Pain Management Rules
Attachment A

Language Changes:

The adopted rules include the following changes from the proposed rules published as WSR 11-04-086:

- Pain management—Intent – WAC 246-854-240. Language is added to clarify that these rules do not restrict the current scope of practice for the physician assistant or the working agreement between the physician assistant and the osteopathic physician, which may include pain management.

- Definitions – WAC 246-853-662 and WAC 246-854-242
    - The terms "Episodic care," "Morphine equivalent dose", and" Multidisciplinary pain clinic" are added to the definitions.
    - The terms "Physical dependence," "Psychological dependence," and "Tolerance" are deleted as these terms are not used in the rules.

- Written agreement for treatment – WAC 246-853-666(4) and WAC 246-854-246(4). "or multidisciplinary pain clinic" and "or pharmacy system" are added.

- Long-acting opioids, including methadone – WAC 246-853-668 and WAC 246-854-248. In the third sentence, after "one-time", "(lifetime)" is added.

- Consultation: Recommendations and requirements – WAC 246-853-670(2) and WAC 246-854-250(2). The word "adult" is added to clarify the morphine equivalent dose (MED) threshold is for adults. The word "oral" is also added to clarify that the threshold is based on an "oral" dose. Language regarding pediatric patients is also added at the end of the paragraph: "Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged."

- Pain management specialist – WAC 246-853-673 (1)(d)(ii). Language is added to clarify the cycle in which to complete the required continuing education is two years for physicians and three years for osteopathic physicians.

- Pain management specialist – WAC 246-853-673 (1)(d)(iii) and (3)(d). Language is added to clarify that the current practice may also be in a multidisciplinary pain clinic setting.

The adopted rules also include edits for grammar, punctuation, and formatting.

PAIN MANAGEMENT

NEW SECTION

WAC 246-853-660 Pain management--Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

NEW SECTION

WAC 246-853-661 Exclusions. The rules adopted under WAC 246-853-660 through 246-853-673 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.

NEW SECTION

WAC 246-853-662 Definitions. The definitions in this section apply in WAC 246-853-600 through 246-853-673 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 provider other than the designated primary provider 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 may include care provided by multiple available disciplines or treatment modalities; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, 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.

NEW SECTION

WAC 246-853-663 Patient evaluation. The osteopathic physician 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

osteopathic physician.

(3) The initial patient evaluation shall include:

(a) Physical examination;

(b) The nature and intensity of the pain;

(c) The effect of the pain on physical and psychological function;

(d) Medications including indication(s), date, type, dosage, and quantity prescribed;

(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:

(i) History of addiction;

(ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;

(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;

(v) Poorly controlled depression or anxiety;

(vi) Evidence or risk of significant adverse events, including falls or fractures;

(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;

(viii) Repeated visits to emergency departments seeking opioids;

(ix) History of sleep apnea or other respiratory risk factors;

(x) Possible or current pregnancy; and

(xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

(a) Any available diagnostic, therapeutic, and laboratory results; and

(b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

(a) The diagnosis, treatment plan, and objectives;

(b) Documentation of the presence of one or more recognized indications for the use of pain medication;

(c) Documentation of any medication prescribed;

(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the osteopathic physician; and

(f) The osteopathic physician's instructions to the patient.

NEW SECTION

WAC 246-853-664 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 osteopathic physician should adjust drug therapy to the individual health needs of the patient. The osteopathic physician 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 osteopathic physician 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.

NEW SECTION

WAC 246-853-665 Informed consent. The osteopathic physician 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.

NEW SECTION

WAC 246-853-666 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one osteopathic physician 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 osteopathic physician 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 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;

(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 osteopathic physician 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 osteopathic physician.

(7) A written authorization that the osteopathic physician 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 osteopathic physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

NEW SECTION

WAC 246-853-667 Periodic review. The osteopathic physician 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 nonescalating 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 osteopathic physician 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 osteopathic physician's evaluation of progress towards treatment objectives.

(2) The osteopathic physician 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 osteopathic physician 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 osteopathic physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.

(4) The osteopathic physician should periodically review any relevant information from a pharmacist provided to the osteopathic physician.

NEW SECTION

WAC 246-853-668 Long-acting opioids, including methadone. Long-acting opioids, including methadone, should only be prescribed by an osteopathic 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 osteopathic physician 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.

NEW SECTION

WAC 246-853-669 Episodic care. (1) When evaluating patients for episodic care, such as emergency or urgent care, the osteopathic physician 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 osteopathic physician 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 246-853-666(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.

NEW SECTION

WAC 246-853-670 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 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 an osteopathic physician 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 246-853-673 is required, unless the consultation is exempted under WAC 246-853-671 or 246-853-672. Great caution should be used when prescribing opioids to children with chronic noncancer pain, and appropriate referral 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 osteopathic physician;

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

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

(b) An osteopathic physician 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 osteopathic physician, the osteopathic physician 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 246-853-660 through 246-853-673, "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.

NEW SECTION

WAC 246-853-671 Consultation--Exemptions for exigent and special circumstances. An osteopathic physician is not required to consult with a pain management specialist as described in WAC 246-853-673 when he or she has documented adherence to all standards of practice as defined in WAC 246-853-660 through 246-854-673 and when any one or more of the following conditions apply:

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

(2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level; or

(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 morphine equivalent dose (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.

NEW SECTION

WAC 246-853-672 Consultation--Exemptions for the osteopathic physician. The osteopathic physician is exempt from the consultation requirement in WAC 246-853-670 if one or more of the following qualifications are met:

(1) The osteopathic physician is a pain management specialist under WAC 246-853-673; or

(2) The osteopathic physician 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 within the last three years a minimum of eighteen continuing education hours on chronic pain management approved by the profession's continuing education accrediting organization, with at least three of these hours dedicated to long acting opioids, to include methadone; or

(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 his or her current practice is the direct provision of pain management care.

NEW SECTION

WAC 246-853-673 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 for a physician or three years for an osteopathic physician; and

(iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

(2) If a 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.

PAIN MANAGEMENT

NEW SECTION

WAC 246-854-240 Pain management--Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer 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.

NEW SECTION

WAC 246-854-241 Exclusions. The rules adopted under WAC 246-854-240 through 246-854-253 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.

NEW SECTION

WAC 246-854-242 Definitions. The definitions in this section apply in WAC 246-854-240 through 246-854-253 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 provider other than the designated primary provider 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 may include care provided by multiple available disciplines or treatment modalities; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, 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.

NEW SECTION

WAC 246-854-243 Patient evaluation. The osteopathic physician assistant 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 osteopathic physician assistant.

(3) The initial patient evaluation shall include:

(a) Physical examination;

(b) The nature and intensity of the pain;

(c) The effect of the pain on physical and psychological function;

(d) Medications including indication(s), date, type, dosage, and quantity prescribed;

(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:

(i) History of addiction;

(ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;

(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;

(v) Poorly controlled depression or anxiety;

(vi) Evidence or risk of significant adverse events, including falls or fractures;

(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;

(viii) Repeated visits to emergency departments seeking opioids;

(ix) History of sleep apnea or other respiratory risk factors;

(x) Possible or current pregnancy; and

(xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

(a) Any available diagnostic, therapeutic, and laboratory results; and

(b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

(a) The diagnosis, treatment plan, and objectives;

(b) Documentation of the presence of one or more recognized indications for the use of pain medication;

(c) Documentation of any medication prescribed;

(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the osteopathic physician assistant; and

(f) The osteopathic physician assistant instructions to the patient.

NEW SECTION

WAC 246-854-244 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 osteopathic physician assistant should adjust drug therapy to the individual health needs of the patient. The osteopathic physician assistant 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 osteopathic physician assistant 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.

NEW SECTION

WAC 246-854-245 Informed consent. The osteopathic physician assistant 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.

NEW SECTION

WAC 246-854-246 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one osteopathic physician assistant 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 osteopathic physician assistant 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 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;

(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 osteopathic physician assistant 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 osteopathic physician assistant;

(7) A written authorization that the osteopathic physician assistant 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 osteopathic physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

NEW SECTION

WAC 246-854-247 Periodic review. The osteopathic physician assistant 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 nonescalating 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 osteopathic physician assistant 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 osteopathic physician assistant's evaluation of progress towards treatment

objectives.

(2) The osteopathic physician assistant 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 osteopathic physician assistant 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 osteopathic physician assistant should periodically review information from any available prescription monitoring program or emergency department-based information exchange.

(4) The osteopathic physician assistant should periodically review any relevant information from a pharmacist provided to the osteopathic physician assistant.

NEW SECTION

WAC 246-854-248 Long-acting opioids, including methadone. Long-acting opioids, including methadone, should only be prescribed by an osteopathic 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 osteopathic physician assistant prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four continuing education hours relating to this topic.

NEW SECTION

WAC 246-854-249 Episodic care. (1) When evaluating patients for episodic care, such as emergency or urgent care, the osteopathic physician assistant 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 osteopathic physician assistant 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 246-854-246(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.

NEW SECTION

WAC 246-854-250 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 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 practitioner 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 246-854-253 is required, unless the consultation is exempted under WAC 246-854-251 or 246-854-252. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referral 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 osteopathic physician assistant;

(iii) An electronic consultation between the pain management specialist and the osteopathic physician assistant; or

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

(b) An osteopathic physician assistant 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 osteopathic physician assistant, the osteopathic physician assistant 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 246-854-240 through 246-854-253, "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.

NEW SECTION

WAC 246-854-251 Consultation--Exemptions for exigent and special circumstances. A physician assistant is not required to consult with a pain management specialist as described in WAC 246-854-253 when he or she has documented adherence to all standards of practice as defined in WAC 246-854-240 through 246-854-253 and when any one or more of the following conditions apply:

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

(2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level; or

(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 is stable and the patient is on a nonescalating dosage of opioids.

NEW SECTION

WAC 246-854-252 Consultation--Exemptions for the osteopathic physician assistant. The physician assistant is exempt from the consultation requirement in WAC 246-854-250 if one or more of the following qualifications are met:

(1) The sponsoring physician is a pain management specialist

under WAC 246-854-253; or

(2) The sponsoring physician and the physician assistant have 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 within the last three years a minimum of eighteen continuing education hours on chronic pain management approved by the profession's continuing education accrediting organization, with at least three of these hours dedicated to long acting opioids, to include methadone; or

(3) The physician assistant is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility.

NEW SECTION

WAC 246-854-253 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) If a physician, 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 for a physician or three years for an osteopathic physician; and

(iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or 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.