (1) To prescribe an opioid in Washington state, a physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.
- (2) The physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the physician assistant'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 training in prescribing of opioids count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

## **Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain**

### **WAC 246-918-830 Patient evaluation and patient record—Acute nonoperative pain.**

Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the physician assistant shall:

- (1) Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;
- (2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and
- (3) Inquire about any other medications the patient is prescribed or is taking.

### **WAC 246-918-835 Treatment plan—Acute nonoperative pain.**

The physician assistant shall comply with the requirements in this section when prescribing opioids for acute nonoperative pain.

- (1) The physician assistant should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-918-820.
- (2) The physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-918-935.
- (3) If the physician assistant 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 three-day supply or less will often be sufficient. The physician assistant 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 physician assistant shall reevaluate the patient who does not follow the expected course of recovery, and 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 may include:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional indicated diagnostic evaluations.
- (6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.
- (7) Long-acting or extended release opioids are not indicated for acute nonoperative pain.
- (8) Medication assisted treatment medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-918-925.

- (9) If the physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician assistant 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 246-918-845 and 246-918-850 shall apply.

**WAC 246-918-840 Treatment plan—Acute perioperative pain.**

The physician assistant shall comply with the requirements in this section when prescribing opioids for perioperative pain.

- (1) The physician assistant should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-918-820.
- (2) The physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-918-935.
- (3) If the physician assistant 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 three-day supply or less will often be sufficient. The physician assistant 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 physician assistant shall reevaluate a patient who does not follow the expected course of recovery and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.
- (5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:
  - (a) Change in pain level;
  - (b) Change in physical function;
  - (c) Change in psychosocial function; and
  - (d) Additional indicated diagnostic evaluations or other treatments.
- (6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.
- (7) Long-acting or extended release opioids are not indicated for acute perioperative pain.
- (8) Medication assisted treatment medications must not be discontinued when treating acute perioperative pain, except as consistent with the provisions of WAC 246-918-925.
- (9) If the physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the physician assistant shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-918-845 and 246-918-850, 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****WAC 246-918-845 Patient evaluation and patient record—Subacute pain.**

The physician assistant shall comply with the requirements in this section when prescribing opioids for subacute pain.

- (1) Prior to issuing an opioid prescription for subacute pain, the physician assistant shall assess the rationale for continuing opioid therapy:
  - (a) Conduct an appropriate history and physical examination;
  - (b) Reevaluate the nature and intensity of the pain;
  - (c) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-918-935;
  - (d) Screen the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;
  - (e) Obtain a biological specimen test if the patient's functional status is deteriorating or if pain is escalating; and
  - (f) Screen or refer the patient for further consultation for psychosocial factors if the patient's functional status is deteriorating or if pain is escalating.
- (2) The physician assistant treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following is 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 or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode;
  - (c) Pertinent concerns discovered in the PMP;
  - (d) An appropriate pain treatment plan including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;
  - (e) The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;
  - (f) Results of psychosocial screening or consultation;
  - (g) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies; and

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- (h) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable.
- (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 indicated diagnostic evaluations or other treatments.

### **WAC 246-918-850 Treatment plan—Subacute pain.**

The physician assistant, having recognized the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase shall develop an opioid treatment plan.

- (1) If tapering has not begun prior to the six- to twelve-week subacute phase, the physician assistant shall reevaluate the patient. Based on effect on function or pain control, the physician assistant shall consider whether opioids will be continued, tapered, or discontinued.
- (2) If the physician assistant prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain that is severe enough to require opioids. During the subacute phase the physician assistant shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.
- (3) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.
- (4) If the physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the physician assistant shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-918-855 through 246-918-905, shall apply.

### **Opioid Prescribing—Chronic Pain Management**

#### **WAC 246-918-855 Patient evaluation and patient record—Chronic pain.**

When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician assistant shall include in the patient's record:

- (1) An appropriate history including:
  - (a) The nature and intensity of the pain;
  - (b) The effect of pain on physical and psychosocial function;
  - (c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and
  - (d) Review of comorbidities with particular attention to psychiatric and substance use.
- (2) Appropriate physical examination.
- (3) Ancillary information and tools to include:
  - (a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;
  - (b) Any pertinent diagnostic, therapeutic, and laboratory results;
  - (c) Pertinent consultations; and
  - (d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.
- (4) Assessment. The physician assistant must document medical decision making to include:
  - (a) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
  - (b) Consideration of the risks and benefits of chronic opioid treatment for the patient;
  - (c) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids; and
- (5) Pertinent concerns discovered in the PMP.
- (6) Treatment plan as provided in WAC 246-918-860.

#### **WAC 246-918-860 Treatment plan—Chronic pain.**

The physician assistant, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop an opioid treatment plan as follows:

- (1) Treatment plan and objectives including:
  - (a) Documentation of any medication prescribed;
  - (b) Biologic specimen testing ordered;
  - (c) Any labs, diagnostic evaluations, referrals, or imaging ordered;

- (d) Other planned treatments; and
  - (e) Written agreement for treatment as provided in WAC 246-918-865.
- (2) The physician assistant shall complete patient notification in accordance with the provisions of WAC 246-918-815 or provide this information in the written agreement.

**WAC 246-918-865 Written agreement for treatment—Chronic pain.**

The physician assistant shall use a written agreement that outlines the patient's responsibilities for opioid therapy. This written agreement for treatment must include the following provisions:

- (1) The patient's agreement to provide samples for biological specimen testing when requested by the physician assistant;
- (2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
- (3) Reasons for which opioid therapy may be discontinued;
- (4) The requirement that all opioid prescriptions for chronic pain are provided by a single prescriber or a single clinic, except as provided in WAC 246-918-915 for episodic care;
- (5) The requirement that all opioid prescriptions for chronic pain are to be dispensed by a single pharmacy or pharmacy system whenever possible;
- (6) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
- (7) A violation of the agreement may result in a tapering or discontinuation of the prescription; and
- (8) The patient's responsibility to safeguard all medications and keep them in a secure location.

**WAC 246-918-870 Periodic review—Chronic pain.**

- (1) The physician assistant shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-918-935, 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 physician assistant's discretion.
- (2) During the periodic review, the physician assistant shall determine:
  - (a) The patient's compliance with any medication treatment plan;
  - (b) If pain, function, and quality of life have improved, diminished, or are maintained; and
  - (c) If continuation or modification of medications for pain management treatment is necessary based on the physician assistant's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.
- (3) Periodic patient evaluations must also include:
  - (a) History and physical examination related to the pain;
  - (b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and
  - (c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-918-935 and subsection (1) of this section.
- (4) If the patient violates the terms of the agreement, the violation and the physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

**WAC 246-918-875 Long-acting opioids—Chronic pain.**

Long-acting opioids should only be prescribed by a physician assistant 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. The physician assistant prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.

**WAC 246-918-880 Consultation—Recommendations and requirements—Chronic pain.**

- (1) The physician assistant shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.
- (2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician assistant 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 246-918-895 is required, unless the consultation is exempted under WAC 246-918-885 or 246-918-890.

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- (3) The mandatory consultation must consist of at least one of the following:
  - (a) An office visit with the patient and the pain management specialist;
  - (b) A telephone, electronic, or in-person consultation between the pain management specialist and the physician assistant;
  - (c) An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician assistant or a licensed health care practitioner designated by the physician assistant or the pain management specialist;  
or
  - (d) Other chronic pain evaluation services as approved by the commission.
- (4) A physician assistant shall document each consultation with the pain management specialist.

### **WAC 246-918-885 Consultation—Exemptions for exigent and special circumstances—Chronic pain.**

A physician assistant is not required to consult with a pain management specialist as defined in WAC 246-918-895 when the physician assistant has documented adherence to all standards of practice as defined in WAC 246-918-855 through 246-918-875 and when one or more of the following conditions are met:

- (1) The patient is following a tapering schedule;
- (2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with an expected return to their baseline dosage level or below;
- (3) The physician assistant 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 physician assistant documents the patient's pain and function are stable and the patient is on a nonescalating dosage of opioids.

### **WAC 246-918-890 Consultation—Exemptions for the physician assistant—Chronic pain.**

The physician assistant is exempt from the consultation requirement in WAC 246-918-880 if one or more of the following qualifications are met:

- (1) The physician assistant is a pain management specialist under WAC 246-918-895;
- (2) The physician assistant has successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders;
- (3) The physician assistant is a pain management physician assistant working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or
- (4) The physician assistant has a minimum of 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.

### **WAC 246-918-895 Pain management specialist—Chronic pain.**

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

- (1) If an allopathic physician assistant or osteopathic physician assistant must have a delegation agreement with a physician pain management specialist and meets the educational requirements and practice requirements listed below:
  - (a) A minimum of three years of clinical experience in a chronic pain management care setting;
  - (b) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for an allopathic physician assistant or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;
  - (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 physician assistant's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.
- (2) If an allopathic physician, in accordance with this section.
- (3) If an osteopathic physician, in accordance with WAC 246-853-750.
- (4) If a dentist, in accordance with WAC 246-817-965.
- (5) If a podiatric physician, in accordance with WAC 246-922-750.
- (6) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

### **WAC 246-918-900 Tapering considerations—Chronic pain.**

The physician assistant shall consider tapering or referral for a substance use disorder evaluation when:

- (1) The patient requests;
- (2) The patient experiences a deterioration in function or pain;
- (3) The patient is noncompliant with the written agreement;

- (4) Other treatment modalities are indicated;
- (5) There is evidence of misuse, abuse, substance use disorder, or diversion;
- (6) The patient experiences a severe adverse event or overdose;
- (7) There is unauthorized escalation of doses; or
- (8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

**WAC 246-918-905 Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician assistant.**

- (1) When a patient receiving chronic opioid pain medications changes to a new physician assistant, it is normally appropriate for the new physician assistant to initially maintain the patient's current opioid doses. Over time, the physician assistant may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
- (2) A physician assistant's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-918-880 if:
  - (a) The patient was previously being treated with a dosage of opioids in excess of a 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 history of compliance with treatment plans and written agreements documented by medical records and PMP queries; and
  - (d) The patient has documented functional stability, pain control, or improvements in function or pain control at the presenting opioid 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 246-918-880 shall apply.

**Opioid Prescribing—Special Populations**

**WAC 246-918-910 Special populations—Children or adolescent patients, pregnant patients, and aging populations.**

- (1) Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician assistant shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.
- (2) Pregnant patients. The physician assistant shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment for opioids, such as methadone or buprenorphine, must not be discontinued during pregnancy without consultation with a MAT prescribing practitioner.
- (3) Aging populations. As people age, their sensitivities to and metabolizing of opioids may change. The physician assistant 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.

**WAC 246-918-915 Episodic care of chronic opioid patients.**

- (1) When providing episodic care for a patient who the physician assistant knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the physician assistant, or their designee, shall review the PMP and document their review and any concerns.
- (2) A physician assistant providing episodic care to a patient who the physician assistant knows is being treated with opioids for chronic pain should provide additional analgesics, including opioids when appropriate, to adequately treat acute pain. If opioids are provided, the physician assistant shall limit the use of opioids to the minimum amount necessary to control the acute pain until the patient can receive care from the practitioner who is managing the patient's chronic pain.
- (3) The episodic care physician assistant shall coordinate care with the patient's chronic pain treatment practitioner, if possible.

**Opioid Prescribing—Coprescribing**

**WAC 246-918-920 Coprescribing of opioids with certain medications.**

- (1) The physician assistant shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:
  - (a) Benzodiazepines;
  - (b) Barbiturates;
  - (c) Sedatives;
  - (d) Carisoprodol; or
  - (e) Nonbenzodiazepine hypnotics.
- (2) If, because of a prior prescription by another provider, a prescription written by a physician assistant results in a combination of opioids and medications described in subsection (1) of this section, the physician assistant issuing the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care.

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### **WAC 246-918-925 Coprescribing of opioids for patients receiving medication assisted treatment.**

- (1) Where practicable, the physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.
- (2) The physician assistant providing acute nonoperative pain or acute perioperative pain treatment shall not discontinue MAT medications without documentation of the reason for doing so, nor shall the use of these medications be used to deny necessary operative intervention.

### **WAC 246-918-930 Coprescribing of naloxone.**

The opioid prescribing physician assistant shall confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.

### **Opioid Prescribing—Prescription Monitoring Program**

#### **WAC 246-918-935 Prescription monitoring program—Required registration, queries, and documentation.**

- (1) The physician assistant shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe Schedule II-V medications in Washington state.
- (2) The physician assistant is permitted to delegate performance of a required PMP query to an authorized designee.
- (3) At a minimum, the physician assistant shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-918-920 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 physician assistant shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:
  - (a) For a high-risk patient, a PMP query shall be completed at least quarterly;
  - (b) For a moderate-risk patient, a PMP query shall be completed at least semiannually; and
  - (c) For a low-risk patient, a PMP query shall be completed at least annually.
- (5) The physician assistant shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.
- (6) The physician assistant shall ensure a PMP query is performed when providing episodic care to a patient who the physician assistant knows to be receiving opioids for chronic pain, in accordance with WAC 246-918-915.
- (7) If the physician assistant is using an electronic medical record (EMR) that integrates access to the PMP into the workflow of the EMR, the physician assistant shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-918-920.
- (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 physician assistant or their designee due to a temporary technological or electrical failure.
- (9) Pertinent concerns discovered in the PMP shall be documented in the patient record.