Opioid Prescribing
General Provisions for MDs & PAs

Rules Workshop

October 27, 2026

Rules Workshop Agenda

WASHINGTON Medical Commission
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Virtual via Teams Webinar

Tuesday, October 27, 2026 – 9 am to Noon

Opioid Prescribing—General Provisions for MDs & PAs

Register for this meeting at: Rules Workshop

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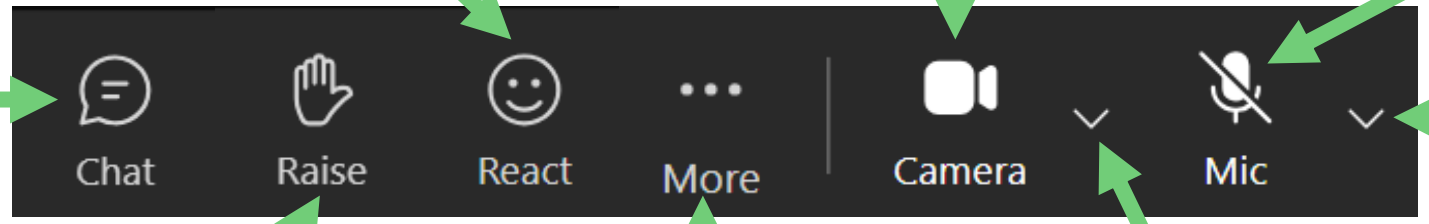

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Proposed Rule Development Timeline

April 2025
Preproposal Statement of Inquiry, or CR-101, filed

July 2025
Interested parties work begins – workshops, drafts, formal input

January 2027
Request to initiate CR-102, Proposed Rules

May 2027
Public hearing and written comments

July 2027
CR-103 – Final rule adoption and Concise Explanatory Statement

October 2027
Rules effective

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WAC 246-919-850 - Intent & Scope
Draft as of October 21, 2026

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-919-850 Intent and scope. The rules in WAC 246-919-851 through 246-919-985 provide requirements and guidance for prescribing opioids to treat pain. They establish that patients in Washington should have access to safe, effective, and appropriate pain relief, and that pain management is an integral part of quality medical care. Physicians are encouraged to be knowledgeable about assessing pain, using both pharmacologic and non-pharmacologic treatments, and understanding the legal and regulatory requirements for prescribing opioids, including traditional opioid agonists and partial agonists.

The rules recognize that tolerance and physical dependence from long-term opioid use are normal and distinct from opioid use disorder. Physicians are expected to incorporate safeguards to reduce the risks of misuse, diversion, and harm, including monitoring prescriptions, using urine drug testing, educating patients on safe storage and disposal, and ensuring naloxone availability when appropriate.

A prescription is considered legitimate when issued in the course of professional practice, based on sound clinical judgment, and supported by appropriate documentation of the patient's clinical needs and treatment. Physicians should not fear disciplinary action by the commission for ordering, prescribing, dispensing, or administering controlled substances, including opioids, for a legitimate medical purpose in the course of professional practice.

The Medical Practice Act and commission rules govern the practice of medicine and opioid prescribing in Washington. Physicians should exercise their professional judgment in applying federal and state guidelines to individual patients. Consistent with applicable laws, commission rules take precedence over conflicting guidelines. Applying blanket dosing limits or requiring tapering solely on the basis of federal or state guidelines, without an individualized assessment of the patient's clinical needs and circumstances, may fall below the standard of care.

Treatment decisions should be individualized, considering the patient's diagnosis, overall functioning, and clinical needs, rather than relying solely on dosage or quantity limits. A physician should not refuse to initiate or continue opioid therapy solely because a patient is using or has used opioid medications. Such a decision may undermine access to appropriate medical treatment and may fall below the standard of care. Decisions to initiate, continue, modify, or discontinue opioid therapy should reflect clinical need, patient stability, and the physician's professional judgment. Physicians should not deny or taper opioid therapy automatically based on prior or current opioid use without an individualized assessment.

Physicians retain professional judgment to adapt care based on patient circumstances, available resources, and evolving clinical knowledge, with documentation supporting clinical decisions.

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

~~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.~~

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]

Revised October 21, 2026

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-919-850 Intent and scope.

Proposed language for this section as of 9/22/25:

The rules in WAC 246-919-85~~0~~1 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

Commented [DB1]: WSMA suggests deleting most of this section and it reading: "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. Likewise no clinician should fear discipline for not utilizing controlled substance in a treatment plan if not clinically indicated."

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 Suggested changes from Dr. Stanos (comment #112): traditional opioid agonists such as hydrocodone, morphine, hydromorphone, and tramadol and partial agonists, such as buprenorphine. All physicians should become knowledgeable about co-occurring prescriptions. Accordingly, these rules Suggested addition from Dr. Stanos (comment #112): have been developed to clarify the commission's position on pain control, particularly as related to the use of Suggested changes from Dr. Stanos (comment #112): opioid agonist and partial-agonists analgesics~~controlled substances~~, to alleviate physician uncertainty and to encourage better pain management.

Commented [DB2]: Approved 9/22

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 Suggested addition from Dr. Stanos (comment #112): such as traditional agonists and partial agonists are analgesics that may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery Suggested addition from Dr. Stanos (comment #112): and chronic pain, whether due to cancer or non-cancer origins. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

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

Commented [DB3]: Dr. Stanos suggests adding the following here but it may be more appropriate elsewhere - (A proposed new section has been added WAC 246-919-951 - the language proposed by Dr. Stanos has been revised to read more like a rule): Buprenorphine, a partial agonist, may be used for both the management of opioid use disorder (MOUD), chronic pain, and tapering depending on the patient's needs and diagnoses. The care of patients on buprenorphine for chronic pain and maintenance therapy for MOUD requiring additional analgesia for acute pain and/or planned surgical interventions should be coordinated between the primary prescriber with the provider managing acute pain and/or a planned surgical intervention. Physicians should be aware of the evolving understanding of the unique pharmacology of buprenorphine, the range of formulations available (i.e. topical, sublingual, and submucosal), and evidence-based strategies to manage patients on maintenance therapy for MOUD or those using buprenorphine for chronic pain who require additional analgesia for acute or planned surgical or medical interventions.

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 Suggested addition from Dr. Stanos (comment #112): analgesics and are not the same as Suggested addition from Dr. Stanos: addiction 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 Suggested addition from Dr. Stanos (comment #112): analgesics for other than legitimate medical purposes poses a threat to the individual and society Suggested change from Dr. Stanos (comment #112): and that. The inappropriate prescribing of controlled substances, including opioids Suggested addition from Dr. Stanos (comment #112): analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances Suggested

addition from Dr. Stanos (comment #112): including monitoring the prescription monitoring database, integrating urine monitoring, educating patients about safe storage and disposal of unused medications, and the need for availability of naloxone in emergency circumstances to reverse a potential opioid overdose.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids Suggested addition from Dr. Stanos (comment #112): , opioid agonists and partial agonist analgesics, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must ~~exist~~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 medical practice act of Washington and commission rules supersede any conflicting federal or state guidelines relating to the practice of medicine or prescribing of opioids for pain control. Establishing blanket dosing limits and forced tapering based on federal guidelines and not individualized patient assessment and need will be deemed a violation of the standard of care.

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.

A physician must not refuse to initiate or continue opioid therapy solely because a patient is using or has used opioid medications. Denying care based on a patient's use of prescribed opioids, without an individualized assessment, undermines access to appropriate medical treatment and may fall below the standard of care. Each patient must be evaluated on a case-by-case basis,

Commented [MM4]: Language from Sierra AGO.

Commented [DB5]: Revised from the 7/30/25 workshop. Needs discussion and decision.

Commented [MM6]: This is a problem every time CDC updates their guidelines or an employer gets a new legal counsel. We get pictures of the signs at front desks sent to us. The long standing issue is we need to be explicit that the WMC rules are what reigns supreme here and everything else are suggestions.

and treatment decisions should reflect clinical need, patient stability, and the physician's professional judgment.

These rules are designed to assist physicians in providing appropriate medical care for patients. Suggested addition from Dr. Stanos (comment #112): They are not inflexible rules or rigid practice requirements and not intended, nor should they be used, to establish a legal standard of care outside the context of the commission's jurisdiction. The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician based on all circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious physician may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the physician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a physician who employs an approach substantially different from these rules is advised to

Commented [DB7]: Distilled language from our Interpretive Statement: WMC IS Opioid Prescribing for MDs & PAs WSR #25-11-078.pdf

Commented [DB8R7]: This was approved on 7/30

document in the patient record information sufficient to justify the approach taken.

The practice of medicine involves not only ~~the science~~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 Suggested change from Dr. Stanos (comment #112): ~~guarantee~~ assure 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]

Physicians

WAC 246-919-851 Exclusions. WAC 246-919-850 through 246-919-985 do not apply to:

Commented [DB9]: WSMA Redline Comment #126 suggests changing this section to read: WAC 246-919-851 Inclusions. WAC 246-919-850 through 246-919-985 apply only to the treatment of non-cancer related pain in the outpatient setting.

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

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

Suggested addition from Higginbotham redline (comment #111): (a) The management of patients receiving palliative care as defined in WAC 246-919-851 when pain significantly impairs function or quality of life.

(4) The treatment of chronic non-cancer pain patients on a stable and non-escalating dose. For the purposes of these rules, stable and non-escalating means a period of six months or more on a consistent dose of opioids that does not fluctuate more or

less than 30 MED per day in a given month and does not exhibit aberrant behavior as defined in WAC 246-919-852 ~~this section~~;

(5) Patients with high-impact chronic pain, as defined in WAC 246-919-852 who are maintained on a stable, non-escalating dosage of medication, where the treatment plan demonstrates ongoing benefit, functional stability, and absence of evidence of misuse or diversion. (Alternate language: Patients with high-impact chronic pain who are maintained on a stable and non-escalating dosage, when the physician documents ongoing clinical benefit, functional stability, and no evidence of misuse.) (Suggested language from WashPIP (comment #115): Patients with high-impact chronic pain, as defined in WAC 246-919-852, where the patient is in compliance with the treatment plan, demonstrates ongoing benefit, functional stability, and absence of evidence of misuse or diversion.)

(6) Suggested language from Higginbotham petition: "Add exemption: Rare diseases-patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National

Commented [MM10]: A suggestion from community to consider. The intent here and with the subsequent edits is as follows:

1. A patient transitioning from sub-acute to chronic will need to be evaluated, treated, and monitored according to the existing chronic opioid rules.
2. After at least six months of stability under this definition, they may be exempt from the chronic opioid rules.
3. Legacy patients would be covered by the safe harbor provision for 90 days and if they are on a stable dose for a further 90 days they would fall under this exemption.
4. The remaining population would be the non-stable escalating dose patients and those displaying aberrant behaviors, which would be subject to the rules if and until they can come into stability and compliance.

Commented [DB11]: WashPIP Comment #115: There is concern regarding the language "non-escalating dose."
The focus cannot be on dose. "Non-escalating dose" does not refer to the condition of the patient, but again to an MED.
As we have seen in the past, providers will error on the side of caution to comply with all available rules. This language offers a loop hole where prescribers could misapply the language to mean that patients must simply have a non-escalating dose to comply with exemptions to the rules. That could result in patients not receiving proper care because they will be held at a non-therapeutic dose, not a dose that is individualized.

Institutes of Health (NIH) are exempt from the guidelines and/or policies."

(5~~4~~) The provision of procedural medications;

(6~~5~~) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

(7~~6~~) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection (5) of this section.

Suggested addition from Higginbotham redline (comment #111)

(8) The treatment of patients with high impact chronic pain as

defined in WAC 246-919-851, when opioid therapy is clinically indicated and documented.

Suggested addition from Higginbotham redline (comment #111)

(9) The continued care of legacy or stable, compliant patients receiving long-term opioid therapy, when treatment has been effective and no evidence of aberrant behavior exists.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-851, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71A.800, 18.71.017, and 18.130.050. WSR 22-22-039, § 246-919-851, filed 10/25/22, effective 11/25/22. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

WAC 246-919-852 Definitions. The following definitions apply to WAC 246-919-850 through 246-919-985 unless the context clearly requires otherwise.

Commented [DB12]: This section will be discussed as a separate agenda item at the October 26, 2026, workshop.

(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) Biopsychosocial assessment means an evaluation that considers the biological, psychological, and social factors that may influence a patient's health status, pain experience, and treatment outcomes. The assessment may include, as clinically appropriate, the patient's medical history, mental health status, substance use history, functional status, and social or environmental factors that may affect treatment planning.

(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. Cancer related

Commented [DB13]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB14]: Added after 2/23 workshop

Commented [DB15]: WSMA Redline Comment #126 suggests deleting this definition.

pain may persist past the treatment and into the remission phase.

(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~~is pain that persists for more than twelve weeks. Suggestion from WashPIP (Comment #107): "Chronic Pain" means pain that persists or recurs for longer than 3 months. Such pain often becomes the sole or predominant clinical problem in some patients. As such it may warrant specific diagnostic evaluation, therapy and rehabilitation.

Suggested addition from Higginbotham redline (comment #111)

(6) "Chronic progressive pain-generating condition" is a condition that causes persistent, often treatment-resistant pain. These conditions may require specialized care or individualized approaches to pain management.

Commented [DB16]: Approved at 7/30 workshop

Commented [DB17]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB18]: Source: IASP definition, https://www.iasp-pain.org/advocacy/definitions-ofchronic-pain-syndromes/ as derived from 'Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the *International Classification of Diseases (ICD-11)*'

Commented [DB19]: This phrase is not used in the redline suggestions from P3/Higginbotham. As such, there is no need to define it. In the Rationale from the redline in the Definitions section, it states adding this definition would "give formal weight to WMC interpretive statements." This phrase is also not used in either of the opioid prescribing interpretive statements.

(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~~ninety-milligram ~~morphine equivalent dose (MED), or more, per day.~~

(10) "High-impact chronic pain" (HICP) means pain that has been present for ninety days or longer and that results in substantial restriction, limitation, or inability to carry out usual life or work activities, such as employment, education, household responsibilities, or social participation, on most or all days during that period.

~~(10) "High-risk" is a category of patient~~patients ~~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~~

Commented [DB20]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB21]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB22]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB23]: Suggestion to add a definition for HCIP. First draft of a possible definition.

This definition is based on the federal standards developed by the U.S. Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). The CDC defines *high-impact chronic pain* as chronic pain (pain on most days or every day in the past three months) that interferes with life or work activities on most or all days during that period. The NIH and National Center for Complementary and Integrative Health (NCCIH) further describe it as pain lasting three months or longer that substantially limits a person's ability to engage in major life activities such as employment, household responsibilities, or social participation.

Commented [DB24]: WSMA Redline Comment #126 suggests retaining this definition and revising it to read "…dose of opioids (new language) above one hundred twenty morphine equivalents a day, or the use…"

~~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 patientpatients 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 milligramfifty milligram morphine equivalent dose per day.~~

Suggested addition from Higginbotham redline (comment #111)

(13) "Legacy patient" means a patient who is continuing on an opioid therapy dose or regimen initiated by a previous provider prior to the adoption of newer prescribing guidelines, and for whom opioid therapy remains stable and clinically appropriate. These patients should not be excluded from care solely due to historical prescribing thresholds; instead, their treatment

Commented [DB25]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB26]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB27]: Suggested rewrite of this proposed definition: "Legacy patient" means a patient continuing on a stable and clinically appropriate opioid regimen initiated by a previous provider.

Commented [DB28]: If we include this definition, this should be removed - guidelines are a guide and not a requirement so any previous guidelines would be irrelevant to these rules.

should be assessed based on current medical necessity, functional benefit, and risk assessment.

(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~~patients ~~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~~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~~standardized measurement expression the potency of opioids in terms of an equivalent dose of morphine. MED is considered the same as morphine milligram equivalent or MME.

Commented [DB29]: If we include this definition, this sentence should be moved to section 955 "Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician."

Commented [DB30]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB31]: WSMA Redline Comment #126 suggests deleting this definition.

(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~~illnesses.

Suggested addition from Higginbotham redline (comment #111) "Palliative care" is patient-centered care in any care setting for people of any age and at any stage of a serious illness or disease that substantially affects a patient's quality of life. Palliative care includes, but is not limited to, comprehensive pain and symptom management while addressing, physical, intellectual, emotional, social, and spiritual needs. Palliative

Commented [DB32]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB33]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB34]: WSMA Redline Comment #126 suggests deleting this definition.

care does not always include a requirement for hospice care or attention to spiritual needs.

(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, 18.71B or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.~~57A~~ 71C 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~~is 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

Commented [DB35]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB36]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB37]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB38]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB39]: WSMA Redline Comment #126 suggests deleting this definition.

Commented [DB40]: WSMA Redline Comment #126 suggests deleting this definition.

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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

WAC 246-919-865 Patient notification, secure storage, and disposal. (1~~2~~) The requirements in ~~subsection (1)~~ ~~of~~ this section do not apply to the administration of an opioid including, but not limited to, the following situations as documented in the patient record:

(a) Emergent care;

(b) Where patient pain represents a significant health risk;

Commented [MM41]: Should be standard practice. Recommend we keep.

Commented [MM42]: To follow format established in these rules, exemptions should be listed first.

(c) Procedures involving the administration of anesthesia;

(d) When the patient is unable to grant or revoke consent; or

(e) MAT for substance use disorders.

(21) The physician shall discuss with the patient 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, including the risk of dependence and overdose, possible co-prescription of overdose reversal medication as clinically indicated, as appropriate to the medical condition, the type of patient, and the phase of treatment;

(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments, whenever reasonable, clinically appropriate, evidence-based alternatives exist;

(c) The safe and secure storage of opioid prescriptions;

(d) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs; and

(e) That the patient has the right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

~~(2) The requirements in subsection (1) of this section do not apply to the administration of an opioid including, but not limited to, the following situations as documented in the patient record:~~

~~(a) Emergent care;~~

~~(b) Where patient pain represents a significant health risk;~~

~~(c) Procedures involving the administration of anesthesia;~~

~~(d) When the patient is unable to grant or revoke consent; or~~

~~(e) MAT for substance use disorders.~~

(3) If the patient is under eighteen years old or is not competent, the discussion required by subsection (~~1~~2) of this section must include the patient's parent, guardian, or the person identified in RCW 7.70.065, unless otherwise provided by law.

(4) The physician shall document completion of the requirements in subsection (~~1~~2) of this section in the patient's health care record.

(5) The information in subsection (~~1~~2) of this section must also be provided in writing. This requirement may be satisfied with a document provided by the department of health.

(6) To fulfill the requirements of subsection (~~1~~2) of this section, a physician may designate any individual who holds a credential issued by a ~~disciplining~~ regulatory authority under RCW 18.130.040 to provide the information.

[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]

Commented [DB43]: Heather will review.

Revised October 21, 2026

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. Patient function and quality of life are the paramount concerns when considering treatment alternatives. The physician should consider all aspects of multimodal treatment, when clinically appropriate.

Commented [DB44]: Approved 4/27/26

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-870, filed 11/16/18, effective 1/1/19.]

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.~~must complete a minimum of hour hour of continuing education in best practices for pain management.

(2) For the purposes of this section, "best practices" includes, but is not limited to, education relevant to the physician's scope of practice and patient population, including safe prescribing, pain assessment, risk mitigation, and regulatory requirements.

(3~~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~~.

(4~~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.

(5) A review of WAC 246-919-850 through 246-919-985 may be counted toward the one-hour continuing education requirement.

Commented [DB45]: Approved 4/27/26

Revised October 21, 2026

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]

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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-880, filed 11/16/18, effective 1/1/19.]

Revised October 21, 2026

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.~~ When a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a seven-day supply of opioids.

(4) The physician shall reevaluate the patient's progress ~~who does not follow the expected course of recovery,~~ and

Commented [MM46]: Stanos comment requests removal. I do not read this as a hard limit. Question for attendees - is it being read as such? If so, how to alter to communicate intent to show justification?

Commented [DB47]: Revised based off of feedback at the 4/27/26 workshop.

determine ~~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 246-919-970~~in combination with other medications, such prescribing must be in accordance with WAC 246-919-970.

(7) Long-acting or ~~extended~~ extended-release opioids are not indicated for acute nonoperative pain with the exception of buprenorphine.

(8) Medication assisted treatment medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-919-975.

Commented [MM48]: Does the data still support this? My recollection is that this was a suboxone issue.

Commented [DB49]: Approved 4/27/26.

Commented [MM50]: Keep this no matter what. Major intersection between incarcerated population and ED visits discontinuing these medications to their detriment.

(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-885, filed 11/16/18, effective 1/1/19.]

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~~seven-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.~~When a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a seven-day supply of opioids.

(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.

Commented [DB51]: Approved at the 4/27/26 workshop.

Commented [DB52]: Revised based off of comments at the 4/27/26 workshop.

Commented [DB53]: Approved 6/1/26

(6) If a prescription results in the patient receiving opioids in combination with other medications, such prescribing must be in accordance with WAC 246-919-970.~~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~~extended-release opioids are not indicated for acute perioperative pain with the exception of buprenorphine.

(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~~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

Commented [DB54]: Approved 4/27/26.

Commented [MM55]: Does the data still support this statement? For every procedure?

Commented [DB56]: Approved 4/27/26.

Commented [MM57]: Keep.

documented plan and timing for discontinuation of all opioid medications.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-890, filed 11/16/18, effective 1/1/19.]

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 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

(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-895, filed 11/16/18, effective 1/1/19.]

WAC 246-919-900 Treatment plan—Subacute pain. The physician, having recognized the progression of a patient from

Commented [DB58]: Suggestion from M. Higginbotham, for this section, -905, and -930, comment #146: "Progressive disease, worsening pathology, or deterioration in function attributable to the natural progression of an underlying medical condition shall not, by itself, constitute justification for tapering opioid therapy, discontinuing treatment, refusing treatment, or requiring specialist consultation."

Commented [DB59R58]: I do not recommend adding this language because it is already addressed by the existing requirements for individualized clinical assessment and professional judgment. Identifying one specific clinical factor is unnecessary and could create confusion about how other factors should be considered.

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~~thirty~~-day supply of opioids without clinical documentation to justify the need for such a quantity.~~ During the subacute phase, when a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a fourteen-day supply of opioids.

(3) If a prescription results in the patient receiving opioids in combination with other medications, such prescribing must be in accordance with WAC 246-919-970.~~If a prescription~~

Commented [MM60]: The subacute phase is 42 days. Based on Stanos comment and the required revaluation of the patient transitioning from subacute to chronic, 30 days seems a reasonable compromise with the exemption of documenting the justification in the record for prescribing past the subacute timeline.

Commented [DB61]: Revised based off of feedback at the 4/27/26 workshop.

Commented [DB62]: Approved 6/1/26.

Commented [DB63]: Approved 4/27/26.

~~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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-900, filed 11/16/18, effective 1/1/19.]

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 pharmacologic and nonpharmacologic ~~opioids and other medications~~ and their efficacy; ~~and~~

(d) ~~Review of comorbidities with particular attention to psychiatric and substance use.~~ Relevant behavioral health and psychosocial risk factors, including substance use, that may affect the patient's pain, function, or risk of opioid-related harms; and

(e) Patient goals and treatment expectations.

(2) Appropriate physical examination.

(3) Ancillary information and tools ~~to~~ include:

(a) Review of the ~~PMP~~ prescription monitoring program ~~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, or biological specimen test results;

(c) Pertinent consultations; ~~and~~

Commented [DB64]: Approved 9/28/26

Commented [DB65]: Revise based on comments.

Commented [DB66]: Approved 9/28/26

Commented [DB67]: Approved 9/28/26

Commented [DB68]: 6/2 - Proposed changes need review.

Commented [DB69]: Approved 6/1/2026.

(d) Use of ~~a~~ validated screening or ~~risk~~ assessment tools, when clinically appropriate, to evaluate pain, function, behavioral health conditions, or risk for adverse outcomes associated with opioid therapy; and

~~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.~~

(e) Review of prior treatment records or care plans, when available and clinically relevant.

(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 initiating or continuing chronic opioid treatment in the context of the patient's condition, clinical goals, and prior response to care~~for the patient~~;

Commented [DB70]: Approved 9/28/26

Commented [DB71]: Suggested addition from WashPIP as either (i) or new (e): Risk Assessment tools shall not include Scores generated by Automated Decision Making Systems or Automated Decision Support Systems.

Commented [DB72]: Suggested change from Higginbotham redline (comment #111) (d) Individualized treatment goals established through shared decision-making, reflecting patient preferences and disease-specific needs.

Commented [DB73]: Approve language 6/1/26. Research AI requirements/restrictions.

Commented [DB74]: Approved 6/1/26.

Commented [DB75]: Suggested change from Higginbotham redline (comment #111) (b) Consideration of the risiks and benefits of initiating or continuing opioid treatment in the context of the patient's condition, clinical goals, and prior response to care;

Commented [DB76R75]: Approved 6/1/26.

(c) The patient's pain, function, quality of life, and progress toward treatment goals; ~~observed or reported effect on function or pain control forming the basis to continue prescribing opioids;~~ and

(d) Pertinent concerns ~~discovered~~ identified through~~in the~~ PMP review, consultations, or other clinical information.

(5) ~~Treatment plan as provided in WAC 246-919-910~~

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]

WAC 246-919-910 Treatment plan—Chronic pain. (1) The physician, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop and document an individualized opioid treatment plan appropriate to the patient's needs.~~as follows:~~

(~~1~~2) The ~~T~~treatment plan ~~and objectives including~~shall include:

(a) Documentation of any medication prescribed;

(b) Biologic specimen testing ordered;

Commented [DB77]: Suggested change from Higginbotham redline (comment #111) (c) Functional or symptom-related rationale supporting ongoing prescribing; and

Commented [DB78]: Approved 6/1/26.

Commented [DB79]: Approved 9/28/26

Commented [DB80]: Suggested change from Higginbotham redline (comment #111) (d) notable finding from the PMP review.

Commented [DB81]: Approved 6/1/26.

Commented [DB82]: Approved 9/28/26

Commented [DB83]: Approved 6/1/26.

Commented [MM84]: Do we need to say this? What practitioner would not have a treatment plan for ANY patient with a condition? Is that not the standard of care?

Commented [DB85R84]: Since we are moving toward a more individualized medical-decision making model with this draft, keeping this section provides a framework for the evaluation, monitoring, reassessment, and consultation provisions we are proposing elsewhere in these rules.

Commented [DB86]: Approved 6/1/26.

(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.]

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

Commented [MM87]: I think this should stay as one of the remaining requirements. It makes sense for the legacy patient scenario, the new to chronic phase scenario, and aberrant scenario.

Commented [DB88]: Suggested change from Higginbotham redline (comment #111) The physician shall use a written agreement for any patient receiving long-term opioid therapy for chronic pain. The agreement must reflect a mutual understanding of treatment goals, medication safety and shared responsibilities. The written agreement must include the following provisions: (continued in the comments for each subsection below).

Commented [DB89]: Suggested change from Higginbotham redline (comment #111) (1) The patient's agreement to provide biological specimens when requested by the physician and clinically justified.

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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]

WAC 246-919-920 Periodic review—Chronic pain. ~~(1)~~ The physician shall periodically review the course of treatment for

Commented [DB90]: Suggested change from Higginbotham redline (comment #111) (3) A clear outline of clinical circumstances under which opioid therapy may be involuntarily modified, tapered, or discontinued.

Commented [DB91]: Suggested change from Higginbotham redline (comment #111) it should also note that an alternate pharmacy may be used without penalty when necessary due to supply or other unforeseen issue(s);

Commented [DB92]: Suggested change from Higginbotham redline (comment #111) (7) A violation of the agreement may result in treatment plan changes, with involuntary tapering or discontinuation of the prescription(s) being reserved for the extreme violations and/or circumstances;

chronic pain. When conducting periodic reviews of patients receiving chronic opioid therapy, physicians must evaluate all relevant clinical factors, including patient adherence, stability, and functional status. Treatment plans should not be altered or discontinued solely due to the patient exceeding morphine milligram equivalent (MME) dose thresholds or other numeric limits if the patient remains stable and compliant with the treatment plan. Any modifications must be justified by clinical indications and documented in the patient record to support individualized care and maintain patient safety.

~~(1) 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.~~

Commented [DB93]: This additional language reiterates that clinical decisions should be based on each patient's unique needs.

Commented [MM94R93]: Leaving this and deleting the rest to make the review more flexible and less intrusive on the patient.

~~(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.~~

~~(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physicians should not dismiss patients from care on the basis of a biological specimen test result alone.~~
~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-920, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-920, filed 11/16/18, effective 1/1/19.]~~

~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-925, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain. (1) 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.

(~~1~~2) The physician ~~shall~~ may consider referral ~~referring the patient~~ for additional evaluation ~~and~~ or treatment ~~as needed to achieve~~when it may support the patient's treatment objectives. ~~Special attention should be given to those~~Referral may be particularly appropriate for chronic pain patients who:

(a) are under eighteen years of age;

Commented [MM95]: Either make this mandatory (shall) or we should delete.

Commented [DB96]: Suggested language from M. Higginbotham, comment #145: "When a physician determines that opioid therapy should be modified or discontinued, the physician shall provide reasonable notice, appropriate referrals when indicated, and a clinically appropriate transition of care to avoid patient abandonment and promote continuity of medically necessary treatment."

Commented [DB97R96]: I do not recommend adding the suggested language to WAC 246-919-900, 246-919-905, or 246-919-930 because it is outside the scope of those sections.
If we were to add language addressing these concepts, WAC 246-919-950, which ...

Commented [DB98]: Suggested addition from P3 Alliance/Higginbotham (comment #116): (3) Exemptions remain in place for cancer, palliative, hospice, (high- ...

Commented [DB99]: Changes here may affect -935, -940, and the definitions section -852.

Commented [DB100]: Suggested language addition from M. Higginbotham comment #145: "A patient's morphine equivalent dose (MED/MME) alone shall not be the ...

Commented [DB101R100]: While I agree that a patient's MED/MME should not be the sole basis for clinical decision-making, current law requires the rules to ...

Commented [DB102]: This is the current (2). Moved it here so the requirement is up front. No changes have been made to ...

Commented [DB103R102]: Move approved 8/10/26.

Commented [DB104]: Suggested change from P3 Alliance/Higginbotham (comment #116): (2) Consultation shall not be triggered solely by opioid dose or MME level.

Commented [DB105R104]: Due to the requirement in law, we would not be able to include this language.

Commented [DB106]: Suggested change from P3 Alliance/Higginbotham (comment #116): (1) Consultation with a pain management specialist should be required with the ...

Commented [DB107R106]: Both of these items have been incorporated in some way in (2). The first is in (2)(d) and the second is in (2)(e).

(b) experience declining function or lack of clinically meaningful functional improvement;

(c) require escalating opioid therapy without corresponding improvement in pain, function, or other treatment objectives;

(d) present elevated risk factors, which may include, but are not limited to:

(i) a history of substance use disorder or overdose;

(ii) concurrent use of sedating medications; or

(iii) lack of clinically meaningful improvement in pain or function;

(e) have diagnostic uncertainty or have not responded to prior treatment approaches; or

(f) present any other clinical circumstance in which additional expertise would reasonably support patient care ~~or who are potential high-risk patients~~.

Commented [DB108]: Approved 9/28/26

~~(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.~~

Commented [DB109]: Moved to (1)

(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; or

(e) Participation in peer case presentations such as Project ECHO, documented e-consult, or similar. A physician who participates in or observes a case presentation that involves

comparable clinical circumstances may document how the consultation informed the patient's treatment plan and may use that participation as meeting the consultation requirement.

(4) A physician shall document each consultation with the pain management specialist.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-930, filed 11/16/18, effective 1/1/19.]

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;

Commented [MM110]: We have a WMC correspondence on this. We should consider incorporating it: Project ECHO case presentation - if a substantially similar case is presented, the licensee may document that and proceed as recommended.

Commented [DB111]: Approved 8/10/26.

Commented [DB112]: WSMA Redline Comment #126 suggests deleting this section.

Commented [MM113]: Keep. Maintains flexibility for practitioner.

(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

Suggested change from Higginbotham redline (comment #111)

(3) The patient meets the requirements in WAC 246-919-852 of a legacy patient;

(4) The physician documents the patient's pain and function are stable and the patient is on a non-escalating dosage of opioids.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-935, filed 11/16/18, effective 1/1/19.]

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:

Commented [DB114]: Suggest changing this word to "definition" as -852 is the definitions section and does not include requirements.

Commented [DB115]: Review based on approved changes to -852 at the 10/27 workshop.

Commented [DB116]: WSMA Redline Comment #126 suggests deleting this section.

Commented [MM117]: Keep. Maintains flexibility.

Commented [DB118]: Note from Higginbotham redline (comment #111): Consistent with our prior recommendation to eliminate the fixed-MED pain specialist consultation requirement, we recommend removing this section entirely if that trigger is no longer in effect. If the consultation threshold remains, our proposed revisions to this section are outlined below.

Commented [DB119R118]: Statutorily required to maintain consultation threshold.

(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.

Suggested addition from Higginbotham redline (comment #111)

(5) The patient meets the criteria for a legacy patient, as outlined in relevant interpretive statements or agency guidance, or has a rare, progressive, or palliative condition, and referral is not expected to alter the course of care or would risk treatment interruption.

Commented [DB120]: If Commissioners would like this added, I suggest the following instead: "The patient meets the definition of a legacy patient, and referral is not expected to alter care or would risk treatment interruption."

Commented [DB121R120]: Revisit this section once the Exemptions section has been finalized.

Revised October 21, 2026

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]

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

Commented [DB122]: WSMA Redline Comment #126 suggests deleting this section.

Commented [MM123]: Keep. Tied to previous two sections.

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 18 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 30 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 a physician assistant, in accordance with WAC 246-918-895.

(3) If a dentist, in accordance with WAC 246-817-965.

(4) If a podiatric physician, in accordance with WAC 246-922-750.

(5) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

[Statutory Authority: RCW 18.71.017 and 2020 c 80. WSR 24-23-042, s 246-919-945, filed 11/14/24, effective 12/15/24. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and

2017 c 297. WSR 18-23-061, § 246-919-945, filed 11/16/18, effective 1/1/19.]

WAC 246-919-950 Tapering ~~considerations~~ Chronic pain. Not all patients with chronic pain ~~patients~~ will need their opioid prescriptions tapered. Patients who are stable on long-term opioid therapy and following their treatment plan should not be tapered solely to meet a pre-predetermined policy limit or dosage thresholds. Relying on medical decision making and patient-centered treatment, the physician ~~shall~~ should consider tapering or referral for a substance use disorder evaluation when requested by the patient or clinically indicated. If tapering is initiated, the reason for tapering shall be documented in the patient record. Examples of clinical indications for tapering include but are not limited to:

~~(1) The patient requests;~~

(1~~2~~) The patient experiences a deterioration in function or pain;

~~(3) The patient is noncompliant with the written agreement;~~

(2~~4~~) Other treatment modalities are indicated;

(3~~5~~) There is evidence of misuse, abuse, substance use disorder, or diversion;

(4~~6~~) The patient experiences a severe adverse event or overdose;

(5~~7~~) There is unauthorized escalation of doses; or

(6~~8~~) The patient is receiving an ongoing escalation in opioid dosage with no improvement or maintenance in their pain or function.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-950, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]

NEW SECTION

WAC 246-919-951 **Buprenorphine.** Buprenorphine may be used for the treatment of opioid use disorder, management of chronic pain, or tapering, depending on the patient's needs and diagnoses.

(1) Physicians managing patients receiving buprenorphine for opioid use disorder or chronic pain who require additional analgesia for acute pain or a planned surgical or medical

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intervention must coordinate care with the provider managing the acute pain or intervention.

(2) Physicians must consider the pharmacology of buprenorphine, available formulations, and evidence-based strategies for managing patients receiving buprenorphine for opioid use disorder or chronic pain who require additional analgesia for acute pain or a planned surgical or medical intervention.

WAC 246-919-955 Patients with chronic pain~~, including those on high doses of opioids,~~ - establishing a relationship with a new physician. Due to the scarcity of chronic opioid management prescribers generally, the commission encourages all physicians who are capable to consider taking chronic pain patients into their practice.

(1) When a patient receiving chronic opioid pain medications changes to a new physician, it is normal and ~~ly~~ appropriate for the new physician to initially maintain the patient's current opioid doses. Over time, the physician may evaluate ~~if~~whether any ~~tapering or other~~ adjustments in the

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Commented [DB125]: See WSMA's Redline Comment #126 for their suggested edits.

treatment plan can or should be done. Suggested language from Higginbotham petition: "Treatment plans should not be altered or changed unless a violation occurs."

Suggested change from Higginbotham redline (comment #111):

The new physician shall:

(1) Review the patient's record and previous opioid treatment history, including past trials of opioid and non-opioid therapies;

Proposed draft language: Treatment plans should not be altered or discontinued unless there is documented evidence that the patient has violated the terms of the treatment plan.

Suggested alternate language to petition proposal: Alteration of treatment plans should not occur outside of the circumstances listed in WAC 246-919-950.

(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~~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 non-escalating;

(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.

Suggested change from Higginbotham redline (comment #111):

The physician shall (2) Conduct a physical examination and assess pain intensity, functional status, and patient-identified treatment goals;

Amelia note: If the "Legacy patient" definition is added, the second sentence of the proposed definition should not be included in the definition but here instead: (4) These patients should not be excluded from care solely due to historical prescribing thresholds; instead, their treatment should be assessed based on current medical necessity, functional benefit, and risk assessment.

Commented [DB126]: Should we include "risk assessment" in this section?

(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 if or until the patient qualifies for exemption from these rules under WAC 246-919-851.

Suggested change from Higginbotham redline (comment #111):

The new physician shall: (3) Query the prescription monitoring program; and

(4) Document the medical necessity of continued opioid therapy before prescribing. The physician shall develop a treatment plan that reflects the patient's clinical history, prior treatment outcomes, and any relevant diagnoses, including rare, progressive, or palliative conditions. Tapering should not be initiated solely due to dosage level or prior prescriber status; any change in therapy should follow a documented risk-benefit assessment and shared decision-making.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-919-960 Special populations—~~Children or adolescent patients, p~~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.~~

Suggested change from Higginbotham redline (comment #111):

The physician shall use clinical judgement and caution when prescribing opioids to children, adolescents, pregnant individuals, and older adults. These populations may present with unique vulnerabilities or comorbidities but also have legitimate pain management needs. The requirements in this section are in addition to existing requirements and apply to all patients and patient populations.

(1~~2~~) Pregnant patients. The physician shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment

Commented [DB127]: WSMA Redline Comment #126 suggests deleting this section.

Commented [MM128]: Is this needed? The adolescent is basic medicine and the geriatric is too. I would consider leaving (2) due to the MAT/pregnancy complication.

Commented [DB129]: This sentence is not necessary and contradictory to the exclusions section. If Commissioners decide to keep this suggested language in this first paragraph, this sentence will need to be revised.

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.~~

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-960, filed 11/16/18, effective 1/1/19.]

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

Commented [MM130]: Changes to reduce requirements and provide flexibility.

Commented [DB131]: WSMA Redline Comment #126 suggests deleting this.

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~~ should coordinate care with the patient's chronic pain treatment practitioner, if possible. Suggested addition from Higginbotham redline (comment #111): Coordination efforts and relevant communication shall be documented. When immediate coordination is not possible, the physician shall ensure continuity of care by clearly documenting rationale for prescribing decisions and any instructions provided to the patient.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

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: Suggested change from

Commented [DB132]: Is this already standard of care and required?

Commented [DB133]: See WSMA's Redline Comment #126 for their edits.

Commented [MM134]: Chemistry has not changed so this should stay.

Revised October 21, 2026

Higginbotham redline (comment #111): (1) The physician may prescribe opioids in combination with the following medications when clinically indicated, based on an individualized assessment of benefits and risks, and with documented rationale in the medical record:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics.

Suggested addition from Higginbotham redline (comment #111): Prescribing decisions shall reflect clinical judgment and patient-specific needs. The physician shall document informed consent, the rationale for combination therapy, and any applicable safety measures (e.g., naloxone prescription, care coordination).

(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. Suggested addition from Higginbotham redline (comment #111): Coordination efforts and care planning should be documented, but shall not delay necessary treatment.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]

WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where ~~practicable~~feasible, 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.

Commented [DB135]: WSMA Redline Comment #126 suggests deleting this section.

(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-975, filed 11/16/18, effective 1/1/19.]

~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]~~

Amelia's suggested language: The physician shall confirm that the patient has access to naloxone or provide a current prescription when clinically appropriate, including circumstances that may increase the risk of opioid overdose, such as concurrent benzodiazepine use, high opioid doses, history of substance use disorder, or other patient-specific factors.

Suggested change from Higginbotham redline (comment #111): The physician shall confirm or provide a current prescription for naloxone when prescribing opioids to a patient who is

Commented [MM136]: Referenced previously in patient counseling. Delete.

Commented [DB137R136]: I could not find this referenced in these rules besides this subsection. I think we need to keep this and expand it a bit since we are proposing no longer using high-, moderate-, or low-risk.

determined, based on individualized clinical assessment, to be at elevated risk of overdose. This assessment and rationale must be documented in the patient's medical record. Factors that may increase risk include, but are not limited to:

(1) Concurrent use of opioids with benzodiazepines or other central nervous system depressants;

(2) Personal history of opioid overdose or known substance use disorder;

(3) Chronic respiratory conditions such as COPD or sleep apnea;

(4) Recent transitions in care, including post-hospital discharge or change in prescribing provider;

(5) Higher total daily opioid dose, though MME alone shall not be determinative.

The physician shall provide patient education on naloxone use and ensure the prescription is accessible.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation. The PMP is a powerful tool for clinicians and patients, but its limitations must be understood and accepted. For these reasons, the Legislature has seen fit to limit access to licensees, patients, relevant regulatory authorities, and law enforcement as the data

Commented [DB138]: See WSMA's Redline Comment #126 for their suggested edits.

contained within the PMP is not actionable without additional clinical data that is individualized to the specifics of the patient. Use of the PMP must support safe, coordinated, and informed patient care. PMP data must not be used as the sole justification to withhold, taper, or discontinue treatment for patients who are stable and compliant with their treatment plan.

Commented [MM139]: Placing this to head off PH researchers and SAO issues like we experienced a couple of years ago.

Commented [DB140]: Approved 9/22

(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~~

Commented [MM141]: Reduced requirement on practitioner and patient. Rely on aberrant behavior standard and requirements in written agreement.

Commented [DB142]: Comment that this should be kept if long term stable chronic pain patients are not exempt.

Commented [DB143R142]: Revisit when exemptions section has been finalized.

Commented [DB144]: See comment #142 from Dr. Tauben.

Commented [DB145R144]: "Reduced requirement for use of *Prescription Drug Monitoring Program*, despite patient and community proven life-saving outcomes, due to *incidental opioid prescriptions by multiple providers, misuse, abuse, and diversion related opioid overdose deaths.*"

~~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~~ should be documented in the patient record.

Suggested addition from Higginbotham redline (comment #111):

(10) Use of the PMP or automated risk scoring tools, shall not replace individualized assessment and clinical judgement. Prescribing decisions must be based on the totality of clinical information, not algorithmic thresholds.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]

Commented [MM146]: This may seem like a significant removal, but it represents a large workload as this applies to all pain phases. We still maintain the standards above for pain phase refills and transitions along with the aberrant standard.

Commented [MM147]: This is standard of care so moving to should in response to comments received.

Next Steps

- Additional workshops
  - 12th workshop – Dec. 7, 2026 @ 1 pm – Register Here
  - 13th workshop – Jan. 18, 2027 @1:30 pm – Register Here

Written comments may be posted to this rule's page:
Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission
or emailed to: medical.rules@wmc.wa.gov

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Upcoming Agenda Items

December 7 workshop

- Follow up on items from October 26 workshop if needed
- Crosswalk of comments

January 18 workshop – final

- Follow up on items from December 7 workshop if needed
- Crosswalk of comments continued
- Finalize draft language – will request to initiate CR-102 at the Commission's March 12, 2027, Business meeting

WSR 25-10-039
PREPROPOSAL STATEMENT OF INQUIRY
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed April 30, 2025, 12:09 p.m.]

Subject of Possible Rule Making: Opioid prescribing—General provisions for allopathic physicians (MD) and physician assistants (PA). The Washington medical commission (commission) is considering amending the following opioid prescribing rules to modernize the language, add clarity, and bring the rules more in line with current practice: MD, WAC 246-919-850 through 246-919-985; and PA, WAC 246-918-800 through 246-918-935.

Statutes Authorizing the Agency to Adopt Rules on this Subject: RCW 18.71.017 and 18.130.050.

Reasons Why Rules on this Subject may be Needed and What They Might Accomplish: The commission received a petition in July 2024 that requested amendments to the opioid prescribing rules. The petition requested changes to WAC 246-919-850 through 246-919-990 and 246-918-800 through 246-918-835 to ensure that opioid prescribing rules do not impose unnecessary restrictions on stable chronic pain patients or those with rare diseases. The petitioner's requested revisions seek to clarify that stable and compliant chronic pain patients should not have their opioid medications reduced, tapered, or discontinued, as doing so may be harmful and fall below the standard of care. Additionally, the petitioner requested the elimination of predetermined morphine milligram equivalent guidelines in prescribing decisions, emphasizing that neither Washington state nor federal law mandates specific dose, strength, quantity, or duration limitations. Lastly, the petitioner requested an exemption for patients with rare diseases, as defined by the National Organization for Rare Disorders or the National Institutes of Health, ensuring they are not subject to restrictive opioid prescribing policies.

The commission reviewed the petition in July 2024 and voted to initiate rule making on this subject. Based on the petition, the commission is considering updating opioid prescribing rules for MDs and PAs to modernize language, add clarity, and better align with current medical practices.

Clear and well-structured rules help ensure that medical professionals understand their responsibilities and that patients receive safe, high-quality care. Over time, medical practices, technology, and patient care standards evolve, making it important to update regulations so they remain relevant and effective.

The intent of this rule making is to further establish clearer expectations for MDs and PAs regarding professional conduct, patient care, and regulatory compliance. By modernizing them, the commission can remove outdated language, clarify ambiguous requirements, and ensure they align with best practices in health care. This can also help streamline processes for medical professionals while maintaining strong oversight to protect patients. Additionally, aligning state rules with federal policies and national standards reduces confusion, improves consistency in medical regulation, and ensures that Washington health care providers are held to the same high standards as those in other states.

Updating these rules is intended to support patient safety, enhance professional accountability, and foster a health care system that reflects current medical knowledge and ethical considerations. It also helps prevent regulatory gaps that could lead to inconsistencies in care, ensuring that both health care providers and patients benefit from clear, well-defined expectations.

Process for Developing New Rule: Collaborative rule making.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email amelia.boyd@wmc.wa.gov, website https://wmc.wa.gov.

Additional comments: To join the interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

April 29, 2025
Kyle S. Karinen
Executive Director
Washington Medical Commission

Comments from the WMC Rules page July 29-August 18

Susan Olson (not verified)-*Jul 29, 2025 03:10 PM* Comment #108

As someone who has lived with chronic pain, I have been under supervised pain management for over eight years. Unfortunately, the shortage of pain management providers is becoming increasingly overwhelming. With the introduction of new guidelines, I believe there should be specific language that supports primary care providers (PCPs) in the treatment and ongoing care of chronic pain patients. For example, consider a patient who has been prescribed 80 MME for an extended period. This patient has consistently followed all treatment protocols — no issues with urine drug screenings, accurate pill counts, regular appointment attendance, and no early refill requests. In short, a fully compliant patient. Could we develop language in the guideline that allows PCPs to safely monitor and manage patients like this? Such a change would reduce the burden on specialized pain management clinics and allow patients to receive comprehensive care through their regular primary care providers. One possible approach could be allowing PCPs to oversee care while partnering with another physician who serves as a backup or consultant.

Kama Erickson (not verified)-*Aug 08, 2025 10:00 AM* Comment #109

I have chronic pain from several issues I constantly get denied pain meds even if I can get a doctor to prescribe them then I fight to get a pharmacy to fill them . If I was an IV drug user I could go get clean needles , I could go get methadone if I was an adict but because I have 3 kinds of arthritis and neuropathy and fibromyalgia just to give a few issues I can no longer find a doctor to prescribe my pain medication i had been on the same dose for 20 years and it worked great I was able to work and live a quality life then we all got our medication taken less each month they tell us the FDA rules make them reduce us but now I have no quality of life im lucky to get out of bed to shower on my own . We deserve to be treated as human too . Please let our doctors and pharmacy give us our medication let the er room give meds let the presciber use there license and skills they went to school for they know what we need but they are scared to get in trouble now .

Cyndi Hoenhous (not verified)-*Aug 18, 2025 10:22 PM* Comment #110

Hello workgroup. I'd like to keep the discussion open on the topic of High-impact chronic pain that was briefly mentioned in the first workshop meeting. The correlating sections for

discussion would be Definitions 246-919-852 to include the definition of High-impact chronic pain and Exclusions 246-919-851 with discussions around excluding High-impact chronic pain. I have also included the Appendix from the National Pain Strategy I mention. Chronic Pain defined by duration lasting greater than three months does not accurately describe the multidimensional nature of pain and its varying effect on all aspects of life, nor does it differentiate between those with debilitating chronic pain and those with less impactful pain. A more accurate description would include the additional concept of high-impact chronic pain (HICP), supported by the National Pain Strategy. HICP incorporates both disability (activity limitations/participation restrictions) and pain duration. Those with HICP experience pain most or all days in the past three months and pain that interferes with life or work; activities on most or all days. Identifying High-impact chronic pain as a unique experience validates special consideration when prescribing long term opioid therapy. The WA opioid prescribing rules could make that update. The patients represented in the rule making public comments have one thing in common, they describe High-impact chronic pain. They describe loss of function, employment, enjoyment of life and request a return to individualized care. High-impact chronic pain should • First, be acknowledged, • Second, defined Examples: High-impact chronic pain is associated with substantial restriction of participation in work, social, and self-care activities for six months or more. High-impact chronic pain is defined as the presence of pain on at least half of days in the previous 3-6 months with substantial restriction of functional participation in work, social, and self-care activities. • Lastly, High-impact chronic pain should be added to the list of exclusions. High-Impact chronic pain is the constant, not a particular rare disease or injury. Steps must be taken for patients to regain their care. We are working from the perspective of "How do we protect patients from the current culture of tapering, cessation, and inappropriate treatment, or nontreatment, of their pain? How do we encourage physicians to treat patients with complex pain issues like High-impact pain? Exclude High-impact chronic pain. The National Pain Strategy has already created a one-page document to differentiate between patients with chronic pain, and those with high impact pain that is easy to use. Patients who are benefitting from opioid therapy, compliant, and have no adverse reactions have not been historically "dangerous" to exempt. Science does not support the idea that large portions of patients on long term opioid therapy develop opioid use disorder or are overdosing. Now that the data is clear, how do we fix the damage already done to patients? Can we have a meaningful discussions around exempting High-impact chronic pain? Sources Prevalence and Profile of High-Impact Chronic Pain in the United States Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023 Pain Management Collaboratory High Impact Chronic Pain (HICP) Recommendations National Pain Strategy

Comment #110 Attachments

Discussions on High-impact chronic pain

Chronic Pain defined by duration lasting greater than three months does not accurately describe the multidimensional nature of pain and its varying effect on all aspects of life, nor does it differentiate between those with debilitating chronic pain and those with less impactful pain.

A more accurate description would include the additional concept of high-impact chronic pain (HICP), supported by the National Pain Strategy. HICP incorporates both disability (activity limitations/participation restrictions) and pain duration. Those with HICP experience pain most or all days in the past three months and pain that interferes with life or work; activities on most or all days.

Identifying High-impact chronic pain as a unique experience validates special consideration when prescribing long term opioid therapy. The WA opioid prescribing rules could make that update.

The patients represented in the rule making public comments have one thing in common, they describe High-impact chronic pain. They describe loss of function, employment, enjoyment of life and request a return to individualized care.

High-impact chronic pain should

- First, be acknowledged,
- Second, defined

  Examples:

  High-impact chronic pain is associated with substantial restriction of participation in work, social, and self-care activities for six months or more.

  High-impact chronic pain is defined as the presence of pain on at least half of days in the previous 3-6 months with substantial restriction of functional participation in work, social, and self-care activities.
- Lastly, High-impact chronic pain should be added to the list of exclusions. High-Impact chronic pain is the constant in these patients, not the disease or injury.

Steps must be taken for patients to regain their care. We are working from the perspective of "How do we protect patients from the current culture of tapering, cessation, and inappropriate treatment, or nontreatment, of their pain? How do we encourage physicians to treat patients with complex pain issues like High-impact pain? Excluding High-impact chronic pain could be a possibility.

The National Pain Strategy has already created a one-page document to differentiate between patients with chronic pain, and those with high impact chronic pain that is easy to use.
Patients who are benefitting from opioid therapy, compliant, and have no adverse reactions have not been historically "dangerous" to exempt. Science does not support the idea that large portions of patients on long term opioid therapy develop opioid use disorder or are overdosing. Now that the data is clear, how do we repair the damage already done and prevent further inappropriate care? Can we have a meaningful discussion around exempting High-impact chronic pain?
Sources: Prevalence and Profile of High-Impact Chronic Pain in the United States

Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023

Pain Management Collaboratory High Impact Chronic Pain (HICP) Recommendations

National Pain Strategy

Appendix D. Chronic pain screener questions

Definition	Item	Criteria
Pain on at least half the days for 6 months	Over the last six months, on about how many days have you had pain? ☐ I have not had pain ☐ I have had pain, but on less than half the days ☐ I have had pain on more than half the days, but not every day ☐ I have had pain every day, but not all the time ☐ I have had pain all day, every day, without break	Chronic pain is pain on at least half the days over the past six months.
Chronic pain severity (mild, moderate, severe)	In the past 7 days, how would you rate your pain on average? 0=No pain 10= Worst imaginable pain In the past 7 days, how much did pain interfere with <u>your day-to-day activities</u>? 0=No interference 10=Completely interferes In the past 7 days, how much did pain interfere with <u>your enjoyment of life</u>? 0=No interference 10=Completely interferes	Mean or sum of the three 0-10 pain ratings. **<u>Mean</u>** **<u>Sum</u>** Mild < 4 < 12 Moderate 4 to < 7 12 to 20 Severe 7 to 10 21 to 30 NOTE: If only two pain ratings are available, divide by the sum by two and multiple by 3 to obtain an estimated sum score.

Appendix E. Operational questions for determining high-impact chronic pain

Among people with chronic pain (as determined by screener questions in Appendix D), high-impact chronic pain is operationally defined by enduring participation restrictions because of pain, including:		
Participation restrictions because of pain	• ***Over the past 6 months because of pain…*** I have had trouble doing my usual work (including work for pay, work around the home, volunteer work). Never Rarely Sometimes Usually Always • I have had trouble doing my regular social and recreational activities (such as visiting friends, going to the movies, attending clubs or religious activities). Never Rarely Sometimes Usually Always • I have had trouble taking care of myself (for example dressing, bathing, or feeding myself). Never Rarely Sometimes Usually Always	At least one item rated "usually" or "always"

Comment #111

Executive Summary

In July 2024, the Washington Medical Commission (WMC) accepted a petition submitted by Maria Higginbotham, Washington State Director of P3Alliance, urging revision of chronic pain prescribing rules in light of ongoing harm to stable patients. The petition requested clarification that patients on long-term opioid therapy should not face involuntary tapering without cause, elimination of outdated morphine milligram equivalent (MME) thresholds, and exemptions for those with rare or progressive diseases. This submission responds to that petition by providing detailed proposed revisions to Washington Administrative Code (WAC) sections 246-919-850 through 985 (MDs) and 246-918-800 through 935 (PAs). These changes are informed by updated medical standards, recent FDA data, and lived patient experience — and are designed to support individualized care while improving clarity, accountability, and ethical practice in opioid prescribing.

Each WAC section below includes a professional rationale, a redline reflecting the proposed revision, and formatting that ensures compatibility with current WMC structure. Many of these changes are narrowly tailored, focused on removing ambiguity, preventing unintended stigma, and improving alignment with FSMB, AMA, and HHS guidance on individualized, evidence-informed care. In some cases, new definitions or sections are recommended to fill critical gaps in continuity protections for high-risk patients.

Human Impact and Urgency

This reform is not abstract. Washington is in a public health crisis where some patients with incurable pain are quietly making suicide pacts or end-of-life plans simply because they cannot get adequate relief. One of them was Gretchen Lont.

Gretchen's story is shared with permission from her family because it exemplifies exactly what this rulemaking is meant to prevent. After a spinal injury, she pursued multiple treatment options to manage her pain. Ultimately, her physicians determined that opioid therapy was the only

approach that consistently allowed her to function. For several years, she was stable, well-managed, and able to live independently.

That changed when her longtime physician retired. She was referred to a pain clinic, where the plan was to transition her to an intrathecal pain pump. Gretchen completed all evaluations and was approved for the procedure — but before she could receive it, she was told she must first taper her opioid dose by 75%. She complied. The rapid and drastic reduction left her in unbearable pain and completely bedbound.

For four months, she deteriorated. In that time, she learned that Medicaid would not cover the intrathecal pain pump after all. She begged to have her previous dose reinstated. Her pleas were denied. Unable to walk, eat, or leave her home, Gretchen became emaciated and hopeless. In October 2023, she attempted suicide. Her son found her in time and called an ambulance. Hospital staff reportedly declined to place her on a psychiatric hold — not because they didn't take her condition seriously, but because they recognized it as untreated physical pain, not mental illness.

Eventually, a friend found a physician willing to help. But it was too late to reverse the damage. Gretchen had lost nearly 90 pounds, was falling frequently, and could no longer swallow. In December 2024, she contracted pneumonia. Her doctor referred her to the University of Washington Neuroscience Center. Within seven days of admission, she was diagnosed with ALS. On the nineteenth day, she died — frightened, emaciated, and in pain that had been dismissed, untreated, and denied for far too long.

Her family believes — and we agree — that this outcome was preventable. Gretchen followed every rule. She had no history of misuse. What failed her was a system that rewarded box-checking over clinical reasoning and discouraged physicians from acting boldly on behalf of their patients.

The changes suggested in this proposal have been a labor of love in order to honor the memory of those lost and to prevent more from meeting that fate. Our intention is to remove the administrative and cultural barriers that make stories like Gretchen's common, yet invisible. It is about aligning our policies with the real-world complexity of pain — and the ethical duty of

clinicians to reduce suffering, not just risk. You'll find that many of our revisions retain strong safety standards, if not enhance them. We ask you to review this document with both discernment and urgency. Because for some, like Gretchen, reform is already too late. She did everything right — and still, the system failed her. Others remain on that same path unless we act now to interrupt it.

Table of Contents

Each WAC section listed in the Table of Contents links to a corresponding page that includes: a rationale for the proposed edits, the full redline text, applicable governing RCW(s), citation numbers linked to a master evidence index, and cross-references to other relevant and/or amended WACs. Every change is transparently sourced, cross-linked, and justified to ensure consistency, legal defensibility, and clarity across the rulemaking framework.

Executive Summary

Human Impact and Urgency

WAC Section	Title
246-919-850	Intent and scope
246-919-851	Exclusions
246-919-852	Definitions
246-919-870	Use of alternative modalities for pain treatment
246-919-875	Continuing education requirements for opioid prescribing
246-919-905	Patient evaluation and patient record — Chronic pain
246-919-910	Treatment plan — Chronic pain
246-919-915	Written agreement for treatment—Chronic pain
246-919-935	Consultation — Exemptions for exigent and special circumstances — Chronic pain
246-919-940	Consultation — Exemptions for the physician — Chronic pain
246-919-950	Tapering considerations — Chronic pain

WAC Section	Title
246-919-955	Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner
246-919-960	Special populations — Patients twenty-five years of age or under, pregnant patients, and aging populations
246-919-965	Episodic care of chronic opioid patients
246-919-970	Co-prescribing of opioids with certain medications
246-919-980	Co-prescribing of naloxone
246-919-985	Prescription monitoring program

Proposed New Sections: Clinical Judgment and Continuity of Care

Note on Physician Assistant (PA) WAC Alignment

Master Citation Index

WAC 246-919-850 Intent and Scope

As discussed in the July 30, 2025 meeting, this section remains open pending final approval of all subsequent WAC revisions, after which we will revisit the intent and scope to ensure continuity.

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

WAC 246-919-851 Exclusions

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

(3) The provision of palliative, hospice, or other end-of-life care~~.~~

(a) The management of patients receiving palliative care as defined in WAC 246-919-851 when pain significantly impairs function or quality of life;

(4) The provision of procedural medications;

(5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010;

(e) Residential treatment facilities as defined in RCW 71.12.455;

(6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection (5) of this section.

(7) The treatment of patients with high impact chronic pain as defined in WAC 246-919-851, when opioid therapy is clinically indicated and documented.

(8) The continued care of legacy or stable, compliant patients receiving long-term opioid therapy, when treatment has been effective and no evidence of aberrant behavior exists.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800**, and **18.130.050**. WSR 25-05-091, s 246-919-851, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW **18.71A.800**, **18.71.017**, and **18.130.050**. WSR 22-22-039, § 246-919-851, filed 10/25/22, effective 11/25/22. Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW **18.71.450**, **18.71A.100**, **18.71.017**, and **18.71A.020**. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

Citation Index

[FDA PMR 3033, 2025 ER/LA Opioid Evaluation] https://www.fda.gov/media/186256/download
[NIH/NORD] https://rarediseases.info.nih.gov
[U.S. Pain Foundation, 2023] https://uspainfoundation.org
[Congressional Research Service, 2024] https://www.congress.gov/crs-product/LSB11270

WAC 246-919-852 Definitions

Rationale:
In addition to the commission's planned updates to the definitions of acute, subacute, and chronic pain, below we redline changes to accomplish two things. First, we propose aligning the definition of palliative care more closely with AMA and FSMB models, which have already been incorporated into several state statutes. Second, we suggest defining "legacy patient" and "high impact chronic pain" and "chronic progressive pain generating disease" in order to give formal weight to WMC interpretive statements. Finally, we urge removal of "high dose" labels and specified morphine equivalent dosing (MED) thresholds from the risk category definitions. This change reflects current CDC and FSMB guidance and is intended to reduce unintended stigma and clinical misapplication that have historically resulted from rigid or arbitrary MED references. (Please note, we did not redline changes in numbering.)

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 **(current or past)** 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.~~ (in all risk categories, the reference to the dose the patient is on should be removed due to the requirement to look at the overall context of the patient which includes dose. Any extra mention of dose reinforces the harmful excessive focus on MED. We also strongly recommend to remove all requirements to consult with pain management at 120MED leaving that decision of if and when to the prescriber.)

(9) add High impact chronic pain definition

(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) "Legacy Patient" means a patient who is continuing on an opioid therapy dose or regimen initiated by a previous provider prior to the adoption of newer prescribing guidelines, and for whom opioid therapy remains stable and clinically appropriate. These patients should not be excluded from care solely due to historical prescribing thresholds; instead, their treatment should be assessed based on current medical necessity, functional benefit, and risk assessment.

(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.~~ **"Palliative care" is patient-centered care in any care setting for people of any age and at any stage of a serious illness or disease that substantially affects a patient's quality of life. Palliative care includes, but is not limited to, comprehensive pain and symptom management while addressing physical, intellectual, emotional, social, and spiritual needs. Palliative care does not always include a requirement for hospice care or attention to spiritual needs.**

(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.

(2x) “Chronic progressive pain-generating condition” is a condition that causes persistent, often treatment-resistant pain. These conditions may require specialized care or individualized approaches to pain management.

(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.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW **18.71.450**, **18.71A.100**, **18.71.017**, and **18.71A.020**. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

WAC 246-919-870 Use of Alternative Modalities for Pain Treatment

Rationale:

This revision clarifies that while multimodal care is encouraged, patients should not be required to repeat ineffective or high-risk interventions solely to satisfy documentation requirements. It reflects best practices supporting individualized care.

~~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.~~

The physician should consider multimodal treatment, when clinically appropriate, including nonpharmacologic and nonopioid pharmacologic options. Treatment decisions should reflect a patient's diagnosis, treatment goals, and individualized clinical judgment, not inflexible mandates or coverage limitations. Documentation of a patient's prior attempts or failures is sufficient to avoid duplicative, costly, or ineffective interventions.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-870, filed 11/16/18, effective 1/1/19.]

Citation Index

[HHS Pain Management Best Practices, 2019] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
[AMA D-120.932]https://policysearch.ama-assn.org/policyfinder/search/D-120.932/
[HRW, 2018] https://www.hrw.org/report/2018/03/27/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us

WAC 246-919-875 Continuing Education Requirements for Opioid Prescribing

Rationale:

This update ensures that requirements for this training explicitly list important yet often overlooked topics such as palliative care, complex and rare conditions, ethical pain management, safe opioid prescribing, recognition of physical dependence verses substance use disorder, as well as the harms of forced tapering.

These updates align with current national recommendations from the AMA, HHS, and FSMB, and aim to ensure prescribers are well-informed and better equipped to treat patients with rare, progressive, or palliative diagnoses.

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.

(a) Qualifying education includes, but is not limited to, appropriate pain management for complex, and/or progressive conditions; the clinical impact of opioid tapering; principles of palliative care; and the distinction between physical dependence and substance use disorder as defined in WAC 246-919-852.

(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**.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]

Citation Index

[AMA D-120.932] https://policysearch.ama-assn.org/policyfinder/detail/D-120.932
[FSMB 2024 Guidelines] https://www.fsmb.org/siteassets/advocacy/policies/opioid_prescribing_guidelines.pdf
[HHS Pain Management Best Practices] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

WAC 246-919-905 Patient Evaluation and Patient Record-Chronic Pain

Rationale:

This section is substantially revised to support individualized evaluations and to eliminate the use of prescriptive risk assessment tools. It reinforces the need for holistic documentation tailored to the patient's clinical history and response to care. For patients with rare diseases or progressive conditions causing chronic pain, evaluations should include disease-specific pain mechanisms (e.g., neuropathic, inflammatory) and documented prior treatment failures (e.g., non-opioid medications, interventional procedures).

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 **evaluation and** 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~~ **Prior nonopioid and nonpharmacologic treatments, including identification of those that were ineffective or harmful;**

(d) ~~Review of comorbidities with particular attention to psychiatric and substance use.~~ **Past or current opioid therapy, including any successful prior use that may inform ongoing care decisions;**

(e) Substance use and psychiatric history, which shall be considered as part of a comprehensive assessment but must not be used in isolation to deny medically appropriate care; and

(f) Comorbidities relevant to pain management.

(2) ~~Appropriate physical examination.~~ **An appropriate physical examination.**

(3) ~~Ancillary information and tools to include:~~ **Ancillary information and clinical tools include:**

(a) ~~Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;~~ **Review of the prescription monitoring program (PMP) in accordance with 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.~~ **Individualized treatment goals established through shared decision-making, reflecting patient preferences and disease-specific needs.**

(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;~~ **Consideration of risks and benefits of initiating or continuing opioid treatment in the context of the patient's condition, clinical goals, and prior response to care;**

(c) ~~The observed or reported effect on function or pain control forming the basis to continue prescribing opioids;~~ **Functional or symptom-related rationale supporting ongoing prescribing;** and

(d) ~~Pertinent concerns discovered in the PMP.~~ **Notable findings from the PMP review.**

(5) Treatment plan as provided in WAC 246-919-910.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]

Citation Index

[HHS Pain Management Best Practices] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
[FSMB 2024 Guidelines] https://www.fsmb.org/siteassets/advocacy/policies/opioid_prescribing_guidelines.pdf
[HRW, 2018] https://www.hrw.org/report/2018/03/27/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us
[AMA D-120.932] https://policysearch.ama-assn.org/policyfinder/detail/D-120.932

WAC 246-919-910 Treatment plan—Chronic pain

Rationale:

This section is revised to ensure that treatment plans for chronic pain prioritize individualized, long-term care strategies. Revisions reinforce that goals should reflect realistic function and quality of life, not arbitrary discontinuation benchmarks. They affirm that opioid therapy may continue when effective, and that patients with rare or progressive conditions may not have viable alternatives. These changes align with ethical guidance from AMA, HHS, and the FSMB, and are consistent with patient-centered national best practices.

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) **A record of patient-informed goals for function, quality of life, and pain control, developed through shared decision-making and tailored to the patient's condition.**

~~(e)~~ **(f)** 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.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.]

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

Rationale:

This revision updates the structure of written agreements to reflect shared decision-making, patient rights, and individualized care. It preserves essential elements of accountability while clarifying that treatment agreements must not be used to enforce non-individualized tapers, penalize patients for pharmacy access issues, or stigmatize rare and complex conditions.

~~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:~~
The physician shall use a written agreement for any patient receiving long-term opioid therapy for chronic pain. The agreement must reflect a mutual understanding of treatment goals, medication safety, and shared responsibilities. The written agreement must include the following provisions:

(1) ~~The patient's agreement to provide samples for biological specimen testing when requested by the physician;~~
The patient's agreement to provide biological specimens when requested by the physician and clinically justified.

(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;~~
A clear outline of clinical circumstances under which opioid therapy may be involuntarily modified, tapered, or 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**. It should also note that an alternate pharmacy may be used without penalty when necessary due to supply or other unforeseen issue(s)**;

(6) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;

(7) A violation of the agreement may result in **treatment plan changes, with** ~~a~~ **involuntary** tapering or discontinuation of the prescription**(s) being reserved for the extreme violations and/or circumstances.**

(8) The patient's responsibility to safeguard all medications and keep them in a secure location.

(9) The agreement must be signed by both the physician and patient and retained in the health record.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]

Citation Index

[1] AMA Opioid Policy D-120.932 — https://policysearch.ama-assn.org/policyfinder/detail/D-120.932
[2] Human Rights Watch (2018) — https://www.hrw.org/report/2018/03/12/not-allowed-be-compassionate/chronic-pain-opioid-crisis-and-unintended-harms
[3] FSMB 2024 Guidelines — https://www.fsmb.org/siteassets/advocacy/policies/opioid-prescribing-guidelines.pdf

WAC 246-919-935 Consultation Exemptions for Exigent and Special Circumstances – Chronic Pain

Rationale:

Consistent with our prior recommendation to eliminate the fixed-MED pain specialist consultation requirement, we recommend removing this section entirely if that trigger is no longer in effect. If the consultation threshold remains, our proposed revisions to this section are outlined below.

~~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 non escalating dosage of opioids.~~

A physician is not required to consult with a pain management specialist in the following circumstances:
(1) The patient is following a tapering schedule;

(2) The patient requires a temporary increase in dose due to a medical procedure or acute exacerbation of pain that cannot be managed with a lower dose;

(3) The patient meets the requirements in WAC 246-919-852 of a legacy patient;

(4) The physician documents why consultation is not necessary; this may include patient-specific factors such as rare disease, progressive illness, or a history of treatment stability that supports continued prescribing under the physician's care. In such cases, documentation must reflect medical necessity and consideration of alternative options.

WAC 246-919-940 Consultation—Exemptions for the Physician—Chronic Pain

Rationale:

Consistent with our prior recommendation to eliminate the fixed-MED pain specialist consultation requirement, we recommend removing this section entirely if that trigger is no longer in effect. If the consultation threshold remains, our proposed revisions to this section are outlined below.

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.

(5) The patient meets the criteria for a legacy patient, as outlined in relevant interpretive statements or agency guidance, or has a rare, progressive, or palliative condition, and referral is not expected to alter the course of care or would risk treatment interruption.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]

Citation Index

[FSMB 2024 Guidelines] https://www.fsmb.org/siteassets/advocacy/policies/opioid_prescribing_guidelines.pdf
[HHS Pain Management Best Practices, 2019] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
[California 2023 Guidelines] https://www.mbc.ca.gov/Portals/0/Resources/Opioid-Guidelines.pdf
[FDA April 2025 Postmarketing Requirements ER/LA Opioid Analgesics Risk Evaluation Study] https://fda.gov/media/186256/download

WAC 246-919-950 Tapering Considerations — Chronic Pain

Rationale:

This revision ensures tapering decisions are based on individualized clinical judgment and shared decision-making, rather than automatic triggers or non-clinical pressures. It clarifies that tapering is not appropriate when opioid therapy remains effective and risks do not outweigh benefits—particularly in patients with rare, progressive, or palliative conditions. The language aligns with national guidance from HHS, AMA, and FDA data confirming low misuse rates among stable patients, and supports careful documentation to protect patient safety and care continuity.

~~Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician shall consider tapering or referral for a substance use disorder evaluation when:~~

The physician shall not mandate tapering of opioid therapy for patients with chronic pain from rare, progressive, or palliative conditions unless the risks clearly outweigh benefits and alternative treatments are viable. When tapering is clinically appropriate, it shall be guided by an individualized plan that incorporates shared decision-making.

Tapering considerations may include:

(1) ~~The patient requests~~; **Patient-initiated requests for tapering;**

(2) ~~The patient experiences a deterioration in function or pain~~; **Inadequate achievement of patient-specific pain or function goals despite optimization of opioid therapy and not related to expected progression based on diagnosis;**

(3) ~~The patient is noncompliant with the written agreement~~; **Evidence of nonadherence to the written agreement, which should prompt reassessment and implementation of appropriate risk mitigation strategies before initiating any tapering decision;**

(4) Other treatment modalities are indicated**, tapering should occur as part of a shared, documented plan that allows for return to an effective opioid regimen if treatment goals are not met**;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event **directly attributable to prescribed opioids, or clear evidence of overdose or concurrent illicit substance use is present;** ~~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.~~

Any tapering plan shall include gradual dose reduction, active monitoring for withdrawal symptoms or adverse outcomes (e.g., increased pain, anxiety, suicidal ideation), and clear documentation of clinical rationale for either continuation or tapering. This documentation should include patient-reported impact to ensure continuity and transparency in future care.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800**, and **18.130.050**. WSR 25-05-091, s 246-919-950, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]

WAC 246-919-955 Patients with Chronic Pain, Including Those on High Doses of Opioids, Establishing a Relationship with a New Physician

Rationale:

This section is revised to ensure that new physicians inheriting patients on chronic opioid therapy are guided by clinical documentation, not default tapering or assumptions based on dosage alone. The updated language supports continuity of care, reinforces shared decision-making, and safeguards patients with rare, progressive, or palliative conditions who may benefit from ongoing therapy. These revisions align with AMA, FSMB, and HHS guidance and reduce the risk of care disruption during provider transitions.

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.

Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician.

The new physician shall:

(1) Review the patient's record and previous opioid treatment history, including past trials of opioid and non-opioid therapies;

(2) Conduct a physical examination and assess pain intensity, functional status, and patient-identified treatment goals;

(3) Query the prescription monitoring program;

(4) Document the medical necessity of continued opioid therapy before prescribing. The physician shall develop a treatment plan that reflects the patient's clinical history, prior treatment outcomes, and any relevant diagnoses, including rare, progressive, or palliative conditions. Tapering should not be initiated solely due to dosage level or prior prescriber status; any change in therapy should follow a documented risk-benefit assessment and shared decision-making.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]

WAC 246-919-960 Special Populations—Children or Adolescent Patients, Pregnant Patients, and Aging Populations

Rationale:

This section is revised to prevent undertreatment or discriminatory exclusion of patients in special populations, particularly older adults and adolescents with legitimate medical indications for opioid therapy. These revisions align with AMA and FSMB guidance emphasizing that individualized care and professional judgment - not age or pregnancy status alone - should guide prescribing decisions.

The physician shall use clinical judgment and caution when prescribing opioids to children, adolescents, pregnant individuals, and older adults. These populations may present with unique vulnerabilities or comorbidities but also have legitimate pain management needs. The requirements in this section are in addition to existing requirements which apply to all patients and patient 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.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-960, filed 11/16/18, effective 1/1/19.]

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[HHS Pain Management Best Practices, 2019] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
FDA (April 2025) Postmarketing Requirements (PMR) 3033 ER/LA Opioid Analgesics Risk Evaluation Study US Food and Drug Administration https://www.fda.gov/media/186256/download

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

Rationale:

This update clarifies that episodic opioid prescribing must be managed in close coordination with the patient's primary provider, underpinned by informed consent and clear justification. It supports continuity of therapy, respects patient autonomy, and aligns with national patient-centered care principles.

(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. **Coordination efforts and relevant communication shall be documented. When immediate coordination is not possible, the physician shall ensure continuity of care by clearly documenting rationale for prescribing decisions and any instructions provided to the patient.**

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

WAC 246-919-970 Co-prescribing of Opioids with Certain Medications

Rationale:

This section is revised to clarify that co-prescribing opioids with medications such as benzodiazepines or sedatives is permissible when clinically justified. The update affirms that decisions must be based on individualized assessments, not categorical restrictions, and emphasizes informed consent, documentation, and safety planning. These revisions support clinical flexibility while maintaining safeguards, consistent with national best practices and recommendations from HHS, ASIPP, and the AMA. By reducing ambiguity, the changes protect both patient access and prescriber accountability.

(1) ~~The physician shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:~~ **The physician may prescribe opioids in combination with the following medications when clinically indicated, based on an individualized assessment of benefits and risks, and with documented rationale in the medical record:**

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics.

Prescribing decisions shall reflect clinical judgment and patient-specific needs. The physician shall document informed consent, the rationale for combination therapy, and any applicable safety measures (e.g., naloxone prescription, care coordination).

(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. **Coordination efforts and care planning should be documented, but shall not delay necessary treatment.**

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]

WAC 246-919-980 Co-prescribing of Naloxone

Rationale:

This section is revised to reflect a more individualized and clinically appropriate approach to naloxone prescribing. The outdated term "high-risk patient" is replaced with language emphasizing specific, evidence-informed risk factors assessed by the clinician. The update clarifies that morphine milligram equivalent (MME) thresholds should not be used in isolation, and reinforces the need for documentation and patient education. These changes align with guidance from the FDA, HHS, and national consensus bodies, and support stigma-free, proactive overdose prevention.

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

The physician shall confirm or provide a current prescription for naloxone when prescribing opioids to a patient who is determined, based on individualized clinical assessment, to be at elevated risk of overdose. This assessment and rationale must be documented in the patient's medical record. Factors that may increase risk include, but are not limited to:

1. **Concurrent use of opioids with benzodiazepines or other central nervous system depressants;**
2. **Personal history of opioid overdose or known substance use disorder;**
3. **Chronic respiratory conditions such as COPD or sleep apnea;**
4. **Recent transitions in care, including post-hospital discharge or changes in prescribing provider;**
5. **Higher total daily opioid dose, though MME alone shall not be determinative.**

The physician shall provide patient education on naloxone use and ensure the prescription is accessible.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]

Citation Index

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[HHS Pain Management Best Practices] https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

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U.S. Food & Drug Administration (2025). PMR 3033-3/4. ER/LA Opioid REMS Assessment Report. Retrieved from: https://www.fda.gov/media/186256/download

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

Rationale:

This addition clarifies that while the Prescription Monitoring Program (PMP) is a valuable clinical tool, it must not override individualized clinical judgment. Automated risk scoring systems like NarxCare have been shown to disproportionately flag stable patients and may contribute to biased or abrupt care decisions. The new language affirms that prescribers must rely on comprehensive, patient-specific evaluations rather than algorithmic outputs. This protects against discrimination and aligns with FDA, AMA, and HHS guidance prioritizing clinical context and shared decision-making.

(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.

(10) Use of the prescription monitoring program (PMP), including automated risk scoring tools such as NarxCare, shall not replace individualized assessment and clinical judgment. Prescribing decisions must be based on the totality of clinical information, not algorithmic thresholds.

[Statutory Authority: RCW **18.71.017**, **18.71.800**, **18.71A.800** and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]

Proposed New Sections: Clinical Judgment and Continuity of Care

Proposed WAC 246-919-xxx: Interference with Clinical Judgment in Pain Management

Overview:
Prohibits administrative, insurer, or pharmacy practices that interfere with a physician's clinical judgment in managing pain, particularly regarding opioid prescribing. Recognizes that undue restrictions, formulary refusals, or coverage denials can undermine patient safety and lead to harmful outcomes, especially in complex or legacy cases. Affirms the physician's right to exercise clinical discretion consistent with evidence-based, patient-centered care.

Proposed WAC 246-919-xxx: Continuity of Care and Safe Transitions for Patients on Long-Term Opioid Therapy

Overview:
Requires physicians to ensure appropriate continuity of care when discontinuing opioid therapy or ending a patient relationship. Physicians must provide referrals, reasonable notice, and documentation supporting the decision. The rule codifies protections against abandonment, especially for patients at risk of withdrawal, destabilization, or harm due to abrupt termination. Reflects ethical obligations and aligns with HHS/AMA guidance.

Note on Physician Assistant (PA) WAC Alignment

To ensure consistency, clarity, and equitable application of care standards, we respectfully request that all proposed amendments described in the MD WAC sections 246-919-850 through 985 be applied in parallel to the corresponding Physician Assistant (PA) WAC sections 246-918-800 through 935. Unless otherwise noted, the proposed revisions reflect policy positions, safety considerations, and patient protections that are equally applicable to both prescribing populations.

This request is made to streamline the rulemaking process, reduce redundancy, and preserve alignment across clinical roles involved in pain management.

Master Citation Index

FDA PMR 3033, 2025. Postmarketing Requirements for ER/LA Opioids. https://www.fda.gov/media/141350/download?attachment

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[HRW, 2018] https://www.hrw.org/report/2018/12/18/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us

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[AMA Code of Medical Ethics] https://code-medical-ethics.ama-assn.org/

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Comment #112

Consideration of including language related to buprenorphine

Steven Stanos, DO Aug 24, 2025

WAC 246-919-850 ((Pain management—))**Intent and scope**.
((These)) The rules in WAC 246-919-850 through 246-919-985 govern the
((use)) prescribing of opioids in the treatment of ((patients for
chronic noncancer)) 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 ((this)) 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 ((or)), perioperative, subacute, and chronic((, and it is especially urgent for patients who experience)) pain ((as a result of terminal illness)). 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 ((controlled substances)) opioids (including traditional opioid agonists [i.e. hydrocodone, oxycodone, morphine, and tramadol) and partial agonists, such as buprenorphine, ~~including~~ All physicians should become knowledgeable about co-occurring prescriptions. Accordingly, ((this rule has been developed to)) these rules clarify the commission's position on pain
control, particularly as related to the use of opioid agonist and partial-agonist analgesics, 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, ((and)) 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 such as traditional agonists (i.e. hydrocodone, oxycodone, morphine, tramadol, etc.), and partial agonist (i.e. buprenorphine) ~~((analgesics))~~are analgesics that may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness,
trauma or surgery ((and chronic pain, whether due to cancer or non-
cancer origins)). Buprenorphine, a partial agonist, may be used for both the management of opioid use disorder (MOUD), chronic pain, and tapering depending on the patient's needs and diagnoses. The care of patients on buprenorphine for chronic pain and maintenance therapy for MOUD requiring additional analgesia for acute pain and/or planned surgical interventions should be coordinated between the primary prescriber with the provider managing acute pain and/or a planned surgical intervention. Physicians should be aware of the evolving understanding of the unique pharmacology of buprenorphine, the range of formulations available (i.e. topical, sublingual, and submucosal), and evidence-based strategies to manage patients on maintenance therapy for MOUD or those using buprenorphine for chronic pain who require additional analgesia for acute or planned surgical or medical interventions.

The commission will refer to current clinical prac-
[1] OTS-9762.2tice 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. 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 ((analgesics)) and are not the same as ((addiction)) 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 ((analgesics)) for other than legitimate medical purposes poses a threat to the individual and society ((and that)). The inappropriate prescribing of controlled substances, including opioids ((analgesics)), may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safe- guards into their practices to minimize the potential for the abuse and diversion of controlled substances including monitoring the prescription monitoring database, integrating urine monitoring, educating patients about safe storage and disposal of unused medications, and the need for availability of naloxone in emergency circumstance to reverse a potential opioid overdose.
Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids ((opioid agonist and partial agonist analgesics)), for a legitimate medical purpose and in the course of professional practice. The commission
will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based
on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.
The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The
goal is to control the patient's pain while effectively addressing
other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.
These rules are designed to assist ((practitioners)) physicians in providing appropriate medical care for patients.
((They are not inflexible rules or rigid practice requirements and are not intended,
nor should they be used, to establish a legal standard of care outside the context of the medical quality assurance committee's jurisdiction. The ultimate judgment regarding the propriety of any specific
procedure or course of action must be made by the practitioner based on all the circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the
approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of
the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. How-
ever, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken.))

[2] OTS-9762.2The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions
make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to these rules will not ((assure)) guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist ((practitioners)) 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.

Comment #113

Rebecca Mass-Krajewski, ARNP-BC, FNP, MSN, RN
The EDS Clinic PLLC
15790 Redmond Way, Ste 1269
Redmond, WA 98052
Email: rebecca@theedsclinic.com
Phone: (425) 610-18030
Date: 8/21/25

To Whom It May Concern,

Re: Policy Revisions on Pain Management and Patient-Centered Care

I appreciate the opportunity to provide feedback on the current draft, and I want to begin by affirming the thoughtful inclusion of community comments. It is clear that effort has been made to listen to lived experiences, and I strongly support that direction.

Key Support and Recommendations

- Comment DB1 – "Inform, Not Replace"
  The updated language emphasizing that opioid Morphine Milligram Equivalent (MME) standards are meant to inform, not replace clinical judgment is a significant improvement. This clarity protects both providers and patients by preserving individualized care, which is especially vital for those with rare or complex illnesses.

- Comment DB3 – Inclusive Wording
  I recommend adopting language such as "rare diseases known to be associated with acute and chronic pain" and "intractable incurable illnesses." Currently, cancer and palliative care patients often have robust systems of support. However, patients with hypermobile Ehlers-Danlos Syndrome (hEDS), Hypermobility Spectrum Disorder (HSD), and generalized hypermobility represent an entire population living with intractable, incurable conditions who remain without a home in the current framework. It is essential to explicitly include them so that policies do not inadvertently exclude large groups of patients suffering equally severe, lifelong pain.

- Comment DB7 – Retaining "Other Planned Treatments"
  This section must remain highlighted. Many community comments describe being forced into injections—a theme I see echoed in my own clinical practice. Patients with hEDS and other intractable illnesses are frequently pressured into injections or suboxone trials while simultaneously tapered down or off opioids.

These treatments can absolutely help. I also suggest them to my patients. The difference lies in approach: when providers explain why a treatment might help a particular patient, and lead with empathy, patients often find success. When education is minimal and coercive, patients become suspicious, disengage, and ultimately fail. This distinction—empathy versus enforcement—cannot be overstated. These are challenging patients in an already overburdened system with most providers bordeline burnt out. Let us not make it more difficult to seak or give care.

Patients living with intractable, incurable illnesses outside of cancer and palliative diagnoses remain largely unsupported. They face lifelong pain, high disability burdens, and fragmented care. Without explicit recognition in policy, they are left at risk of inappropriate tapering, forced treatment pathways, and lack of safe options.

As someone who works closely with this community, I have seen first-hand that success in pain management is not only about the intervention chosen, but about the manner in which it is offered. Empathy, validation, and informed choice consistently change outcomes.

I urge you to ensure that policies reflect inclusivity of all pain patients—particularly those with rare, incurable illnesses—and to reinforce that treatments should be offered with education and compassion, not coercion. By doing so, we honor both the science of medicine and the humanity of those we serve.

Thank you for your consideration.

Sincerely,

Rebecca Mass-Krajewski, ARNP-BC, FNP, MSN, RN

Comments from the WMC Rules page

August 25

Susan Olson (not verified)-*Aug 25, 2025 10:21 AM* Comment #114

As someone who has lived with chronic pain, I have been under supervised pain management for more than eight years. Unfortunately, the shortage of pain management providers has become increasingly overwhelming. With the introduction of new guidelines, I believe there should be specific language that supports primary care providers (PCPs) in the treatment and ongoing care of chronic pain patients. For example, consider a patient who has been prescribed 80 MME for an extended period and has consistently complied with all treatment protocols: no issues with urine drug screenings, accurate pill counts, regular appointment attendance, and no early refill requests. In short, a fully compliant patient. Could language be included in the guidelines that allows PCPs to safely monitor and manage patients such as this? Such a change would reduce the burden on specialized pain management clinics while enabling patients to receive comprehensive care through their regular PCPs. One possible approach might be to allow PCPs to oversee care while collaborating with another physician who could serve as a backup or consultant.

Susan Olson (not verified)-*Aug 25, 2025 12:34 PM* Comment #115

One area I would like to see addressed in the updated guidelines involves issues related to Prescription Monitoring Program (PMP) records. Currently, prescription drug shortages can make it difficult to fill an entire prescription at one pharmacy. I personally use a single pharmacy to ensure continuity of care and maintain a strong working relationship with my pharmacist. However, when shortages occur, I am sometimes required to fill part of my prescription at one location and the remainder at another. Unfortunately, this creates the appearance in the PMP that I am using multiple pharmacies, which is misleading. Would it be possible to add a comment field in the PMP to indicate that the original prescription could not be filled in full, and that a secondary pharmacy was required to dispense the remainder? While this may seem like a minor issue, it has significant implications for how a patient's medication use is interpreted. In addition, I am prescribed a benzodiazepine for procedural purposes, such as MRIs or injections, due to the stress and anxiety associated with these procedures. On the PMP, however, it only appears as though I am prescribed both a benzodiazepine and an opioid medication, without clarification that the benzodiazepine is for intermittent, procedure-related use. I believe this distinction is clinically important. Accurate documentation of medication use and dispensing history in the PMP is essential for ensuring safe, effective, and contextually appropriate patient care.

From: Cyndi Hoenhous
To: Boyd, Amelia (WMC)
Subject: WashPIP Sept. Draft Comments
Date: Monday, September 15, 2025 6:36:04 AM

Comment #115

External Email

Good morning Amelia,

I am deeply grateful for the ongoing discussions, work, and compassion given to help repair the system of pain care in our state.

I'd like to provide the following draft comments for next week's meeting specifically in the Exclusions section of the draft.

I approve most of the following language in the Exclusions section offered in last month's document as follows:

(5) Patients with high-impact chronic pain, as defined in WAC 246-919-852(?) who are maintained on a stable, non-escalating dosage of medication, where the treatment plan demonstrates ongoing benefit, functional stability, and absence of evidence of misuse or diversion.

However, there is concern regarding the language "non-escalating dose."

The focus cannot be on dose. "Non-escalating dose" does not refer to the condition of the patient, but again to an MED.

As we have seen in the past, providers will error on the side of caution to comply with all available rules. This language offers a loop hole where prescribers could misapply the language to mean that patients must simply have a non-escalating dose to comply with exemptions to the rules. That could result in patients not receiving proper care because they will be held at a non-therapeutic dose, not a dose that is individualized.

I offer the following language as an alternative to the statement "non-escalating dose".

(5) Patients with high-impact chronic pain, as defined in WAC 246-919-852(?) where the patient is in compliance with the treatment plan, demonstrates ongoing benefit, functional stability, and absence of evidence of misuse or diversion.

High impact pain refers directly to the patient. *Compliant, benefit, functional stability, absence of misuse and diversion* all refer to the condition of the patient, not to the dose of medication.

Thank you so much,

Cyndi Hoenhous, Co-Chair, Washington Patients in Intractable Pain

Comment #116

P3 Alliance – Addendum Submission

Re: WAC 246-919-930 Consultation Requirements

To: Washington Medical Commission

From: P3 Alliance

September 15, 2025

Primary Request (on record)

This is an addendum to P3's suggested (WAC) rule revisions submitted August 15, 2025. Those revisions addressed (WAC) sections 246-919-850 through 985 (MD's) and 246-918-800 through 935 (PA's). These suggested revisions address broad patient protections, progressive disease exemptions, and other suggestions for rule changes that may help eliminate harmful practices such as forced tapering.

Purpose of This Addendum

We recognize that the Commission may prefer to address certain barriers incrementally. In that spirit, we respectfully submit this document as a secondary solution specific to WAC 246-919-930, offering the Commission another pathway to reduce patient harm while staying within statutory authority.

Legal Authority

- RCW 18.71.450 requires the Commission to adopt consultation rules but does not mandate specific numerical thresholds.
- Courts defer to agency interpretation of ambiguous statutes (see Waste Management of Seattle, Inc. v. Utilities & Transportation Commission, 123 Wn.2d 621 (1994)).
- The Commission therefore has full discretion to define consultation triggers based on clinical judgment rather than a fixed MME number.

Clinical Evidence

- AMA opposes rigid MME thresholds, urging individualized assessment.
- FSMB (2024) recommends moving away from fixed MME triggers.
- CDC (2022) guidelines retreat from numerical limits and warn against forced tapering.
- FDA PMR 3033 (2025) demonstrates stable outcomes for long-term opioid therapy and low rates of opioid use disorder, undercutting assumptions behind rigid dose caps.
- Peer-reviewed studies (Agnoli et al., JAMA, 2021) show that MME-based forced tapers increase overdose and mental health crises.

Patient Harm

Arbitrary thresholds have resulted in:
- Patients being forced off stable regimens.
- Increased emergency visits, destabilization, and suicides.
- Documented harm in Washington patients, including those later found to have progressive diseases.
- Broader national harms confirmed in Human Rights Watch's 2018 report.

Supplemental Rule Option (WAC 246-919-930 Revision)

1. Consultation with a pain management specialist should be required when the prescriber's clinical evaluation identifies risk factors such as:
 - Unexpected dose escalation not tied to functional or clinical improvement.
 - Indicators of high risk (e.g., overdose history, active substance use disorder, psychiatric instability, or diversion concerns).

2. Consultation shall not be triggered solely by opioid dose or MME level.

3. Exemptions remain in place for cancer, palliative, hospice, (high-impact chronic pain, and legacy) patients as provided in WAC 246-919-851.

Conclusion

This supplemental pathway may allow the Commission to eliminate the 120 MME consultation threshold while maintaining robust safety protections through evidence-based, clinically relevant triggers.

Importantly, this addendum does not replace or amend our submission of 8/15/2025. It is offered as an alternative legal and clinical solution the Commission may choose if it seeks a more narrowly tailored reform.

Respectfully submitted,

P3 Alliance
Maria Higginbotham
Tamera Stewart

Comments from Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission

From September 16 to October 20, 2025

Jodi Lamoreaux (not verified)-*Sep 23, 2025 05:11 PM* Comment #117

Regarding WACs 246-919-851 & 246-918-801 (Exclusions) There has been confusion amongst surveyors regarding opioid prescriptions for pain when a patient has been admitted to a nursing home for at least 24 hours. We have also identified significant confusion regarding responsibilities for prescribing opiates for NH residents when the resident is engaged in drug treatment for opioids. Clarification would be helpful.

Kari Lehman (not verified)-*Sep 24, 2025 11:53 AM* Comment #118

As a chronic pain patient of nearly a decade, who has been well managed on a stable dose of opiates after every other possible alternative treatment failed, I just had my care discontinued after a failed trial of buprenorphine to replace my previous medication. I was told that I could return to my previous medication (at equivalent dosage, the same that I've been on for years) if the trial was not effective. When I requested to do so due to poor efficacy and difficulty in getting prescriptions filled in a timely manner, I was not only denied but told they would be discontinuing the buprenorphine as well, under the justification that pain medication would make my pain worse (???) When I complained about this treatment I was dismissed from care with no referral to an alternative provider. I am a person in constant pain who takes the only medication that relieves my pain and allows me to function - I am not an addict and do not deserve to be treated as such. In fact, I suspect I would receive *better* care if I was to seek addiction treatment. Doctors hold our lives in their hands and their needs to be adequate legislation directing them to treat pain patients appropriately with dignity and empathy, and consequences for failing to do so based on personal biases.

Janice G (not verified)-*Oct 11, 2025 09:14 AM* Comment #119

I am 65 and have lived with chronic pain since I was 47 and had a work related spine injury. The accident knocked a vertabrae out of its normal position causing me after 3 years, to have to retire. I could no longer cope with the pain. I also suffer with damage to literally every level of my spine including cervical pain. I suffer with bi lateral carpal tunnel from repetitive motion on the job for almost 29 years too. I lost my career.... Now I have difficulty finding medical care for my painful conditions. It is ridiculous to think the ILLICIT FENTANYL POISONING CRISIS we are experiencing in USA will be solved by denying responsible patients, safe effective opiate/opioid based medications! Rates of addiction have remained consistent throughout this whole nightmare of medical care since 2016

CDC guidelines were issued. As proven by the govts own records!! The GLs have been weaponized against legitimate patients and doctors who actual care about them. Enough with this insanity! ALL BARRIERS to doc/patient care need to be removed! Being in pain is not a crime! Treating pain is not a crime! OTC meds can damage kidneys and livers long term. They ARE NOT a safe alternative.. Implanted devices, injections and other coerced, dangerous procedures being done to patients are appalling! Rarely effective and cause further damage and suffering! God gave us the Poppy plant and humans the receptors to use their pain relieving properties for a reason. Mankind has no business denying these gifts to ANYONE!! It's abhorrent! No one is immune to aging, accidents or painful disease. At any time you or your loved ones can find themselves in this position. My life was changed in a matter of seconds! THINK ABOUT IT!

Dawn (not verified)-*Oct 17, 2025 08:57 PM* Comment #120

You are sending people to the streets. So many people I know are suffering. Poking people with injections over and over. The hoops to get MRIs. The high med cost for anything different. Mme is a joke. 6 pain pills for a major knee surgery is ridiculous. You are overloading our er and the er treats people like crap. Yet they never feel pain bc they don't let themselves or their loved ones suffer. You also allow hospitals to lie on charts. Then to get it off the chart is hard. Ers lie so much you need to investigate! Do something! You treat people awful

Comment #121

U.S. PAIN FOUNDATION

BEHIND THE NUMBERS

WHAT IT REALLY MEANS TO LIVE WITH CHRONIC PAIN

2025 NATIONAL SURVEY REPORT

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INTRODUCTION & METHODOLOGY

Chronic pain affects nearly one in four Americans. Yet, its complexity and far-reaching consequences remain largely unaddressed in health policy and care delivery. According to November 2024 CDC data, 24.3% of adults live with chronic pain, a figure that reflects more than medical discomfort—it signals a national public health crisis.

Beyond its physical toll, chronic pain deeply impacts emotional health, relationships, school and employment, and daily independence. Pain reshapes lives—but those living with it remain marginalized, misunderstood, and undertreated.

To illuminate the realities behind these numbers, the U.S. Pain Foundation conducted a nationwide survey from May 5–25, 2025. A total of 2,420 individuals responded, including those living with chronic pain, caregivers, parents of children with pain, and health care professionals—as well as many individuals falling into multiple categories. This report focuses on the 2,098 respondents who completed the chronic pain-specific section of the survey. Findings from caregivers, children with pain and their parents, and health care professionals, who completed other sections of the survey, are summarized in separate reports to ensure their unique perspectives are fully represented.

These individuals' stories—and the data they provided—paint a vivid and urgent picture: chronic pain is not sporadic, not imagined, and certainly not a niche concern. It is a multidimensional lived experience shaped by stigma, gaps in care, and persistent systemic failures.

CHRONIC PAIN IS NOT SPORADIC, NOT IMAGINED—AND NOT A NICHE CONCERN.

SCOPE AND SCALE OF PAIN

Respondents ranged from 18 to 89 years old, with a median age of 57. They represented all 50 states, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, and 32 international locations. A striking 81% identified as women, 16% as men, and 3% as nonbinary or gender-diverse. Most were white, while 13% identified as Black, Latino, Indigenous, multiracial, or other communities of color.

While this demographic profile aligns with known trends in some aspects—chronic pain disproportionately affects women and older adults—it also reveals gaps in outreach and research. Future studies must ensure more inclusive representation, including among men, nonbinary or gender-diverse individuals, and communities of color—particularly since the latter two populations often experience chronic pain at higher rates.

Key Findings:

- **87%** have lived with chronic pain for over five years
- 32% have lived with it for **over 25 years**
- Respondents reported an average of **10 distinct diagnoses** per person
- Conditions like **back pain (64%)**, **arthritis (53%)**, **neuropathic or nerve pain (48%)**, **osteoarthritis (42%)**, and **fibromyalgia (37%)** were among the most reported

Pain Is Multifaceted—And Rarely Isolated

Most people experience **multiple overlapping pain types**:

- 84% of those with **inflammatory pain** also had **musculoskeletal pain**
- 83% of those with **nociceptive pain** also had **neuropathic pain**
- 79% of those with **musculoskeletal pain** also had **neuropathic pain**

These patterns highlight the inadequacy of “one-size-fits-all” care. Pain is not just felt in the nerves, joints, or tissues—it often spans all of these. Effective care must address this complexity through **integrated, multimodal treatment plans**.

Specific Patterns of Overlap Reveal the Need for Comprehensive Care

Survey data also reveal striking multi-mechanism overlap—challenging assumptions about "typical" pain presentations. These findings confirm that many forms of chronic pain do not have a single root, but exist within an intricate interaction between musculoskeletal, neuropathic, inflammatory, nociceptive, and nociplastic processes. For example, individuals living with the following conditions reported experiencing multiple types of pain:

- **Hip and knee pain** almost always presented with **musculoskeletal** pain, with **inflammatory** pain not far behind. But almost **85%** of each group also had **neuropathic** involvement, at similar rates to the inflammatory overlap—challenging the notion that joint pain is solely joint-specific or tissue-based.
- **CRPS (complex regional pain syndrome)** showed the **highest neuropathic involvement (92%)** of all conditions, with significant musculoskeletal (70%) and inflammatory (72%) features.
- **Fibromyalgia** typically involved multiple classes of pain, including several at similarly high rates—**musculoskeletal (87%)**, **neuropathic (81%), inflammatory (80%).**
- **Rheumatoid** and **psoriatic arthritis** were overwhelmingly associated with inflammatory pain (**93%** and **95%**, respectively) but also showed significant musculoskeletal and neuropathic overlap.
- **Sciatica**, commonly considered a nerve condition, also exhibited high **musculoskeletal** involvement (**87%**)—underscoring the common **back-nerve-joint** interaction.

While living with multiple conditions and comorbidities certainly contributes to overlaps in pain types, these patterns also indicate that chronic pain is almost never "just nerve" or "just inflammation." It is a **multi-pathway condition** that demands **integrated care**: medication, restorative and complementary therapies, injections or surgeries, psychosocial support, and more. Programs, policies, and education must evolve to reflect this complexity—because people with pain are already living it every day.

CHRONIC PAIN IS ALMOST NEVER 'JUST NERVE' OR 'JUST INFLAMMATION'—IT IS A MULTI-PATHWAY CONDITION THAT DEMANDS INTEGRATED CARE.

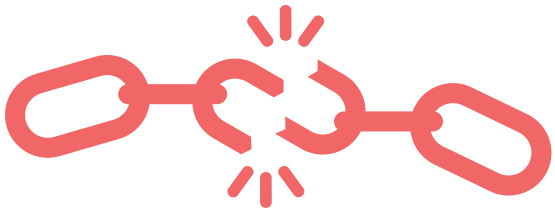
THE FULL IMPACT OF CHRONIC PAIN

Chronic pain is not confined to a physical sensation. It ripples through every corner of a person's life—limiting movement, affecting mental health, straining relationships, impacting income, and reshaping identity. For most respondents, pain is not only a medical issue. It is a pervasive experience that alters how they live, work, and connect.

Physical and Functional Impact

- **93%** said pain significantly limited physical activity or hobbies
- **79%** struggled with household chores
- **76%** reported serious sleep disruption
- **76%** missed work or school regularly
- **74%** said pain significantly interfered with employment or job performance
- **61%** were unable to care for children or dependents due to pain

Chronic pain also pushes many out of the workforce entirely—eliminating not just income, but a sense of purpose and agency. These disruptions reinforce a cycle of economic instability and emotional strain.



Emotional and Social Disruption

The psychological toll is also severe:

- **72%** reported a significant impact on their mental and emotional health
- **73%** felt socially isolated or misunderstood
- **50%** lacked emotional support from others

Relationships are deeply affected. Nearly all respondents **(97%)** said chronic pain has impacted their ability to socialize with family and friends in the past year. **70%** reported a significant impact on romantic relationships and intimacy, while **40%** also said pain caused tension or frustration in romantic relationships.

Pain isolates. It can sever bonds and foster silence instead of support. These patterns often go unseen—but they shape whether people feel loved, understood, or supported.

PAIN ISOLATES. IT SEVERS BONDS AND FOSTERS SILENCE INSTEAD OF SUPPORT.

Differences Across Populations

- **Women** often reported higher social and emotional impact across all ages in many categories
- **Nonbinary or gender-diverse** respondents reported the greatest emotional burden—**83%** said their mental health was significantly affected
- **Adults between the ages of 35 and 64** experienced the most disruption to employment, relationships, and household chores
- **Adults who were 50 and older** continued to face physical limitations, sleep disruptions, and challenges with household chores

These findings reflect a powerful truth: Chronic pain changes everything—not just how people feel, but how they live.

Stigma Still Shapes the Pain Experience

Stigma was an all-too-common experience for respondents. Whether related to their condition or the treatments they use, individuals experienced stigma from a range of sources: friends, employers, family members, and even health care providers.

Stigmatization impacted respondents in a variety of ways: **61%** have experienced stigmatization from providers or pharmacies related to opioid prescriptions; **21%** are concerned about using medical cannabis or CBD for pain management because of associated stigma; and **79%** believe that stigma around chronic pain and its treatments are a major barrier to improving pain-related policies.

Common experiences included being labeled:

- “Drug-seeking”
- “Difficult”
- “Dramatic” or exaggerating their condition

Such judgment reinforces isolation, discouraging individuals from advocating for the care they need or openly sharing their realities with others.

THE MENTAL HEALTH TOLL—AND THE POWER OF PEER SUPPORT

Chronic pain is not only a physical condition—it is a **biopsychosocial** one. It touches every part of a person's identity, well-being, and relationships. The mental health consequences of living with persistent pain are deep, complex, and often invisible.

Psychological Distress Is the Norm, Not the Exception

- **95%** of respondents reported feeling emotionally **drained or irritable** due to pain
- **88%** said they experienced **anxiety or depression** due to their pain
- **85%** felt overwhelmed by the **combined weight of pain and mental health** symptoms
- **78%** said chronic pain had **significantly impacted** their mental health
- **57%** noted that their mental health conditions (e.g., anxiety, depression) **made pain harder to manage**

These findings reveal a **detrimental feedback loop:** mental distress heightens physical symptoms, and pain deepens emotional struggle. Yet, few respondents reported receiving support that integrated both components.

Emotional Isolation and Lack of Support

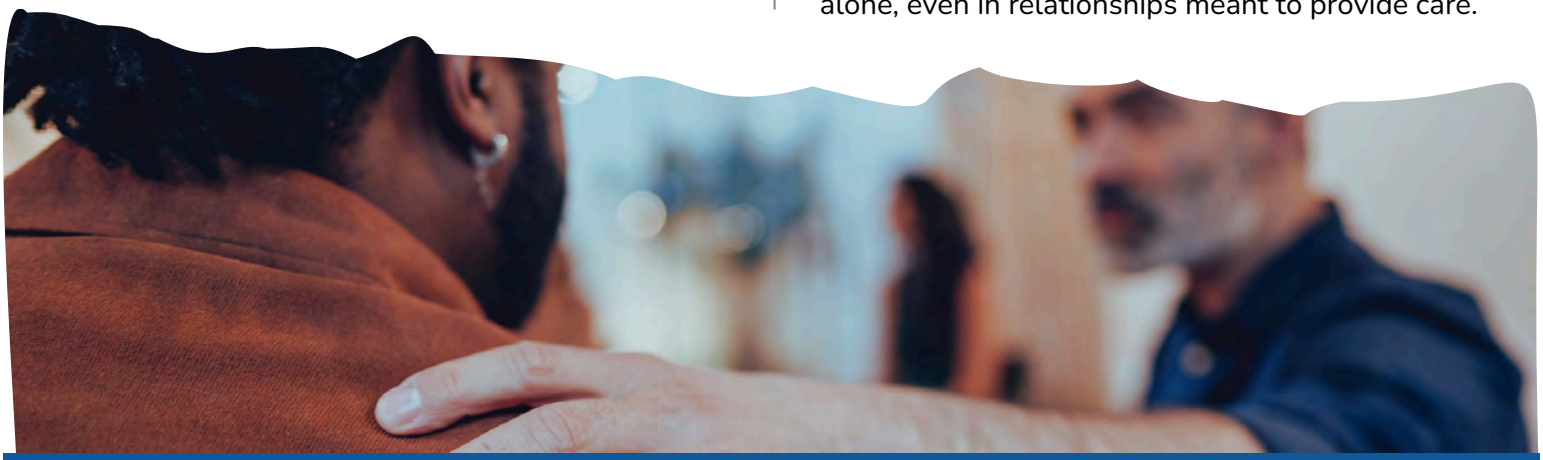
The emotional burden of chronic pain is intensified by social isolation. **90%** of respondents said they had missed social events in the past year due to their pain. Even more concerning, only **28%** said their family and friends are **very supportive**.

This means the **vast majority** of people with chronic pain navigate their daily lives—managing symptoms, responsibilities, and emotional distress—**without consistent personal support.**

Isolation is unhealthy. It reduces emotional resilience, increases pain perception, and weakens the ability to cope.

- **73%** of respondents felt **socially isolated or misunderstood**
- **79%** said their pain makes it **difficult to spend time** with family or friends
- **65%** reported **difficulty communicating with loved ones** about their pain or limitations
- **70%** said their **romantic relationships** were significantly impacted

These experiences paint a picture of disconnection—where people feel unseen, silenced, and emotionally alone, even in relationships meant to provide care.



Peer Support: A Path to Belonging and Validation

In this context, **peer support** emerges as a uniquely powerful intervention. It offers not just information—but **connection and belonging**.

Utilization and Impact

- Only **42%** of respondents had ever joined a peer support group
- But of those who did, **77%** found it helpful

Reported benefits included:

- Reduced feelings of isolation
- Emotional validation
- Sharing experiences with others who understand
- Resources and practical coping tools shared from lived experience

PEER SUPPORT CREATES CONNECTION, VALIDATION, AND A SENSE OF BELONGING.

Who's Participating—And Who's Missing Out

Peer support serves as a resource for lower-income individuals who may have less access to other resources; **40%** of survey respondents with a household income under $25,000 have participated in a support group. But this type of support also emerged as a preferred resource even for those with more financial stability; **42%** of respondents with a household income of $100,000-200,000 had also joined a group.

However, a majority still had **not participated**, despite clear interest.

Why People Haven't Joined

Barrier	% of Nonparticipants
No local options	37%
Didn't know support groups existed	31%
Unsure what to expect	19%
Struggled to find a good fit	19%

Encouragingly, **73%** of those who hadn't joined a group said they **would consider it in the future**—especially if groups were flexible, welcoming, and confidential. Online formats were especially valued by those facing mobility challenges, health limitations, or geographic barriers—suggesting virtual models are critical to equitable access.

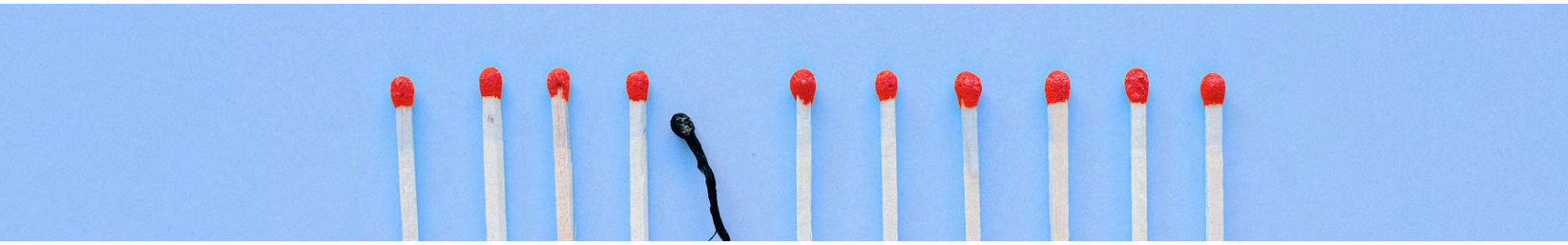
When asked what made a peer support group effective, respondents emphasized:

- Compassionate, understanding participants (88%)
- Safe, nonjudgmental environments (81%)
- Experienced facilitators (73%)
- Access to helpful resources (71%)
- Confidentiality and privacy (69%)

The U.S. Pain Foundation offers more than 60 free online peer support groups each month—yet participation continues to lag behind need. This gap is not just a missed opportunity—it's a solvable problem.

Increasing awareness, simplifying access, and improving outreach could dramatically expand participation. Strengthening the connection between people with pain and the support systems designed for them isn't just helpful—it's essential. Empowering individuals to feel seen, heard, and supported may be one of the most effective tools we have to improve quality of life.

CAREGIVING AND THE INVISIBLE WORKLOAD



For individuals living with chronic pain, even routine activities—bathing, cooking, driving, managing medications—can become overwhelming. Many need help. But too often, they go without it.

The Support Gap

- 56% said they **need caregiving assistance**
- Yet only 32% **currently receive it** (through family, friends, or paid caregivers)
- 24% of all respondents **go without support** they know they need

This gap is not evenly distributed. Among those with a household income of **under $25,000/year**, one in three **(33%)** reported unmet caregiving needs. In contrast, only **11%** of those with a household income of **$100,000 or more** faced the same issue. Income strongly shapes access to help.

At the same time, 40% said they **don't need caregiving**. But that number deserves scrutiny: given that 93% of respondents **face physical limitations** and 79% **struggle with chores**, many are likely managing without the support that could truly make a difference for them—perhaps due to pride, financial constraints, lack of availability, or limited knowledge about available resources and how to access them.

Caregiver Access by Income

Income Level	Receive Help	Need But Don't Get Help	Report No Need
Under $25K	34%	33%	29%
$25K–$50K	31%	29%	35%
$50K–$100K	35%	23%	40%
$100K+	31%	11%	54%

Without caregiving assistance, people with chronic pain are left to manage physical limitations alone—fueling a **vicious cycle** of greater pain, reduced capacity, and declining economic stability. Caregiving is not a luxury. It is a lifeline.

THE DIAGNOSTIC JOURNEY: TRUST, DELAYS, AND DISMISSAL

For many respondents, the path to a diagnosis was **long, confusing, emotionally taxing, and not always successful.** Even when pain was severe or constant, providers were slow to offer answers and validation.

How Long It Took

- Only **15%** received a diagnosis within 6 months of symptoms
- **33%** waited 1–5 years
- **29%** waited more than 5 years
- Others were **never diagnosed at all**

Delays in diagnosis aren't just frustrating—they're harmful. They often lead to **worsening symptoms, unnecessary procedures, emotional suffering, economic hardship,** and a **loss of trust in the medical system.**

Delayed diagnosis appears to be a generational problem, not just a one-off barrier. Younger respondents—especially those under 35—were more likely to report waiting three or more years for a diagnosis. This suggests systemic dismissal of younger people's pain, lack of access to specialists early on, or the bias that pain in youth or young adulthood is "psychosomatic" or temporary.

Adults who were 55 and older were more likely to receive a diagnosis within a year of symptom onset, possibly reflecting more-frequent health care interactions, higher likelihood of belief from providers, or more obvious physical correlations with aging.

However, those between the ages of 35 and 54 also showed meaningful rates of diagnostic delays, confirming that this issue cuts across generations.

The "never-diagnosed" category appeared across all age groups—but especially among younger respondents, highlighting critical gaps in early recognition and validation of pain.

The road to obtaining a diagnosis often includes significant detours for those living with pain:

- **21%** had seen **more than 10** providers in search of answers
- Another **32%** had seen between 6 and 10 providers

And for many, that road is unending.

FOR MANY, THE ROAD TO DIAGNOSIS IS LONG, CONFUSING, EMOTIONALLY TAXING —AND SOMETIMES UNENDING.

Most Common Suspected But Undiagnosed Conditions

Even after years of seeking answers, many individuals continue to live with **unexplained symptoms** and a sense that something important has been overlooked. In fact, 38% of respondents—even those with a diagnosis—or their providers believe they **still have undiagnosed conditions**.

When asked which conditions they **suspect but have never been formally diagnosed with**, respondents cited a range of pain-related disorders:

- Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)
- Fibromyalgia
- Arthritis
- Neuropathic pain
- Ehlers-Danlos syndrome (EDS)
- Postural orthostatic tachycardia syndrome (POTS)

These are **complex, overlapping conditions**—some frequently dismissed as psychological, especially in women and youth. These suspected diagnoses reflect both the complexity and the overlapping nature of chronic pain. Many respondents are living with multiple coexisting pain-related conditions—further complicating the diagnostic picture and highlighting how pain often manifests as a web of interconnected disorders rather than a single identifiable illness.

What Delays Diagnosis?

Reported Barriers	% of Respondents
Dismissive attitudes from providers	71%
Lack of access to specialists	43%
Financial constraints	31%
Insurance limitations	20%

Diagnosis is not just a clinical event—it is often a **milestone of validation and a road forward**. And too often, people living with pain are denied that validation.

However, even after a diagnosis, the journey does not get easier:

- Only **12%** felt their providers **fully understood** their pain
- **60%** said others (medical and non-medical) **don't understand at all**
- Only **3%** felt **very well understood**

When diagnosis is delayed or dismissed, people are not only denied treatment—they are denied **trust, clarity, answers, and hope**.

GEOGRAPHIC AND STRUCTURAL BARRIERS TO PAIN CARE

Access to effective, affordable pain care remains deeply uneven across the United States. Respondents—urban and rural alike—described a common challenge: **finding nearby pain specialists, clinics, or comprehensive services.**

More than one-third **(35%)** of respondents cited a **lack of nearby providers** as a barrier to care. This is particularly consequential in **rural or underserved areas**, where geographic isolation and transportation challenges make delays in care even more detrimental.

States with the Highest Reported Geographic Gaps

- **Alabama** (55%)
- **Iowa** (41%)
- **Colorado** (40%)
- **Oregon** (39%)
- **Texas** (38%)

These gaps potentially stem from multiple causes: rural hospital closures, limited pain specialists, lack of Medicaid expansion (e.g., Alabama, Texas), and inadequate integrative services outside major metro areas.

Even in states like Colorado and Oregon that reported strong health systems or expanded insurance, **pain-specific services** are often limited, unevenly distributed, or entirely absent—especially beyond urban centers. **General health care access ≠ chronic pain care access.**

Another resounding message from respondents: **Insurance coverage does not guarantee access to chronic pain care**. Many insured individuals still faced months-long waits, had no nearby options, or couldn't find providers offering multidisciplinary treatment.

These gaps are not just a rural problem, nor one that insurance reform alone can solve. They represent a **widespread, systemic failure** that cuts across geography, income, and infrastructure, leaving patients without the specialized support they need.

GENERAL HEALTH CARE ACCESS ≠ CHRONIC PAIN CARE ACCESS.

COVERAGE WITHOUT CARE: THE HEALTH INSURANCE PARADOX

Even when services are available nearby, and even when individuals have health insurance, many still face significant access challenges. The following data from our survey reveal the disconnect between **coverage on paper** and **care in reality**.

Survey respondents reported a wide range of insurance types:

- **Medicare**: 52%
- **Private or employer-sponsored**: 40%
- **Medicaid**: 18%
- **Marketplace plans (healthcare.gov)**: 7%
- **VA or military**: 3%
- **Uninsured**: 2%

Despite this broad coverage, significant barriers to pain care were reported across every insurance category—demonstrating that insurance status alone is a poor predictor of whether someone will receive effective or appropriate treatment.

For individuals living with chronic pain, **insurance often serves as a gatekeeper rather than a gateway**—limiting not only what treatments are covered but also which options are affordable, accessible, and timely.

Across all insurance types, cost emerged as one of the most frequently cited barriers to care, with **50%** listing it as a factor (and **26%** also citing high copays). Cost posed an access hurdle for respondents at the following levels based on their insurance coverage category:

- **53%** of respondents with private or employer-sponsored insurance
- **46%** of those with public insurance (e.g., Medicare or Medicaid)

These findings challenge the assumption that private insurance invariably offers superior access. In reality, the broad fluctuations in coverage through employer-sponsored plans mean that many participants still face high deductibles, copays, or out-of-pocket costs, and limited coverage for non-drug or alternative therapies.

Disproportionate Impact on Low- and Middle-Income Households

Cost-related barriers were especially acute. Nearly **1 in 4** of respondents with a household income of less than $50,000 **had not seen a medical provider at all for their pain**.

Middle-income respondents (with a household income of $50,000–$100,000) also faced significant barriers. Often ineligible for public programs yet unable to afford high out-of-pocket expenses, they frequently fell into a **"coverage gap."** Notably, those in this income bracket with private insurance **were more likely to report cost barriers** than their publicly insured peers—highlighting shortfalls in employer-based insurance plans.

Even among higher-income respondents (with a household income of more than $100,000), **more than 20% still cited cost as a barrier**, underscoring the fact that affordability challenges are structural—not confined to low-income populations.

Bureaucratic Hurdles and Delays

Financial concerns were only part of the picture. Many respondents also encountered **insurance-related administrative barriers** that delayed or denied access to care:

- **Prior authorization requirements** (46%)
- **Step therapy or "fail-first" protocols** (26%)
- **Annual visit limits** (11%)
- **Non-medical switching practices** (6%)

Another particularly fraught hurdle facing individuals with pain was **access to prescription medications**—especially opioids. Among respondents who sought opioid prescriptions, **73% encountered at least one barrier**. In addition to cost or insurance access issues, other barriers included stigma from providers or pharmacies, providers who refused to prescribe the medications, dosing reductions, and CDC guideline restrictions.

These challenges often left patients without viable alternatives—**forced to endure unmanaged pain** despite exhausting other treatment options.

Frequency of Care Closely Tracked With Income

Respondents with a household income of **over $100,000** were often more likely to report **five or more medical appointments per month**, while those with a household income of **under $25,000** often had **less-frequent appointments**, many seeing a doctor once a month or even less often. This underscores stark disparities in access to comprehensive care.

Yet **more care did not always mean better care**. Among those with frequent appointments, **21% still felt "not at all understood"** by their providers, a similar rate as those seeing the doctor less frequently—highlighting persistent gaps in provider empathy, communication, and trust.

Rather than being shaped by medical need, access to pain care is more often dictated by a complex web of systemic limitations. These include insurance hurdles, cost, restricted provider availability, geographic inequity, and stigma. Until these barriers are addressed, treatment decisions will continue to reflect what the system allows—not what patients genuinely need to manage their pain and restore their lives.

ACCESS TO PAIN CARE IS TOO OFTEN DICTATED BY BUREAUCRACY—NOT MEDICAL NEED.

NAVIGATING A FRAGMENTED SYSTEM: THE REALITIES OF PAIN MANAGEMENT

People living with chronic pain are often forced to piece together their own treatment and coordinate multiple specialists—facing a disjointed maze of inadequate, ineffective, or unavailable care. Many respondents shared that **no single option offers complete or consistent relief**. Multidisciplinary care is key, but a lack of coordination often curtails effective holistic care.

Respondents were asked what treatments or therapies they *have ever tried* for pain. The **most commonly tried** approaches were:

- **Medications,** both prescription and over-the-counter (89%)
- **Restorative therapies,** such as physical therapy, massage, or heat or cold (87%)
- **Self-management strategies,** like pacing, movement, or mindfulness (86%)
- **Injections, blocks, or infusions** (78%)

This tells a clear story: People with chronic pain are actively engaged in their care and routinely combine multiple treatments, often out of necessity.

PEOPLE LIVING WITH CHRONIC PAIN ARE OFTEN FORCED TO PIECE TOGETHER THEIR OWN TREATMENT.

Self-Management Is the Norm, Not the Exception

Among respondents who had ever tried self-management techniques, **88%** said they *currently* use them. These strategies include:

- **Activity pacing and modification** (81%)
- **Movement or exercise** (69%)
- **Stress reduction** (61%)

This high rate of usage highlights how central self-directed strategies have become. Additionally, many turn to these methods in the absence of formal care, reflecting a population managing symptoms with limited external support.

Restorative Therapies Play a Key Role

73% of respondents who have tried **restorative therapies** reported *currently* using them. Some of the most commonly utilized are:

- **Heat and cold therapy** (76%)
- **Physical therapy** (50%)
- **Exercise programs** (40%)

These treatments are frequently used in tandem with medications or self-management. But access is often determined by **cost and geography**—not clinical appropriateness.

Complementary and Integrative Health: Cost and Access Matter

A total of **55%** of respondents have tried **complementary or integrative health options**, and among those, **41%** are *currently* using them. Examples include **yoga** (52%), **herbal or vitamin products** (51%), and **acupuncture** (35%).

Several trends were noted among lower-income participants:

- **31%** of individuals **currently using these methods** had a household income of less than $50,000.
- **45%** of those **who do not use these strategies** or **skipped this question** are in the same income bracket.

Price, availability, provider awareness, and a **lack of focus on comprehensive care** all suppress uptake—even among those who might benefit.

Mind-Body Approaches Are Desired, But Disjointed

Among the **56%** of respondents who have ever utilized **mind-body or behavioral health approaches**, **78%** are *currently* doing so. These include:

- **Meditation and mindfulness** (71%)
- **Stress reduction** (68%)
- **Counseling or therapy** (51%)

PATIENTS WANT ACCESS TO A BROAD RANGE OF TREATMENTS.

Continued utilization is strong among those accessing these treatments, suggesting a clear patient appetite for nonpharmacologic, whole-person approaches to pain relief. While these techniques are gaining traction, they often exist outside of the traditional medical system, leaving patients to discover and implement them on their own. The growing integration of new chronic pain treatment programs that emphasize the mind-body connection may be an early indicator that this is changing.

Prescription and OTC Medications: Widespread Use, Mixed Results

Medications remain a pillar of pain management, with **89%** of respondents having utilized them at some point.

- **83%** of those *currently* use **prescription medications**.
- **68%** *currently* use **over-the-counter (OTC) medications** like ibuprofen, acetaminophen, or naproxen.

Opioids, muscle relaxants, antidepressants, antiepileptics, and NSAIDs were most frequently cited as helpful—but side effects are common. Many respondents reported **constipation**, **drowsiness**, **brain fog**, **opioid-induced constipation**, and **nausea**.

Despite these risks, **21%** said **no side effect would stop them from trying a medication**—highlighting the desperation some feel for the possibility of relief. This is a recurrent finding that has surfaced in previous surveys.

Barriers to Opioid Access: Systemic and Unequal

Of those who sought or received a prescription for opioid medications, **73%** faced barriers. Among that group, respondents reported:

- **Stigmatization from providers or pharmacies** (61%)
- **Dosing reductions** (56%)
- **CDC guidelines** (56%)
- **Doctors unwilling to prescribe** (55%)
- **Pharmacies unwilling to fill prescriptions** (42%)

These barriers disproportionately affect low-income patients—**45%** of those who faced challenges had a household income of **under $50,000**. The most-affected states included **California, Florida, Texas, Illinois, and Maryland**, indicating that both policy and geography shape access.

Cannabis and CBD Are Being Used More—But Not Fully Integrated

Almost half of respondents **(48%)** have tried **medical cannabis, CBD, or both** to manage their pain. Of that group, **48%** are *currently* using one or both. Among those who responded:

- **66%** found these methods somewhat or very effective.
- **73%** support integrating cannabis and CBD into formal pain care.
- Just **30%** felt their provider was knowledgeable about these options.

Top motivations for trying medical cannabis or CBD included **lack of relief from traditional options**, **personal research**, and **recommendations from friends or family**—often more than formal medical guidance. Reduced pain intensity was the largest impact at **79%**, followed by improved sleep **(63%)** and reduced anxiety **(59%)**.

Common concerns about using these treatments remain: **cost**, **legal or regulatory issues**, **safety and side effects**, **stigma**, **provider cooperation**, **acceptance**, and **lack of research**.

Neuromodulation: Noninvasive, Yet Underused

More than half of respondents **(54%)** have tried external neuromodulation or stimulation devices for pain relief, but only **39%** of those who tried them *currently* use them. **TENS units** were by far the most common (72%), followed by **neuromuscular electrical stimulation** (14%), **infrared light therapy** (13%), and **vagus nerve stimulation** (7%).

While interest in neuromodulation continues to grow, broader adoption may be hindered by barriers including **affordability**, **accessibility**, and **variability in provider awareness or endorsement**. As nonpharmacologic and noninvasive options, these tools warrant greater inclusion in comprehensive pain care.

Interventional Treatments Are Common—But Communication is Lacking

A striking **84%** of those who had tried any **interventional procedure** (such as injections, blocks, infusions, surgical procedures, implanted devices, or neurolysis procedures) had tried more than one type; **68%** had tried more than two; and **53%** had tried more than three. Yet:

- Only **50%** received an in-depth conversation with their health care provider about **risks and benefits** prior to the procedure.
- Just **34%** were thoroughly informed about **non-interventional alternatives** to these procedures.

This suggests that while many people are routed into invasive procedures, there is often a lack of fully informed consent or shared decision-making.

Together, these findings expose a care system that puts the burden of trial and error on patients. People with chronic pain are not passive—they are resourceful individuals trying to navigate a fragmented system, often with incomplete information or a lack of coordinated support.

Despite trying a wide range of therapies—self-management, medications, medical cannabis, procedures, and more—**few found consistent or lasting relief**. Treatment is often piecemeal, shaped more by barriers than by clinical guidance.

Access remains uneven, shaped by income, geography, education, stigma, and poor or disconnected provider communication.

CLINICAL TRIALS AND THE CHRONIC PAIN COMMUNITY

Despite progress in chronic pain research, a deep disconnect remains between scientific advancement and patient participation. Just **11%** of respondents had ever **taken part in a clinical trial**, and **70%** were unaware such studies existed for chronic pain. Yet interest is high: **85%** said they would consider joining—if trials were designed with patient needs in mind.

The top barrier? **Awareness**, cited by 59% of respondents who either have participated in research or are interested in doing so. But other obstacles are present. Many **feared stopping current treatments** (46%), **worried about side effects** (42%), or **hesitated to risk being in a control group without active treatment** (38%). Logistical hurdles—**transportation** (28%), **financial strain** (26%), and **time constraints** (24%)—added further difficulty, especially for those already managing pain and disability. Notably, one in four cited **mistrust of the medical or research system**, reflecting a long-standing **credibility gap** in pain care.

Additional concerns included **unclear study goals** (20%), **data privacy** (19%), and a **lack of study updates or follow-up** (13%).

Yet the survey also revealed a clear path forward to improved patient participation in vital research. Respondents overwhelmingly called for:

- **Virtual participation** (71%)
- **Transparent communication** (65%)
- **Flexible scheduling** (63%)
- **Travel reimbursement or assistance** (60%)
- **Peer or emotional support during studies** (33%)

Health care providers were the most common link to research opportunities—yet **fewer than 10%** of respondents felt that chronic pain research was meaningfully applied in their care. Meanwhile, **95%** agreed that patients should have a voice in shaping research priorities.

These findings reveal a tremendous untapped opportunity. People with pain are willing and ready to engage in research—but only if it becomes more **transparent**, **inclusive**, and **aligned with their day-to-day realities**. For this community, clinical trials aren't just about generating useful data—they're about being **validated, respected, and protected**.

Research must be managed in a way that is considerate of patient needs, centered around patient safety, and respectful of the opinions of individuals with lived experience. Making research patient-centered isn't a luxury. **It's the only path to meaningful breakthroughs.**

THE MISSING PIECE: PATIENT EDUCATION

Patient education is widely recognized as a cornerstone of effective chronic pain management—yet for many, it remains elusive. **Nearly half** of individuals living with chronic pain report that they have either **never received education** from a health care provider about managing their condition (38%) or are **unsure** if they have (11%). Only 51% confirmed receiving any such guidance, underscoring a significant breakdown in communication between patients and providers.

Even among those who did receive education, the quality and impact appear limited. While 42% of respondents found the information helpful, nearly the same proportion expressed indifference, and 16% found it unhelpful. These findings raise serious concerns about both the **relevance** and **delivery** of educational content, especially given its potential to improve outcomes, support self-management, and build therapeutic trust.

Respondents most commonly recalled discussions focused on non-medication approaches such as **physical therapy**, **mindfulness**, **exercise**, **nutrition**, and **lifestyle changes**, as well as **medications**. Yet fewer than half received information on topics like **mental health**, **managing their comorbidities**, or **understanding their condition and its progression**—despite the vital role these areas play in comprehensive pain care.

In response to these gaps, many patients turn to **non-clinical sources**. A majority—**83%**—reported seeking pain management information from outside the medical system. Among these, online resources (96%), books and articles (69%), and social media or online communities (61%) were most frequently used. Respondents also cited educational videos, advocacy organizations, and peer support groups. This pattern reflects both a **thirst for knowledge** and a **systemic failure** to meet that need within clinical settings.

83% OF PATIENTS SEEK PAIN MANAGEMENT INFORMATION FROM OUTSIDE THE MEDICAL SYSTEM.

Importantly, patients are not turning away from health care—they are supplementing it. The top two preferred learning methods, both sought after by **60%** of respondents, were **in-person discussions with health care providers** and **online resources**, revealing a clear desire for education that blends **credibility with accessibility**.

Encouragingly, nearly **85% of respondents** expressed interest in a **free educational online pain management program**, highlighting a powerful opportunity to meet patients where they are—through comprehensive, affordable, and trustworthy resources.

Taken together, these findings spotlight a critical yet often-overlooked component of pain care: **patient education**. Individuals living with chronic pain demonstrate strong motivation to learn, self-manage, and engage with care—but they are frequently left without adequate guidance from the health care system.

To close this gap, patient education must be repositioned as a **core clinical service**—not an optional add-on. Expanding access to **comprehensive, multidisciplinary education**, delivered in formats that are **trusted, inclusive, and patient-centered**, should be a top priority in any modern approach to chronic pain care.

INDIVIDUALS WITH PAIN ARE STRONGLY MOTIVATED TO LEARN—BUT FREQUENTLY LEFT WITHOUT GUIDANCE.

ADVOCACY, REPRESENTATION, AND POLICY REFORM

People living with chronic pain are emerging as a powerful yet underutilized voice in shaping health care policy. Among respondents, there is both a **deep understanding of systemic challenges** and a **strong desire to be part of the solution**. Yet their insights, experience, and leadership are rarely invited into the rooms where health policy decisions are made.

Despite facing overwhelming daily challenges, this community demonstrates powerful civic potential. While only **34%** of respondents have participated in any form of advocacy to date, a striking **82%** expressed a desire to become more involved—**if** opportunities to engage were **more accessible, inclusive, and low-barrier**. This gap reveals an enormous untapped potential for grassroots advocacy.

For people living with pain, advocacy can be exhausting. Respondents cited barriers such as **pain-related fatigue**, **fear of being dismissed**, **emotional strain**, and **uncertainty about how or where to begin**. Even within a community already connected to structured advocacy opportunities—like the U.S. Pain Foundation—these barriers remain real and persistent.

Yet many are still finding ways to engage. Peer support networks, online campaigns, storytelling platforms, and training programs offering pre-written letters have all helped lower the threshold for impactful action.

When asked what matters most in pain policy, these leading priorities emerged:

Advocacy Priorities	% of Respondents
Increased pain education for health care providers	51%
Developing new pain medications	35%
Balanced opioid prescribing policies	29%
Reducing insurance barriers	28%

These are not abstract policy goals — they reflect the urgent, lived experience of people whose access to care is being compromised. Two-thirds **(66%)** of respondents said current pain policies have made it harder for them to access effective treatment. **Over 70%** believe that opioid regulations are unbalanced and restrictive. And only **10%** felt that health care providers truly understand the policy landscape patients are expected to navigate.

Still, the most painful theme to emerge was **exclusion**. A full **84%** of respondents said they do **not** feel adequately represented in policy discussions. **Only 2%** felt that their voices are genuinely heard.

Participants called for a shift to "**nothing about us without us**" models of engagement—including patient-led advisory boards, accessible testimony opportunities, and co-design of research and clinical programs. Without meaningful inclusion of lived experience, even the best-intentioned policies risk falling short of the needs they aim to serve.

The chronic pain community is ready to lead. But they must be **invited in, supported, and truly heard.**

THE CHRONIC PAIN COMMUNITY IS READY TO LEAD.

WHAT'S NEXT: NINE RECOMMENDATIONS FOR SYSTEMIC CHANGE

This survey exposes the **scale and complexity** of chronic pain in America—and the systemic failures that shape how pain is experienced and treated. But it also illuminates **solutions**. These nine recommendations form a framework for **meaningful, people-centered reform**.

1. Expand insurance coverage to include all evidence-based pain care services, and eliminate short-term cost-driven treatment barriers.

2. Make peer support a standard component of care, recognizing its clinical value and embedding it into health systems and reimbursement models.

3. Develop multidisciplinary care models that center on patient needs and incentivize outcomes over volume.

4. Integrate mental health into all pain care, acknowledging that emotional well-being, trauma, and grief are inseparable from physical pain—and addressing them jointly to foster effective coping strategies.

5. Remove access barriers linked to geography, income, and stigma through telehealth, mobile care, and public awareness.

6. Improve provider education and timely diagnosis by mandating training in chronic pain, implicit bias, and empathetic care.

7. Empower patients through education, offering accessible, evidence-based tools to facilitate self-management, shared learning, and long-term engagement in their care.

8. Democratize research by making clinical trials more inclusive: Co-design with patients, offer flexible participation, and expand access through primary care.

9. Prioritize lived experience in policymaking, giving patients leadership roles in shaping care models and systems.

CONCLUSION: A ROADMAP AND A WARNING

This report is more than data. It is a **portrait of our current lived reality**, drawn from thousands of individuals who have endured pain in silence—and are now speaking out together.

Chronic pain is not simply a symptom. It is a condition shaped by systems: health care, insurance, geography, culture, and policy. It is also shaped by stigma, misconceptions, disbelief, fragmentation, and delay.

Yet in the collective responses to this survey, the **resilience, clarity, and leadership** from those living with pain shines through.

This report is both a warning and a roadmap.

It warns what happens when pain is ignored.

And it points toward what's possible when people with pain are heard.

WHEN PEOPLE WITH PAIN ARE HEARD RATHER THAN IGNORED, POSSIBILITY EMERGES.

ACKNOWLEDGEMENTS

The U.S. Pain Foundation thanks all survey participants for their candor, courage, and insight.

We extend our gratitude to our **Corporate Council members** for supporting this initiative:
Amgen, Averitas, Eli Lilly, Kenvue, Lundbeck, Primus Pharmaceuticals, Salix Pharmaceuticals, Vertex Pharmaceuticals.

Special thanks to our nonprofit community colleagues who helped amplify the survey's reach, and the individuals who sifted through data and provided crucial context.

And finally, thank you to our staff, volunteers, and peer leaders who work tirelessly to move the needle on pain and embody the values of dignity, inclusion, and equity in every interaction.

U.S. PAIN
FOUNDATION

Comment #122

From: WMC Medical Policy
To: WMC Medical Rules
Subject: FW: 9.25.25 Rulemaking WAC 246-919-850 through 985 & WAC 246-918-800 through 935
Date: Thursday, September 25, 2025 4:08:29 PM
Attachments: image003.png
Importance: High

From: Lamoreaux, Jodi L (DSHS/HCLA/RCS) <jodi.lamoreaux1@dshs.wa.gov>
Sent: Thursday, September 25, 2025 3:19 PM
To: WMC Medical Policy <Medical.Policy@wmc.wa.gov>
Subject: 9.25.25 Rulemaking WAC 246-919-850 through 985 & WAC 246-918-800 through 935
Importance: High

Good afternoon,

RCS has received multiple reports of confusion that I'm hoping you can address in current rulemaking.

Effected population:

- Nursing home residents currently engaged in treatment for opioid addiction through a certified opioid treatment center.
- Physicians and PAs who are providing primary care for those residents.

Identified issue:

- Opioids are being prescribed as part of opioid treatment by the certified opioid treatment center.
- Physicians and PAs who are providing primary care for those residents have adjusted the opioid prescription from the treatment center without coordinating with the treatment center, resulting in poor outcomes to residents.

It would be helpful if physician and PA roles and responsibilities in the above circumstances could be further clarified.

Thank you,

Jodi Lamoreaux, MSW (She/Her)
360-464-0487 / Jodi.Lamoreaux1@dshs.wa.gov

Residential Care Services
Home and Community Living
Administration.
Washington State Department of Social and Health Services

Internal Staff Only: Please send policy inquiries to the **RCS Policy Inbox.**

External Interested Parties: Please send policy inquiries to **rcspolicy@dshs.wa.gov**.

Thank you for your email. RCS is currently experiencing staffing changes. We appreciate your patience as our responses may take an extended length of time.

Comment #123

From: WMC Medical Policy
To: WMC Medical Rules
Subject: FW: Comment regarding WAC Opioid Revision -Buprenorphine
Date: Monday, October 6, 2025 1:02:13 PM

Amelia Boyd, BAS
Program Manager
Washington Medical Commission
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Were you satisfied with the service you received today? Yes or No

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From: mims gordon <mimsgo@yahoo.com>
Sent: Friday, October 3, 2025 4:29 PM
To: WMC Medical Policy <Medical.Policy@wmc.wa.gov>
Subject: Comment regarding WAC Opioid Revision -Buprenorphine

External Email

Hello, I'd like to submit a comment regarding adding Buprenorphine to the WAC rules being revised.

First, I think it's unnecessary to mention, much less highlight any of the opiates being considered by a doctor and their patient receiving pain medicine as a part of this WAC. Medications used for pain management, just like surgeries and other treatments etc, are being continually researched, revised, and utilized (or have stopped being utilized) throughout the years that pain conditions have been treated. Highlighting It doesn't seem necessary and could actually conflate this entire section to focus on that one type of opiate is preferable to another, since no other opiates are presented in this matter we are working on revising.

Instead, perhaps all opiates (not just Partial Agonist such as Buprenorphine) could be addressed in a different section such as treatment options? That way, balanced and accurate risk/benefits could be reviewed between doctors and patients in order to make

the best decision for each patient and then develop individualized treatment plans for each pain patient. Additionally, Including this section on Buprenorphine could lead to continual WAC revisions as research finds more and effective medications to treat this population.

Additionally, I am not a doctor but I have been living my last nine years with Complex regional pain syndrome (CRPS), exposure to and involvement in trials and support groups with individual patients across the world regarding different medications that work for some, work for others, and some that don't work at all for pain management . With Buprenorphine, of course it works for some; however not all because it's a Partial Agonist with a ceiling effect for pain where if it stops helping, ("ceiling effect" increasing the dose will not provide additional pain relief) and some may (and possibly have) lead to life-threatening complications such as death when people may try to take more and overdose or turn to illicit drugs and then overdose. Please reference this internet summary for more information:

Buprenorphine: A key example: The opioid buprenorphine is the most prominent example of a partial agonist with a pain-relief ceiling.

- It acts as a partial agonist at the mu-opioid receptor, which is responsible for pain relief.
- At low to moderate doses, buprenorphine provides increasing analgesia (pain relief).
- However, once a certain dose is reached, its analgesic effects plateau due to the ceiling effect.
- Safety advantage: This mechanism provides a significant safety advantage for treating opioid use disorder (OUD) so that as it creates a ceiling for respiratory depression. the risk of fatal overdose is lower with buprenorphine compared to full opioid agonists like fentanyl or heroin, but research comparing patients using opiates for pain management versus people who are using illicit drugs, pain patients are in the small percentage of people who overdose.
- Drawback for severe pain: The analgesic ceiling is a disadvantage when treating severe pain because higher doses are not possible for greater pain relief.

Of course it works for some, and respiratory distress symptoms are reduced, but there are increasing reports that when pain patients reach that ceiling affect they may turn to

illicit drugs, alcohol or take extra Buprenorphine to relieve their pain leading to frustration and possible overdose as pain eludes them. Especially those patients who are forced tapered off of their helpful opiates by their doctors and transferred to Buprenorphine or risk being excluded from that pain management practice altogether. (in my experience I was warned by my pain management provider that he wouldn't treat me again unless I got a spinal cord stimulator), and I've had so much pressure throughout the years to switch to a partial agonist, despite my success using a full agonist to be able to do things like babysit, go out with friends, walk on the beach, etc. Without them, I sit on the couch all day and I am housebound not interacting with anybody because I can't stop crying from the pain.

If it is deemed necessary and/or helpful, why not make separate WAC treatment recommendations to include all opioids (there are many) with the knowledge it will need to be annually updated to include current research findings on treatment for pain management. Again for example, when I was being rolled into surgery to obtain a spinal cord simulator when I was ready to get one, my surgeon approached me and told me that a study had just been completed saying that spinal cord surgeries are not the best option for my CRPS condition and that there research was indicating less positive results than had prior

Personally, speaking with experience as a person with pain over the course of nine years, despite being totally compliant with suggestions from my doctor on invasive procedures such as getting a spinal cord stimulator, over a dozen lumbar pain blocks , Stellate, Ganglion of Impar blocks relieve my pain, sometimes twice a month for several years with minimal success. Additionally, I participated in a FDA clinical trial providing bisphosphonate infusions for my condition as well as in process of participating in a University of California San Francisco clinical trial for deep brain stimulation for chronic pain. Pain patients are in general very vulnerable to the doctors who see them, and who often approach us with a limited tool box to choose from. When it was proposed to me by two different doctors to start on partial agonists, I was given no reassurance that if the switch failed, I could resume my use of successful opiate use to manage my pain. I was also informed that the switch from using full agonist to partial agonist could be an excruciating process of withdrawal due to needing it out of your system to begin the other due to one canceling the other out. Additionally, in this process of switching one drug to the other? This is a really excruciating process of titrating down from a Full Agonist to a Partial Agonist. In response to my hesitation, one of my doctors even laughed at me, saying it would not be as bad as having the flu.... Another variable to consider, many of us are gifted with comorbid conditions which our original diagnosis

brought about due to circulatory issues, mast cell and glial cell involvement etc. These comorbid conditions can be debilitating and disabling piling onto the original diagnosis symptoms that we are dealing with.

Finally, and perhaps most importantly, those of us who are long-term pain patients, and who have never been labeled as anything but low risk for addiction, risk getting a diagnosis (label) of OUD because this medication is tied for OUD treatment. Getting a label such as that when it's not deserved, needed or accurate can be a detrimental to any pain patient getting care in a medical center or even obtaining prescriptions at a pharmacy. Any doctor or pharmacist can"Red Flag" a patient which is a signal that someone might be trying to access medication's for nefarious reasons or purposes.

About me; I was fully employed for 35+ years as a licensed mental health therapist most recently working on JBLM with opportunities to take my career to Europe on military bases. Now, my treatment goals (though I've never been asked for my goals from any pain management doctor) include sitting on the floor with my grandchildren, playing with them and an occasional night out for dinner with friends. 9 years ago on this date, I was employed as a Licensed Mental Health Counselor (since 1985) most recently working on JBLM working with children who had a deployed parent, teaching soldiers and officers ways to successfully deal with stress and trauma related to deployment, and supporting spouses and partners and their families through traumas associated goddamnit how did that happen after I got a square one hold that thanks just hit the outside of my leg. I think it scared me more than anything. Sorry sweetheartqNow I can't walk my dog to the end of my cup-de-sac (about 10 houses away) thank you.without assistance.on JBLM, solo hiked in the Cascades, took walks on beaches and road trips and was able to spontaneously get up and go someplace without having to stop to consider accessibility, the length of time away from This is not something I could achieve without my opiate medications since I went from solo hiking in the cascades to instant disability and losing my full-time job as a mental health, therapist on JBLM, being able to do some things I enjoy such has babysitting my grandchildren and going out with friends and gardening. Over the years I've received pressure to switch to.Bupenepherone again, despite my low risk status and stable positive results from opiate use. Why switch? I would have to detox off of all of my opiate used to even begin using a partial agonist, which would never be able to achieve the level of pain care I require after nine years of having CRPS. It would cause excruciating pain, and because of my cardiac issues related to my CRPS would likely put me in a cardiac crisis. I'm concerned if this is listed as a revision it would draw attention away from other opiates that might be better indicated for their care if they don't have OUD. Plus, including it in the revisions, but no other opiates seems like it would direct doctors to put that at the forefront of treatment options without

understanding some of the very serious concerns and possible side effects of these medications, which is still in the new stages of being researched and used for patients with chronic and intractable pain. When I was approached to try it, there were issues left out that concerned me such as if I needed treatment for acute pain from a car, accident, and not have access to opiate Agnes, which would immediately treat acute pain without having a ceiling effect where it's no longer effective. I just think that's a dangerous that, considering most pain patients don't die from pain, they die from cardiac arrest due to pain.

I also don't think highlighting Buprenorphine in this WAC revision because we are trying to help give patients and doctors the ability to individualized treatment plans to each patients individual needs. Highlighting this medication would likely lead doctors to narrower drug options and the only one listed in the WC would Buprenorphine.

Its pharmacology, evidence base and clinical role distinguish it as primarily a treatment for opioid use disorder (OUD) with only limited u use as a pain medication. Additionally, I don't think it belongs in this WAC, just as I don't think any drugs belong in this WAC. If we included it? Then we would need to include a section or other opiate medications as well, and be prepared to revise continually as these medications are researched and refined for care in the treatment of acute

Mims

Comment #124

To: Washington Medical Commission

Subject: Request for Patient Protections and Individualized Care in Opioid Prescribing Rules (WAC 246-919-850 through 985)

Dear Members of the Washington Medical Commission,

I am writing as a chronic pain patient and caregiver to ask that the Commission ensure Washington's opioid prescribing rules protect patients like me—those living with long-term, high-impact pain who depend on individualized treatment to maintain any quality of life.

I have lived with severe, intractable pain since June of 2000. I have undergone multiple surgeries and tried numerous treatments in an effort to reduce my suffering. Despite every effort to find alternatives, opioids remain the only therapy that allows me to function and care for my husband, who is a struggling with cancer.

My doctor ordered genetic testing that confirmed I am a rapid metabolizer, meaning I process medications more quickly than most people. Even with this medical evidence, I have been forcibly tapered to 90 MME per day. Since then, my pain and fatigue have increased to the point where caring for myself and my husband has become extremely difficult.

I fully support responsible prescribing and recognize the need to address addiction and diversion. But I urge the Commission to recognize that not all patients can or should be tapered. Many, like me, are stable, compliant, and monitored under care plans that have worked safely for years.

I respectfully ask that the Commission consider the following in its ongoing rule revisions:

- Add language clarifying that forced tapering of stable, compliant patients is below the standard of care and may cause serious harm, including withdrawal, depression, or suicide.
- Reaffirm that MME thresholds are not evidence-based clinical limits, and that decisions must be based on each patient's medical condition and response.
- Protect patients with rare, progressive, or palliative diseases by explicitly exempting them from restrictive dosing or arbitrary taper triggers.
- Reinforce that physicians who treat chronic pain appropriately and compassionately should not face disciplinary action when following Commission-approved rules.

I appreciate the Commission's recognition in WAC 246-919-850 that its rules supersede conflicting federal guidelines. That clarification gives hope that patients in Washington may again receive individualized care based on science, not stigma. I do ask however that this clarification be added to the rules that carry the force of law so that it isn't just read and forgotten.

Thank you for your commitment to improving patient safety and restoring compassion to medicine.

With gratitude and respect,

Vicki Sulfaro

Comment #125

From: Evan Starkey
To: WMC Medical Rules
Cc: WMC Medical Complaints; WMC
Date: Thursday, October 16, 2025 9:16:51 AM

External Email

To the Members of the Washington State Medical Commission,

I'm writing as a Washington resident and patient to urge reconsideration of the state's current pain management regulations. These rules, though intended to protect public safety, have had devastating consequences for many people living with chronic pain.

The present guidelines have made it extremely difficult for physicians to practice individualized medicine. In trying to prevent misuse, we've instead created widespread undertreatment and fear. Patients who rely on legitimate, medically supervised pain care are being left to suffer unnecessarily — while physicians are forced into impossible ethical positions.

Pain management should not be dictated by blanket policy. Each patient's situation is different, and the state's approach must allow qualified professionals to make sound, compassionate decisions without fear of reprisal. Restrictive rules do not stop addiction — they only drive suffering underground.

I respectfully ask the Commission to review these regulations and work toward evidence-based reform that balances accountability with access to care. People in pain are not statistics; they're human beings who deserve dignity and relief.

Thank you for your attention to this issue.

Respectfully,

Evan R. Starkey
360-316-9551
estarkeyptpc@gmail.com

Washington State Medical Association
Physician Driven, Patient Focused

February 13, 2026

Dear Members of the Washington Medical Commission,

On behalf of the Washington State Medical Association (WSMA), thank you for the opportunity to submit our attached proposed revisions to WAC 246-919-850 through 246-919-985.

Washington has been a national leader in responding to the opioid epidemic and we recognize the Commission's responsibility to protect patients and promote safe prescribing. At the same time, after extensive engagement with physicians and patients, we believe the current rules are unnecessarily complex and operationally rigid.

In 2024, the WSMA convened a multidisciplinary work group that interviewed a broad range of stakeholders — including physicians across specialties and patients — and developed a report titled "Recommendations for Improving Access to Pain Management Treatment in Washington State." Our central recommendation to the Commission was to conduct recurring regulatory review of opioid prescribing rules with the goal of improving pain management, enhancing access to care, and aligning Washington's framework with current clinical practice.

Regular review is essential to ensure prescribers can follow evolving evidence-based standards while maintaining high-quality care for patients with complex needs. We are therefore grateful for this discussion.

Our proposed revisions are comprehensive because the challenges are structural. Incremental edits will not resolve the underlying problem. We are not advocating for deregulation but for simplification, clarity, and restoration of appropriate clinical discretion within a framework that continues to prioritize patient safety.

Several principles guide our proposal:

- We must preserve access to legitimate pain care while maintaining safeguards. Physicians should not fear disciplinary action when they are acting in good faith for a legitimate medical purpose. Over time, the layering of mandates has created a "freezing effect," especially for complex chronic pain patients. When regulatory burden becomes disproportionate, patients experience the consequences in the form of reduced access.

- Based on our review, Washington's rules exceed national norms in both detail and rigidity. The mandatory 120 MED specialist consultation threshold is a clear example. Consultation is often appropriate and beneficial, but a fixed trigger does not account for clinical nuance or real-world access constraints, particularly in rural communities. Our revisions preserve the expectation of careful assessment while allowing flexibility where consultation is not feasible or not clinically necessary.

- Third, the cumulative use of mandatory language throughout the rules increases liability exposure without necessarily improving outcomes. **The repeated layering of "shall" and "must" provisions across multiple phases of care encourages defensive practice rather than thoughtful, individualized care. In the current rules, there are 109 mandatory directives ("shall" + "must"), 33 advisory directives ("should") and 41 references to documentation ("document", "documented", "documentation", "documenting").**

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Our proposal reduces duplication and streamlines expectations while maintaining core requirements: evaluation, risk assessment, multimodal consideration, and periodic reassessment.

- With respect to tapering, we share the concern that abrupt or inappropriate tapering can harm patients. At the same time, rules must clearly preserve physician clinical judgment. Tapering should be considered when clinically indicated or requested by the patient and not framed in a way that diminishes the physician's responsibility as the ultimate decision-maker. Our revisions reflect that balance.

- We believe future progress will come from strengthening quality improvement efforts rather than expanding regulations. Washington's Better Prescribing, Better Treatment (BPBT) program demonstrates that peer-to-peer, clinician-driven initiatives can meaningfully improve prescribing practices while preserving clinical judgment. That model reflects the right direction: accountability paired with collaboration.

The overdose crisis has evolved, with illicit fentanyl and polysubstance use now driving mortality. Responsible prescribing remains essential, but our regulatory framework should reflect today's public health landscape and avoid destabilizing patients who are appropriately managed.

The attached proposed edits clarify scope, reduce duplication, streamline requirements, and restore proportionality — while preserving meaningful guardrails. We respectfully ask the Commission to view these revisions as a thoughtful effort to protect patients from harm while ensuring they are not denied care because the rules have become too complex to navigate confidently.

WSMA remains committed to working collaboratively with the Commission, AMDG, patient advocates, and other stakeholders to craft a framework that is clear, balanced, and workable for both patients and physicians.

Thank you for your time and continued leadership.

Sincerely,

Jeb Shepard
Director of Policy
Washington State Medical Association

Comment #126

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~~

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~~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. Likewise no clinician should fear discipline for not utilizing controlled substance in a treatment plan if not clinically indicated.~~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.~~[i]

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]~~

Physicians

WAC 246-919-851 ~~**Exclusions**~~**Inclusion**. WAC 246-919-850 through 246-919-985 apply only to the treatment of non-cancer related pain in the outpatient setting.[ii] ~~do not apply to:~~

~~(1) The treatment of patients with cancer-related pain;~~

~~(2) The treatment of patients with sickle cell disease;~~

~~(3) The provision of palliative, hospice, or other end-of-life care;~~

~~(4) The provision of procedural medications;~~

~~(5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:~~

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Commented [DB1]: Suggested language from Higginbotham petition: "Add exemption: Rare diseases-patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National Institutes of Health (NIH) are exempt from the guidelines and/or policies."

NORD's list of 1,500 rare disease: List of Rare Diseases | A-Z Database | NORD

~~(a) Acute care hospitals licensed under chapter 70.41 RCW;~~

~~(b) Psychiatric hospitals licensed under chapter 71.12 RCW;~~

~~(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;~~

~~(d) Long-term acute care hospitals as defined in RCW 74.60.010; or~~

~~(e) Residential treatment facilities as defined in RCW 71.12.455; or~~

~~(6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection (5) of this section.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, § 246-919-851, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71A.800, 18.71.017, and 18.130.050. WSR 22-22-039, § 246-919-851, filed 10/25/22, effective 11/25/22. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]~~

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~~2) "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~~

Commented [DB2]: Suggestion from WashPIP (Comment #107): "Chronic Pain" means pain that persists or recurs for longer than 3 months. Such pain often becomes the sole or predominant clinical problem in some patients. As such it may warrant specific diagnostic evaluation, therapy and rehabilitation.

Source: IASP definition, https://www.iasp-pain.org/advocacy/definitions-ofchronic-pain-syndromes/ as derived from 'Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the *International Classification of Diseases (ICD-11)*'

~~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.~~

(3~~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 above one hundred

twenty morphine equivalents a day, 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.~~

(4~~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.~~

(5~~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~~ one hundred twenty 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.~~

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~~(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.~~[iii]

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]~~

WAC 246-919-865 Patient notification, secure storage, and disposal. ~~(1)~~ The physician, or their designee, at the initiation and change in opioid prescribing, shall discuss with the patient, and legal guardian if a minor, ~~the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic~~the risks and benefits of opioids including overdose, importance of multimodal therapy including pharmacologic and nonphmaracologic treatments, proper storage and disposal of opioids at the conclusion of treatment.[iv] ~~:~~

~~(a) Risks associated with the use of opioids, including the risk of dependence and overdose, as appropriate to the medical condition, the type of patient, and the phase of treatment;~~

~~(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments, whenever reasonable, clinically appropriate, evidence-based alternatives exist;~~

~~(c) The safe and secure storage of opioid prescriptions;~~

~~(d) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs; and~~

~~(e) That the patient has the right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.~~

~~(2) The requirements in subsection (1) of this section do not apply to the administration of an opioid including, but not limited to, the following situations as documented in the patient record:~~

~~(a) Emergent care;~~

~~(b) Where patient pain represents a significant health risk;~~

~~(c) Procedures involving the administration of anesthesia;~~

~~(d) When the patient is unable to grant or revoke consent;~~ ~~or~~

~~(e) MAT for substance use disorders.~~

~~(3) If the patient is under eighteen years old or is not competent, the discussion required by subsection (1) of this section must include the patient's parent, guardian, or the person identified in RCW 7.70.065, unless otherwise provided by law.~~

~~(4) The physician shall document completion of the requirements in subsection (1) of this section in the patient's health care record.~~

~~(5) The information in subsection (1) of this section must also be provided in writing. This requirement may be satisfied with a document provided by the department of health.~~

~~(6) To fulfill the requirements of subsection (1) of this section, a physician may designate any individual who holds a~~

~~credential issued by a disciplining authority under RCW 18.130.040 to provide the information.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]~~

~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-870, filed 11/16/18, effective 1/1/19.]~~

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~~ A one-time continuing education course of one hour length requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules in this chapter is required. ~~The continuing education must be at least one hour in length.~~ The course must be completed by the end of the physician's first full continued education reporting period.[v]

~~(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. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]~~

~~OP~~IOID PRESCRIBING ACUTE AND SUBACUTE ~~NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE~~ PAIN

WAC 246-919-880 Patient evaluation and patient record - acute pain ~~Acute nonoperative pain~~. Prior to issuing an opioid prescription for acute ~~nonoperative~~ or subacute ~~pain or acute perioperative~~ pain, the physician shall conduct an adequate history, including substance use disorder risk factors, physical examination, and a query of the PMP.[vi] ~~:~~

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-880, filed 11/16/18, effective 1/1/19.]~~

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.~~develop a treatment plan that includes multimodal therapy when clinically appropriate. Duration of treatment will generally be of short duration, defined as three days for pediatric patients and seven days for adults, when opioids are required. When follow up visits for pain control require ongoing opioids, a reassessment of function, pain, and side effects should be documented. When more than six weeks of ongoing treatment are required, the patient transitions to subacute pain.[vii]

~~(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;~~

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-885, filed 11/16/18, effective 1/1/19.]~~

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~~**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.~~

Commented [DB3]: Suggestion from WashPIP (Comment #107): revise as follows: (4) The physician shall reevaluate a patient who does not follow the expected course of recovery and consider whether the continued use of opioids is clinically indicated; clinical documentation will be updated accordingly.

~~(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~~

Commented [DB4]: Suggestion from WashPIP (Comment #107): revise as follows: (7) Long-acting or extended release opioids may not be indicated for acute perioperative pain in some cases.

Additional notes: ER/LA opioids are safe and effective for certain more invasive surgical procedures; categorically removing them from the toolbox needlessly harms those patients who would benefit from them. ER/LA opioid medications should not be categorically disallowed from prescribing. Evidence includes (but is not limited to): Efficacy And Safety Of Controlled-Release Oxycodone For The Management Of Moderate-To-Severe Chronic - 2019, Journal of Pain Research

Evaluating the stability of opioid efficacy over 12 months in patients with chronic noncancer pain who initially demonstrate benefit from extended release oxycodone or hydrocodone: harmonization of Food and Drug Administration patient-level drug safety s - 2022, PAIN (IASP)

MD Anderson Peri-Operative Pain Management Guide: https://www.mdanderson.org/documents/for physicians/

~~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. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-890, filed 11/16/18, effective 1/1/19.]~~

~~**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.~~When considering an

~~(1) Prior to issuing an~~ opioid prescription for subacute pain, the physician shall perform an assessment as defined in WAC 246-919-880 ~~assess~~ and document the rationale for continuing opioid therapy~~ as follows:~~. Additional considerations on a patient centered basis may include:

~~(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~~1) Obtaining a biological specimen test; ~~if the patient's functional status is deteriorating or if pain is escalating; and~~

(~~f~~2) Screen or refer the patient for further consultation for psychosocial factors ~~if the patient's functional status is deteriorating or if pain is escalating~~that may be affecting the patient's experience of pain; ~~.~~

(3) Perform a screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy.

(4) Reassessment of function, pain, and side effects at follow-up.[viii] ~~(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 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~~

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-895, filed 11/16/18, effective 1/1/19.]~~

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 with a stated goal of either tapering the patient off of opioids or transitioning to chronic pain management. During this period of transition, prescriptions and re-evaluations should be done every two to four weeks as clinically indicated.[ix]

~~(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~~

Commented [DB5]: Suggestion from WashPIP (Comment #107): revise: The physician shall reevaluate the patient during the six-to-twelve week subacute phase.

~~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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-900, filed 11/16/18, effective 1/1/19.]~~

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. At all assessments for chronic pain visits, the physician shall perform an assessment as defined in WAC 246-919-880 and document the rationale for continuing opioid therapy as part of a multimodal treatment plan. Additional considerations on a patient centered basis may include:

~~The physician shall include in the patient's record:~~

~~(1) An appropriate history including:~~

~~(a) The nature and intensity of the pain;~~

(~~b~~a) The effect of pain on physical and psychosocial function;

(b~~c~~) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; ~~and~~

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(~~d)~~c) Review of comorbidities with particular attention to psychiatric and substance use.

(d) Perform a screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy.

(e) Obtaining a biological specimen test;

(f) Screen or refer the patient for further consultation for psychosocial factors that may be affecting the patient's experience of pain;[x]

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-910 Written Treatment plan—Chronic pain. The physician, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop a~~n~~

Commented [DB6]: Suggestion from WashPIP (Comment #107): add - Risk assessment tools shall not include scores or information generated by automated decision making systems or automated decision support systems.

Additional information: Source for excluding automated decision making/support systems: **"Challenging Disability Discrimination in the Clinical Use of PDMP Algorithms" - https://pubmed.ncbi.nlm.nih.gov/38390676/ -2024**

Commented [DB7]: Suggestion from WashPIP (Comment #107): Any reference to "Chronic opioid treatment" or "chronic opioid therapy should be changed to "long term opioid therapy" or treatment, as per the HHS as it is outdated.. Note: This terminology appears in sections through WAC 246-919-850 through 985.

written opioid treatment plan ~~as follows~~that includes plans for ongoing evaluation, biologic specimen testing, and criteria for treatment termination. The patient will acknowledge their responsibilities including having a single prescriber for chronic opioid therapy, use of medications as prescribed, and safe storage.~~:~~

~~(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.~~[xi]

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.]~~

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~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-920 Periodic review—Chronic pain. ~~(1)~~ The physician shall periodically review the course of treatment for chronic pain to determine the efficacy, risk, and benefits of ongoing opioid treatment with an examination as outlined in WAC 246-919-905. The frequency of visits is at the discretion of the physician, but ~~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~~at a minimum frequency of:

(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;

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(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.~~ ~~:~~[xii]

~~(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~~

Commented [DB8]: Suggestion from WashPIP (Comment #107): add (e) When the physician considers tapering or referral for a potential substance use disorder;

Additional notes: Rationale: Tapering is not a decision taken lightly. Patients have reported unfounded rationale for tapering to unsustainable doses. The decision to taper must be medically based on sound judgement, not predetermined dosage ceilings. The risk to tapering a patient stable on opioid therapy can be significant. Furthermore, physicians should be required to document their decision making when tapering patients.

Commented [DB9]: Suggestion from WashPIP (Comment #107): delete and replace with: The patient's history of compliance with treatment plans and written agreements documented by medical records and PMP queries.

Commented [DB10]: Suggestion from WashPIP (Comment #107): delete and replace with: the observed or reported effect on function and/or pain control and in...

Commented [DB11]: Suggestion from WashPIP (Comment #107): add - including any relevant diagnosis and the nature and intensity of the pain including any relevant imaging and test results; (b) Effect of pain on psychosocial function; (c) ...

~~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.~~

Commented [DB12]: Suggestion from WashPIP (Comment #107): add (4) Observed or reported effects on function or pain control will be documented, as well as the rationale for changes in the treatment plan.

~~(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physicians should not dismiss patients from care on the basis of a biological specimen test result alone.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, § 246-919-920, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-920, filed 11/16/18, effective 1/1/19.]~~

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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.[xiii] ~~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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-925, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain. Consultation should be considered ~~(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 m~~Mandatory consultation with a pain management specialist is required at a threshold is one hundred twenty milligrams MED unless the patient is on a tapering schedule or is only temporarily above the threshold due to an acute episode

of pain. Consultation is not required where the prescribing physician is a pain specialist or has more than three years of experience in the practice of pain management. ~~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.~~Consultation, or the inability to obtain one and the steps taken, should be documented in the chart.[xiv]

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-930, filed 11/16/18, effective 1/1/19.]~~

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~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-935, filed 11/16/18, effective 1/1/19.]~~

~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]~~

~~**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 18 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 30 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 a physician assistant, in accordance with WAC 246-918-895.~~

~~(3) If a dentist, in accordance with WAC 246-817-965.~~

~~(4) If a podiatric physician, in accordance with WAC 246-922-750.~~

~~(5) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.~~

~~[Statutory Authority: RCW 18.71.017 and 2020 c 80. WSR 24-23-042, § 246-919-945, filed 11/14/24, effective 12/15/24. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-945, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-950 Tapering considerations—Chronic pain. Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician should~~all~~ consider tapering or referral for a substance use disorder evaluation when requested by the patient or clinically indicated.~~:~~[xv]

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, § 246-919-950, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]~~

Commented [DB13]: Suggestion from WashPIP (Comment #107): Change to read - (2) Exemptions to the required Periodic Review:
The patient requests;
There is evidence of misuse, abuse, substance use disorder, or diversion;
The patient experiences a severe adverse event or overdose;
There is unauthorized escalation of doses.

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

Commented [DB14]: Suggestion from WashPIP (Comment #107): change to "higher"

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.~~

Commented [DB15]: Suggestion from WashPIP (Comment #107): change to "higher"

Commented [DB16]: Suggestion from WashPIP (Comment #107): add - (a) Physician meets the criteria of a pain management specialist as defined in section 246-919-945;

~~(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this~~ Consultation with a pain specialist is not required within the ~~exemption applies for the~~ first three months of a newly established patient~~care, after which the requirements of WAC 246-919-930 shall apply~~.[xvi] ~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]~~

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~~

Commented [DB17]: Edits suggested here from MM with a note that the adolescent and aging populations requirements are basic medicine and keep just the pregnant patients requirements.

~~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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-960, filed 11/16/18, effective 1/1/19.]~~

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 should~~all~~ coordinate care with the patient's chronic pain treatment practitioner, if possible.[xvii]

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]~~

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) B~~benzodiazepines and other sedative medications~~;~~ without documentation of the medical decision making, risks and benefits, and alternative considerations. If the physician is only prescribing one of the substances,

~~(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, t~~the physician issuing the new prescription ~~shall~~ should consult with the other prescriber to establish a patient care plan surrounding these medications when feasible. ~~This provision does not apply to emergency care.~~[xviii]

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]~~

~~**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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-975, filed 11/16/18, effective 1/1/19.]~~

WAC 246-919-980 Coprescribing of naloxone. The opioid prescribing physician sh~~hall~~ould confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.xix

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]~~

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation. ~~(1)~~ The physician should~~all~~ ~~register to access~~ utilize the PMP ~~or demonstrate~~

Formatted: Indent: First line: 0", Line spacing: Exactly 24 pt

Commented [DB18]: BOMS: WAC 246-853-785:

Commented [DB19]: The definitions for high, moderate, and low risk should remain if we do not change this.

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Commented [DB20]: BOMS rule: WAC 246-853-790:

~~proof of having assured access to the PMP~~ if they prescribe Schedule II-V medications in Washington state when technically feasible. The PMP should generally be reviewed when writing for any controlled substance, but at least annually or when a change in dosing is planned.[xx]

~~(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.~~

Commented [DB21]: MM: Suggests deleting (4). Reduced requirement on practitioner and patient. Rely on aberrant behavior standard and requirements in written agreement.

~~(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.~~

~~[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]~~

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[i] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]

[ii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-851, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71A.800, 18.71.017, and 18.130.050. WSR 22-22-039, § 246-919-851, filed 10/25/22, effective 11/25/22. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

[iii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

[iv] [Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20,

effective 2/28/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]

[v] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]

[vi] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-880, filed 11/16/18, effective 1/1/19.]

[vii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-885, filed 11/16/18, effective 1/1/19.]

[viii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-895, filed 11/16/18, effective 1/1/19.]

[ix] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-900, filed 11/16/18, effective 1/1/19.]

[x] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]

[xi] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]

[xii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-920, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-920, filed 11/16/18, effective 1/1/19.]

[xiii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-925, filed 11/16/18, effective 1/1/19.]

[xiv] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-930, filed 11/16/18, effective 1/1/19.] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-935, filed 11/16/18, effective 1/1/19.] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]

[xv] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-950, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]

[xvi] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]

[xvii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

[xviii] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]

[xix] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]

[xx] [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]

Comment #127

246-919-950
Tapering considerations—Chronic pain.

(1) Not all chronic pain patients will need their opioid prescriptions tapered. The decision to taper should be based on the following;

(a) History of compliance with treatment plans and written agreements documented by medical records and PMP queries;

(b) Documented functional stability, pain control, or improvements/deterioration in function or pain control at the present dose;

© History or indication of misuse, abuse, substance use disorder, diversion, or adverse event.

(2) Maintaining the current dose for patients who are compliant with the treatment plan, demonstrate ongoing benefit, functional stability, have no evidence of misuse or diversion and have no adverse events is within the standard of care.

(3) Document medical decision making for continuation or change to the treatment plan.

(4) Any tapering plan must include:

(a)Gradual dose reduction;

(b)Monitoring for withdrawal symptoms or adverse effects;

© Clear documentation of clinical rationale and patient reported impact to ensure continuity and transparency of care.

AMENDED Comment #127

From: Cyndi Hoenhous
To: Boyd, Amelia (WMC)
Cc: rosebigham@hotmail.com
Subject: WashPIP Feb Taper Language
Date: Friday, February 13, 2026 12:56:48 AM
Attachments: WashPIP Tapering Language Feb 2026.docx
2nd WashPIP Tapering Language Feb 2026.docx

External Email

Amelia,

I have attached WashPIP's most recent proposed language for the Tapering section of the WA Opioid Prescribing Rules. It is significantly shorter than the current draft. We believe clinicians are asking for simplification and the autonomy to make their own prescribing decisions. The language provides a foundation to thoughtfully consider if tapering is appropriate, however it does not tell the clinician what to do. Likewise, patients are asking for protection from non-medical tapers by requiring clinicians to document the reason for the taper and then continue their care to make sure the patient does not have adverse effects. I believe there is a wealth of information on tapering in the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, 2019[1]. I would love to see if a reference to the document would be allowed in the taper section. If that is not possible, please refer to the language in the second document I sent.

Thank you so much,

Cyndi Hoenhous, Co-Chair, Washington Patients in Intractable Pain

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AMENDED Comment #127
Draft #1

246-919-950
Tapering considerations – Chronic Pain

(1) Not all chronic pain patients will need their opioid prescriptions tapered;

In each case the clinician should review the risks and benefits of the current therapy with the patient and decide if tapering is appropriate based on individual circumstances.[1]

(2) The decision to taper should be based on the following;

(a) History of compliance with treatment plans and written agreements documented by medical records and PMP queries;

(b) Documented functional stability, pain control, or improvements or deterioration in function and/or pain control at the present dose;

(c) History or indication of misuse, abuse, substance use disorder, diversion, or adverse event

(3) Document medical decision making for continuation or change to the treatment plan

(4) Clinicians should reference the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, 2019[1]

(a) *Opioids should be tapered gradually due to the risks of significant opioid withdrawal, unless there are indications of a life-threatening issue, such as warning signs of impending overdose*[1] or illegal diversion

1. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, 2019

AMENDED Comment #127
Draft #2

246-919-950
Tapering considerations – Chronic Pain

(1) Not all chronic pain patients will need their opioid prescriptions tapered;

In each case the clinician should review the risks and benefits of the current therapy with the patient and decide if tapering is appropriate based on individual circumstances.[1]

(2) The decision to taper should be based on the following;

(a) History of compliance with treatment plans and written agreements documented by medical records and PMP queries;

(b) Documented functional stability, pain control, or improvements or deterioration in function and/or pain control at the present dose;

(c) History or indication of misuse, abuse, substance use disorder, diversion, or adverse event

(3) Document medical decision making for continuation or change to the treatment plan

(4) *Opioids should be tapered gradually due to the risks of significant opioid withdrawal, unless there are indications of a life-threatening issue, such as warning signs of impending overdose*[1] or illegal diversion

1. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, 2019

AMDG
agency medical directors' group

Comment #128

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

December 12, 2025

Dear Dr. Karen Domino and Commission Members,

The Agency Medical Directors' Group (AMDG) appreciates the opportunity to submit comments regarding proposed changes to opioid prescribing rules (WSR 25-10-039). AMDG members are medical directors and senior policy makers for state agencies that are working together to improve health care quality for Washington State citizens.

Following the 1999 pain management rule changes, opioid prescribing for non-cancer pain increased dramatically, which resulted in a sharp increase in opioid overdoses. In response, the AMDG developed treatment guidelines with the aim of helping providers to more safely and appropriately prescribe opioids for chronic noncancer pain. This was followed by rule changes in 2011 and additional guidelines from the Bree Collaborative focusing on specific patient populations. The state agencies have also undertaken provider education and outreach efforts to support providers who are managing patients on chronic opioid therapy. These efforts have contributed to the decreased rate of prescription opioid-related deaths. Although we have seen progress, the rate of deaths involving prescription opioids continues to be higher than that seen in 1990s, so this warrants continued diligence.

We agree that pain management, including the assessment of benefits and risks for patients on chronic opioid therapy, needs to be individualized, and that patients should not be forced to taper without clear justification. Consistent with this approach, the Bree Collaborative convened a workgroup in 2020 that included clinical and academic experts, patients with lived experience, and representatives from healthcare systems and insurance plans to develop a patient-centered approach for patients who are maintained on chronic opioid therapy for pain. The resulting guideline stresses the importance of engaging patients, performing a comprehensive assessment, and engaging in shared decision-making with patients and their families/significant others regarding whether to stay on opioids or taper at a rate consistent with their clinical and social situation or to treat opioid use disorder, if present.

If the decision is to stay on opioids, then the patient's chronic pain should be managed through a collaborative care model as described in the 2018 Bree Collaborative Care for Chronic Pain Report and Recommendations. Rather than a primary focus on pain relief, these guidelines focus on the use of a care team to achieve goals of improved function, increased quality of life, and greater patient autonomy.

We have several concerns regarding the proposed rule changes:

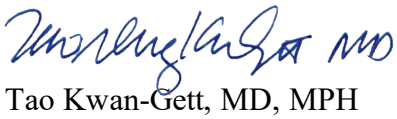
- **Eliminating reference to Morphine Milligram Equivalent (MME) dose in the mandatory consultation and definition rules.** The removal of dosing thresholds and definitions of risk are not reflective of the evidence. The correlation between opioid dose and subsequent risk of overdose events has been demonstrated in four different study populations (Dunn 2010, Bohnert 2011, Gomes 2011 and Zedler 2014). As opioid dose increases, so does the risk of overdose event. In addition, the FDA recently announced major changes to opioid labeling to emphasize risks with chronic opioid therapy, based on two robust postmarketing studies. Study 3033-1 demonstrated that, over a 12-month period, the cumulative incidence of prescription opioid abuse was approximately 9%, and the incidence of prescription opioid misuse was 22%. Study 3033-2 estimated the five-year cumulative incidence of opioid overdose death ranged from 1.5 to 4% across study sites. Any effort to de-emphasize the well-established dose-dependent risks associated with chronic opioid therapy seems counterintuitive.
- **Creating variation in opioid prescribing rules across different provider types.** Historically, legislation on opioid prescribing has provided a framework for coordination among the boards and commissions. Ensuring a singular set of prescribing rules is important to minimize confusion and ensure quality of care. Any effort to revise opioid guidelines and rules should be coordinated across the boards/commissions. It is unclear whether that is occurring in this instance. A lack of uniformity in prescribing rules would undoubtedly lead to confusion and frustration for both providers and patients.
- **Overreliance on the individual provider's ability to identify risk.** This is a return to the 1990s model approach with an emphasis on individual provider assessment of opioid risk. No study has evaluated the effectiveness of risk mitigation strategies that may be used to assess a patient's risk while on opioids. Additionally, the 2020 AHRQ report on the Comparative Effectiveness of Opioid Treatment for Chronic Pain reviewed tools and instruments used to predict risk of OUD, abuse or misuse and overdose and found them to be largely ineffective. We now understand that it is exceedingly difficult to predict which patient, when exposed to chronic opioid therapy, will develop opioid use disorder or suffer an overdose, so it is not realistic to expect a provider to somehow intuit this risk.

We strongly oppose the proposed rule changes because they are not aligned with scientific evidence, could lead to confusion and variation in care, and increase the risk of prescription opioid-related deaths in our state. We look forward to working with you to improve health care for Washington residents, including those with chronic pain.

Sincerely,

Gary Franklin, MD, MPH
Medical Director
Department Labor & Industries

Judy Zerzan-Thul, MD, MPH
Chief Medical Officer
Health Care Authority



Tao Kwan-Gett, MD, MPH
State Health Officer
Department of Health

07-31-2025 FDA Drug Safety Communication. FDA is requiring opioid pain medicine manufacturers to update prescribing information regarding long-term use | FDA. Accessed August 21, 2025.

Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 2011;305:1315-21.

Dr. Robert Bree Collaborative's 2018 Collaborative Care for Chronic Pain Report and Recommendations.

Dr. Robert Bree Collaborative's 2020 Opioid Prescribing: Long-term Opioid Therapy Report and Recommendations.

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152:85-92.

Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. Arch Intern Med 2011;171:686-91.

Zedler B, Xie L, Wang L, et al. Risk Factors for Serious Prescription Opioid-Related Toxicity or Overdose among Veterans Health Administration Patients. Pain Med 2014;15:1911-29.

Comments from Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission October 21, 2025 to February 2, 2026

James K Rotchfo... (not verified)-*Oct 21, 2025 08:44 PM* Comment #129

Please help to eliminate all legal mandates regarding professionally written prescriptions for opioids and other controlled substances. While educating prescribers about the risks and benefits of writing any prescription is most appropriate, especially when Public Health is compromised, when specific legal constraints overshadow well-established professional standards of medical care, unintended consequences are likely. The magnitude of the unintended consequences of the Pain Rules is grievous based on current evidence strengthened by understandings of human behavior, which, when it comes to substance abuse, is often exacerbated by American culture and beliefs. As Americans, we tend to believe that we will be safer and public health will improve with more laws, rules, and consequences. As a professional on the frontlines of managing those with SUDs, it is clear that our "American way" is failing miserably in managing the scourges of substance use disorders, whether related to licit or illicit substances. In the history of medicine, I am not aware of public health outcomes benefiting from mandating the specifics of care provided by a licensed professional. Outcomes associated with the Pain Rules have clearly increased morbidity and mortality for Washingtonians, while they have understandably reduced overdoses from prescription opioids. This only makes sense. That said, it does not make sense to reduce the morbidity and mortality associated with hospitalizations by making laws that interfere with physicians providing the best of individualized care when deciding who to admit. The best of professional medical care has always been individualized care based on current understandings, contextual factors, and adherence to professional ethical standards. I hope the commission will address and work to limit undue cultural and financial biases that limit professional medical care and Public Health outcomes.

Tina Burris (not verified)-*Oct 31, 2025 02:21 PM* Comment #130

A great many innocent people have died because of the heartless and thoughtless acts of doctors, pharmacists, and the men on the hill.

Thomas Michael ... (not verified)-*Nov 11, 2025 07:12 PM* Comment #131

DRUG TESTING CHRONIC PAIN PATIENTS, AND ONLY CHRONIC PAIN PATIENTS IS DISCRIMINATORY AND ILLEGAL. FEDERAL LAW SAYS YOU CANNOT DENY SOMEONE MEDICAL TREATMENT BASED ON THE FACT THAT THEY ARE USING ILLICIT DRUGS. FEDERAL LAW SUPERCEEDES STATE LAW, AND AS SOON AS SOMEONE WITH ENOUGH MONEY TO HIRE A LAWYER, THIS WILL FORCE ALL STATES TO STOP DRUG TESTING CHRONIC PAIN PATIENTS. PALLIATIVE CARE PATIENTS, PATIENTS IN RESIDENTIAL REST HOMES, PATIENTS WITH TERMINAL DISEASES, PATIENTS WHO ARRIVE IN THE

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EMERGENCY ROOM, PATIENTS WHO ARRIVE FOR RADIOLOGY AND OTHE RXRAY TESTS ARE NOT DRUG TESTED. FIFTEEN PERCENT OF ALL DOCTORS AND NURSES WILL DEVELOPE A DRUG ADDICTION DURING THEIR CAREERS, YET NON OF THEM ARE DRUG TESTED. PHARMACY OWNERS AND THOSE WHO WORK THERE ARE NOT DRUG TESTED. AND THE DEA AND LOCAL LAW ENFORCEMENT OFFICERS AND SPECIAL DRUG TASK FORCE AGENTS ARE NOT DRUG TESTED. ONLY CHRONIC PAIN PATIENTS!

Ristine Kay (not verified)-*Dec 07, 2025 07:16 PM* Comment #132

Finally some common sense to opioid prescription drugs! I have had chronic pain for 26 years caused by a failed back surgery by a doctor who caused it and then lied to me about what I had. What I have is spinal adhesive arachnoiditis. In some medical literature it states that this pain is as bad as cancer pain, but without the benefit of death! For 24 years I was able to take ER morphine, less than 100 mgs per day and Percocet for breakthrough pain along with anticonvulsants for the nerve pain. When I was diagnosed with this condition my spinal surgeon said I needed to find a good pain clinic because there was no cure and surgeries and injections can only make it worse. This is still the case and this condition can become progressively worse to where some people end up in wheelchairs. Earlier this year my meds were dropped to no more morphine or Percocet. I am now on a 3rd of what I was prescribed and it is Oxycodone. No longer on morphine because my doctor didn't want to prescribe it AND because every pharmacy in town couldn't stock it, THANKS TO THE DEA! So now I lay in bed most days praying that I don't wake up in the morning. Life is not worth living if you can't take care of yourself, your home, can't enjoy a social life and are a raving bitch because you HURT CONSTANTLY! Pain takes over a person's life. It's difficult to concentrate on tv, reading, socializing, working because your mind constantly focuses on the pain. I have tried everything my doctors have suggested and then some, including distraction, heat, cold, trigger point injections, massage, epidural injections, anti depressants, anti convulsants, therapy, rest, exercise, PT, chiropractic, RFA, and the list goes on. And yet I am still in pain 26 years later. Now one pain doctor has suggested a spinal cord stimulator. But another pain doctor says I should not get one. I have read many negative things about SCS's. I don't want another back operation when my chronic pain was caused by a bad back surgery. Risks of SCS's can include paralysis, nerve damage, worse pain, short term pain relief, needing the device removed etc. chronic pain patients are being pushed to invasive procedures like the SCS because doctors don't want to prescribe opioids anymore. This is not right. I follow all the requirements of taking opioids. Signed pain agreement, urine tests, pill counts, monthly appointments with my pain doctor, no doctor or pharmacy shopping and have never asked for an increase in my medication in 26 y until last month because what I am currently taking is NOT helping. Any of my doctors would state that I am a perfect patient for following all the rules, and yet I am

treated worse than a drug addict. I have seen 2 new primary care doctors and 1 new pain doctor (primary care doctor referred me to another pain doctor) and the first thing these doctors said was “I don’t prescribe pain medication”. Things have got to change.

Cherie A Sandretzky (not verified)-*Jan 22, 2026 03:42 AM* Comment #133

Can you imagine going in for open heart surgery, Having them crack your chest open, strip the veins out of your legs, tie your sternum together with wire, then going to the ICU and they give you Tylenol? How about falling off your lawn mower and having it run over and peeling yoyr skin and tissue from your lower legs and being told in the ER that one pain pill will make you an addict, so all we can offer you is a cold compress and lidocaine patches to your debrided legs. Better yet, how about putting up Christmas lights and falling 15 feet off your roof onto cement or having a semi-truck T-bone your car and you have to be saved out of a crushed car with multiple broken bones, all to be told "This is a Tylenol only hospital, we don't give pain medicine, here's a lavender sachet and some music to help you retrain your pain sensations" Gosh they can't even give them a stick to bite on and a slug of whiskey to stop the pain. How about a Sickle Cell patient in crisis, the pain of malformed blood cells flowing through your veins, scraping your vessels from the inside is excruciating to these patients and they are being told they can have Ibuprofen? The worst, Cancer patients, especially terminal ones, given Gabapentin, a seizure medication and veing told, thats all we csn offer yoy. how dare they! This opioid hysteria has segued from Chronic Pain Patients into the Acute Pain Patients now. Doctors are afraid to prescribe pain medicine fearing jail time, losing their license to practice and being afraid of their practices being invaded by the DOJ and FBI and closed down, all for helping their patients, which is an oath taken. Medical students are being taught that all pain patients are drug seekers and to never prescribe pain medicine, to maybe give Suboxone, which is not a pain medicine, or Gabapentin, that may work abiut 35% if the time on nerve pain. This is a terrible idea to teach these youngsters that probably have never really had horrific pain and cannot identify with a patient in pain. Let me tell you, working as a critical care RN, for the past 4 decades, I can tell you that yes, there was a problem, that yes, there are solutions. But to vilify pain patients, whether acute or chronic is not the answer. The answer is getting the illicit drugs off the streets, it is offering rehab for the people that have become addicted to drugs, to educate providers and civilians about opioids and how they are an effective medication for the faction of society that needs them and doesn't abuse them.. I can tell you the Chronic pain patients that I've had as patients all these years. They never ask for more medicone, they never run out of their medication early, they never have bad UA tests, they never "lose" their prescriptions or abuse their medication. They never ask for an increase in dosage and they are very grateful to just have a somewhat normal life. To have an existence where they might be able to play with their kids or go to work and be a productive member of society

and not feel like a burden to family or society. The Difference in being DEPENDENT on medications versus ADDICTED is huge. Believe me, as a young neophyte RN, the first time I ever learned about the difference, I was working in the ER, and a young man came in, he had said he had fallen out of a tree, and his shoulder was popped out and looked absolutely painful. I quickly ran back to Dr. Anderson and said, oh my gosh this guy, he fell out of a tree, he needs help right away! Dr. Anderson said, come here and he pulled me aside. He showed me a notebook that was about 8 inches thick, and he perused through and pointed out the man's name, I asked, what is that for? he said, this is a book of drug seekers that frequent hospitals and clinics, these are people that come in, fake pain and look for drugs. And I asked him, why would they do that? And he laughed at me, and he said, because they like getting high. It shocked me, I had no idea, oh so many years ago that those things happened! So watching the jaded old ER nurses deal with these drug seekers was an eye opener for me. The lies, the tells and the nurses's keen eyes, I too developed the ability to see through their fake pain stories. But then watching a pain patient come in that suffered from trauma, or a Chronic disease or any painful condition. You just know as a nurse. They don't abuse the system, and they dont deserve to be in a constant state of worry, fear and anxiety, because of untreated pain. This is seriously happening everywhere, Clinics have signs stating they won't prescribe pain medicines. Hospitals have protocols and their made up "laws" posted, all because of greed, money to be made, lawsuits abound, stocks that are owned by certain Doctors that lecture about vilifying opioids and pushing their suboxone for selfish motives because of a forced made up hysteria. All because of inappropriate information being given out to the public, to medical schools, nursing schools, dental schools etc. And not surprisingly, the virtue signaling, self righteous demographic of people wanting a scapegoat, or something to blame, maybe eben for a loved ones OD death, they do not understanding that the illicit Fentanyl crisis is the real reason for these deaths, not a pain patient being monitored and compliant . Does anyone care that the CDC was caught giving false statistics, lumping the illicit drug deaths, (yes one every 11 seconds) in with the pain patients statistics. This needs to be clarified amd rectified immediately. This hysteria needs to stop here and now, yes have parameters, yes have protocols, yes have safety and help for those that ARE addicts, but please do not villify pain patients, both Chronic and Acute anymore. One day you or your loved one will have a trauma or a surgery or a chronic disease, goodness even having intense dental work done. And you will have to watch them suffer, not be medicated appropriately, writhing, screaming in agony and it will truly break your heart. By the way, the examples of pain I gave, those are all true stories, think about that. NO medicine was given.

From: Kimber Rotchford <jkrotchford@gmail.com>
Sent: Sunday, February 1, 2026 3:34 PM
To: WMC Medical Policy <Medical.Policy@wmc.wa.gov>
Subject: opioid prescribing WACs revisions

Comment #133

External Email

Dear Washington Medical Commission,

Please focus on education concerning Chronic Opioid Agonist Therapy (COAT). Calls for evidence regarding when benefits outweigh risks must acknowledge that subgroups benefit at varying doses, routes of administration, half-lives, and comorbiditie let alone age, history, etc. The best medical care will always be individualized. For us to deny that those who meet DSM III or IV criteria for opioid dependence benefit from COAT/MOUD is not honoring the extensive evidence that goes back to the 1950's and is arguably as robust as for any chronic disease. Europeans and International criteria have not adopted the DSM 5 criteria that exclude tolerance and dependence criteria if the opioid is prescribed. The disease of addiction should not be based on cultural factors, such as the legality of use. For example, while they are most commonly used legally, alcohol and tobacco use have morbidity and mortality exceeding that of any illicit substance.

When medical care is mandated by law or regulation, unintended consequences are to be expected, as evidenced by the Pain Rules. I applaud authority when it is accountable. The specifics of professional medical care do not, however, lend themselves to RCW's or WAC's. Contextual variables are crucial to the best of individualized medical care. Even the FDA recognizes their findings are but "recommendations" that warrant individualized attention to ensure the best outcomes.

As both a Fellow of the American Society of Addiction Medicine and a long-time Fellow of the American College of Preventive Medicine, I encourage the State of Washington to facilitate and reward adequate training and education in Addiction Medicine for licensed medical professionals and limit our punitive and shaming approaches when we address SUDs. I encourage you to promote prevention and care by making access easier and rewarding care through contingency management strategies, with their demonstrated benefits.

Lastly, I am aware of multiple examples of experts advising COAT and/or MOUD for patients, but it remains challenging for patients to access, in part due to ignorance and biases, though I believe mostly because of the significant regulatory, administrative, and financial liabilities.

James K. Rotchford, M.D., M.P.H,, F.A.S.A.M., F.A.C.P.M., F.A.A.M.A.

P.S. I am open to educating colleagues and others about the pathophysiology of SUDS and evidence-based care, in particular regarding opioid use disorders and chronic pain management, and will share my Curriculum Vitae on request. I am confident that my expertise would be helpful, especially given that I have been caring for these patients on the front lines and in rural settings throughout my 45-year career.

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Comments from [Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission]

From February 3 to February 16, 2026

Jodi Lamoreaux (not verified)-*Feb 11, 2026 11:05 AM* Comment #134

Clarification of physician roles, responsibilities, and communication requirements - prior to prescribing or modifying an existing opiate prescription - when a patient is enrolled in an opiate addiction treatment program is needed.

JAMES ROTCHFORD... (not verified)-*Feb 16, 2026 04:42 PM* Comment #135

I am hoping to retire in about a year and cannot find colleagues to refer my patients to who are on Chronic Opioid Agonist Therapy (COAT). While I am a pain management specialist and so their opioids can be prescribed by anyone with a DEA registration, I am deeply concerned about some of my patients unduly suffering and even dying as a result of not finding a prescriber to replace me when I retire. My concerns are justified: In the past when I had to stop prescribing controlled substances at least six patients died (some quite young) in the following six months and many more in the subsequent years as a result of not finding prescribers willing to prescribe them opioids for pain management and comorbid OUDs. While the intentions of the pain rules were good, that is to promote public safety, I am confident that the unintended consequences have increased morbidity and mortality as they relate to opioid overdoses and suicides, not to speak of the acknowledged significant morbidity related to poorly managed pain. Despite what I consider as overwhelming evidence as an acknowledged expert in Addiction Medicine, Pain Management, and Public Health, there are still colleagues who believe that all chronic complex pain patients can be managed adequately without opioids, even when they have comorbid opioid use disorders! The DSM III and IV criteria made no distinction of whether a patient was prescribed an opioid for pain management, nor do the ICD-10 criteria for opioid dependence. Using these criteria, the evidence for MOUD is overwhelming in terms of significantly lowering both morbidity and mortality. I also find there are subgroups of chronic pain patients without OUDs who benefit from COAT compared to their risks, or the risks of alternative and accessible therapeutic plans. Even pain management specialists at tertiary care centers often refuse to prescribe COAT to patients referred to them! Please consider overturning the Pain Rules with their criminal and professional liabilities. The practice of medicine was never intended to be amenable to strict laws without respect for contextual variables. Individualized medical care will always be the most cost-effective care. Focus on education and training to better ensure biases and prejudices are limited, and outcomes are optimal.

Comments from **Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission**

From February 17 to March 18, 2026 Comment #136

Jodi Lamoreaux (not verified)-*Feb 20, 2026 08:33 AM*

The RCS policy unit has received multiple questions about physician/PA roles and responsibilities when managing pain management medications for nursing home residents who are also involved with opiate addiction treatment programs. Clarification about the need for communication between prescribing entities, prior to increasing or decreasing opiate medications, would be helpful. Thank you for your consideration.

Comments from Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission

From March 19 to April 23, 2026

JAMES ROTCHFORD... (not verified)-*Mar 21, 2026 09:50 PM* Comment #138

As soon as the specifics of the practice of medicine become codified in WACs or RCW the unintended consequences are what we have seen with the pain rules. The best medical care will remain individualized. The above comments by other respondents testify to the same, let alone the overt evidence of increased morbidity and mortality from poorly managed pain. Opioid overdose rates have increased since the pain rules were instituted. I consider the Pain Rules a Public Health debacle. While ignorance remains high and education regarding COAT is essential, the primary ignorance is assuming that patients with chronic pain have only structural issues or are simply drug seeking. Grievously, when patients are not responding to standard interventions and tend to benefit from COAT, we culturally take on a moralistic stance and "preach" behavioral approaches or encourage ongoing procedures that are traumatic and often have been therapeutically unsatisfactory, and in some cases make pain management worse. It is clear that access to adequate behavioral and complementary support is woefully inadequate, even for some who are wealthy. For those on state insurance or who live in rural areas, it remains disingenuous to assume patients will have adequate access to intense and adequate behavioral, psychiatric, and complementary support to adequately and effectively mitigate pain. When a high-level certified pain specialist at a Seattle Pain Clinic is unaware of what an OTP is and assumes that all patients should be tapered off of opioids, regardless of a patient having a moderate to severe opioid use disorder, we have a "system" problem that has only been exacerbated by the pain rules. Already, there are a few financial incentives to care for complex pain patients when procedures are not the answer. By increasing the obvious liabilities through such measures as the pain rules and other regulatory measures, it is no wonder that colleagues and pharmacies are not inclined to prescribe or dispense opioids, sometimes with dire consequences in a subgroup of patients. As a long-time expert on the front lines nearing retirement, I have spoken with colleagues, and there are no potential homes for many, if not most, patients on COAT, especially for those who are on MOUD as well , even when the patients are stable and doing well by all objective measures and without adherence issues. This is most grievous and represents a serious Public Health concern. Why do we continue to assume a patient with chronic pain management challenges cannot have a comorbid OUD or other psychiatric issues warranting the best of care? Even some OTPs refuse pain patients because they only treat OUDs! This behavior is a direct consequence of our regulatory environment. Let us also acknowledge our

American moralistic inclinations when it comes to substance use and misuse, which I am sure have strongly influenced how we manage pain patients who benefit from COAT, let alone other scheduled medications. Of course, these medications warrant the best of professional oversight, yet let us also acknowledge the glaring prejudices and shaming that goes toward patients with comorbid SUDs and need MOUD, many of them with challenging social determinants. Even some of our state-sanctioned addiction services are adamant about getting people off of all medications. Fortunately, some have recently become "okay" with buprenorphine. Cultural norms about abstinence are understandable, but for a subgroup of patients, the evidence is overwhelming that they can be part of a safe and effective solution. Please abolish the pain rules as rules. If a physician is not providing professional care, let them be accountable as they have and should be and let's be vigorous in educating physicians about the evidence and longstanding biases against opioids and the undue financial incentives for promoting procedures. One man's food is another's poison and it is the same with opioids as well as procedures. Surprise? As a comparison it would be a disaster if we shut down hospitals or write rules with "criminal" implications about hospital admission, despite the serious and well-documented consequences stemming from hospital stays!

Mark Sullivan (not verified)-*Apr 01, 2026 12:58 PM*

Comment #139

These WA rule changes extend changes made in the 2022 revision of the 2016 CDC guidelines to favor individualized shared decision making. This article argues that this may not be adequate policy to promote opioid safety without concurrent dosing guidelines based on population-wide evidence: Sullivan MD, Linder JA, Doctor JN. Centers for Disease Control and Prevention Guideline for Prescribing Opioids, 2022-Need for Integrating Dosing Benchmarks With Shared Decision-Making. JAMA Intern Med. 2023 Sep 1;183(9):899-900. doi: 10.1001/jamainternmed.2023.2847. PMID: 37459113. Subsequent research has shown that more shared decision-making during chronic pain clinic visits is associated with more opioid prescribing: Licciardone JC, Van Alfen B, Digilio MN, Fowers R, Ballout B, Bibi Y, Aryal S. Impact of Shared Decision-Making on Opioid Prescribing Among Patients With Chronic Pain: A Retrospective Cohort Study. J Pain. 2024 Nov;25(11):104522. doi: 10.1016/j.jpain.2024.03.018. Epub 2024 Apr 12. PMID: 38615802. And with less opioid discontinuation: Licciardone JC, Digilio M, Aryal S. Shared Decision-Making and Discontinuation of Opioid Therapy for Chronic Pain. J Am Board Fam Med. 2025 Jun 27;38(2):275-289. doi: 10.3122/jabfm.2024.240290R1. PMID: 40578930; PMCID: PMC12616825. These studies suggest that shared decision-making is not a neutral strategy with respect to opioid prescribing. It is clearly associated with more opioid prescribing and less opioid discontinuation. In my opinion, shared decision-making is a good clinical

strategy. But it must be guided by population evidence-based dosing guidance to be effective at safeguarding opioid safety.

Nicole (not verified)-*Apr 09, 2026 11:10 AM* Comment #140

I have a genetic bone condition, osreochondroma's. Every bone in my body. Osteochondroma are bone tumors, they effect joint health and function, growth plates in younger years, they make physical movements difficult due to restriction and pain. Ostechondroma's has led to early onset of 3 different types of arthritis and stenosis. My femur do not reach my hip joints which makes walking, sitting, lying down difficult. While I was being treated for approx 12 years with a long acting pain opiod, a breakthrough opioid for unmanaged severe pain, I was physically active, and able to work and support my children after the death of my husband. I was healthy. Since 2016, my rheumatologist retired and I discovered that EVERY physician, specialist or not, profiled me as an addict and drug seeker. Now, my physical condition has deteriorated to bed bound. Weight gain of 120lbs+ due to inability to work, afford, and prepare healthy food. inability to even walk to my mail box. Often I'm faced with embarrassment and shame due to my inability to see to my hygiene, my home, my relationship with my adult children and my grandchildren has suffered tremendously. I am a shut away. I'm existing. I'm not part of life. I know of many people my age and older who consider ending life, purchasing illicit substances, which many feel are only alternatives to temporary pain relief. Doctor prescribed medications are not only safe but the care and medication supervision patients receive is humane. People who are aging grandparents have found themselves in dangerous situations and existing through life carrying labels they spent decades of life opposed to becoming part of such groups that are labeled as drug addicts, seekers etc... Every physician hands out anti depressants for pain. We all know that anti depressants take months to work, if ever. I don't understand why patients are forced to take the anti depressants or wear labels, only for their medical records to read, in a nut shell, the patient accepted longer suffering so they must not be suffering to the point of needing working medication. The limits (MME) placed on legitimate suffering patients is cruel because it's not treatment. It's doctors being careful that they are not targeted by DEA. suboxone is pushed on pain patients who have not ever had SUD. I will leave it to the intelligent people reading these comments to research what the active ingredients are in suboxone and how it works on pain receptors and why it was intended for SUD. Using my hands to create this comment has worsened my pain in my hands, wrists,, elbow, shoulders and neck. So now I need to end this prematurely. The rabbit hole of anxiety and depression caused by untreated chronic and severe pain is endless. Thank you for your time. Nicole Culp

From: thomas bertsch
To: Boyd, Amelia (WMC)
Subject: OPIOID PRESCRIBING RULES
Date: Wednesday, May 6, 2026 9:51:49 AM

Comment #141

External Email

THE COMMISSION RECEIVED A PETITION IN 2024? AND YOU ARE PLANNING ANOTHER SEVEN MONTHS OF DISCUSSION.
CHRONIC PAIN PATIENTS , LIKE MYSELF HAVE BEEN TORTURED LONG ENOUGH, WHEN WE HAD ALL OF OUR MEDICATIONS CUT OFF LONG AGO.
MANY HAVE TURNED TO SUICIDE AS AN ONLY ALTERNATIVE.
WE ARE SUFFERING DAY, AFTER DAY , AFTER DAY.
EACH DAY OS A STRUGGLE TO PUT UP WITHTHE PAIN WE ENDURE.
QUIT WASTING TIME, AS EACH AND EVERY DAY YOU DELAY YOUR ACTIVITIES, IS ANOTHER DAY US CHRONIC PAIN PATIENTS SUFFER IN AGONY!

THOMAS M. BERTSCH
CAPTAIN
CAL-FIRE
DISABILITY RETIRED
LONG TERM CHRONIC PAIN PATIENT

Virus-free.www.avast.com

UW Medicine
UNIVERSITY of WASHINGTON

May 6, 2026

To: Karen Domino, MD: Chair of Washingon Medical Commision
Rulemaking Commission members: Amelia Boyd, Micah Matthews

Comment #142

From: David J. Tauben, MD, FACP, ABPM

Re: Opioid Rulemaking: Current Ongoing Revision

My bona fides: UW School of Medicine General Medicine Residency, Boarded Internal Medicine and certified American Board of Pain Medicine, Fellow American College of Physicians; a 27-year career primary care practicioner in a large Seattle multidisciplinary clinic, then 15-years UW School of Medicine faculty member-- and while there, the Division Chief of Pain Medicine until recent retirement.

Twenty-eight years ago I had participated our earlier efforts to improve chronic pain management representing the Washington State Medical Association, along with other physicians practicing office-based Internal Medicine and Primary Care Family Medicine. With the best of intentions, albeit with limited evidence-base, I had promoted what subsequently proved to become a misguided 1999 WA State legislative rule that opened the floodgates of opioid prescriptions. We later discovered this was largely promoted and driven by strong drug-industry support[1]. By 2003 it had become clear that a torrent of prescribed opioids (increasing 500% from 1997 to 2006) led to an epidemic of overdose, misuse and addiction in our state and across the nation[2]. And pain relief was worse, not better.

In 2008, I was among those who participated in expert meetings –open and transparent to the public and patients struggling with an array of painful medical conditions. We included statewide outreach with primary and specialty care clinicians, pharmacists, scientific experts and health agencies, including but not limited to WA State Public Health epidemiologists, Department of Labor and Industries, Department of Social and Health Services, Agency Medical Directors Group and the Bree Collaborative. Deliberating for hundreds of hours, we developed medically proven appropropriate and compassionate patient-centered guidelines. We redirected attention from patients' opioid treatments, so to focus on best-practice multi-modal approaches for alleviation of pain, improved function and quality of life. We

[1]How Opioid Manufacturers Changed Medical Language to Foster Opioid Use. Medicine & Ethics 2026, https://doi.org/10.1017/jme.2026.10258
[2]Opioid Therapy for Chronic Pain. NEJM 2003 https://www.nejm.org/doi/10.1056/NEJMra025411
[3]2010 Washington State Rules *key points*: i) Opioid dosing criteria; ii) Guidance on when to seek pain specialty consultation; iii) Guidance on tracking clinical progress via assessment tools focusing on pain interference, physical function, and overall risk for poor outcome; and iv) Guidance on tracking adherent use of opioids.
[4]Flood of Opioids, Rising Tide of Deaths. NEJM 2010 https://www.nejm.org/doi/full/10.1056/NEJMp1011512
[5]Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: Systematic Review, 2015: https://doi.org/10.7326/M14-2559
[6]CDC Clinical Practice Guideline for Prescribing Opioids for Pain-US, 2022: http://dx.doi.org/10.15585/mmwr.rr7103a1
[7]https://doh.wa.gov/public-health-provider-resources/healthcare-professions-and-facilities/prescription-monitoring-program-pmp/opioid-prescribing/healthcare-providers/toolkits
[8] Opioid Epidemic in WA State: Milestones & Lessons Learned. AJPH 2015 https://doi.org/10.2105/AJPH.2014.302367

David J. Tauben, MD, FACP
Emeritus Clinical Professor
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initiated prescription drug monitoring to reduce misuse and abuse. We improved patient outcomes with lower doses, non-opioid medications and psychosocial and rehabilitation strategies.

By 2010, supported by accumulated data and extraordinary physician, nursing, and public health input and participation across Washington State, our statewide rules have since become the standard of care for opioid prescribing for chronic non-cancer and non-palliative care.[3,4,5] Since then opioid misuse and over-prescribing has led to reduced morbidity and mortality in Washington State, has increased quality and improved outcomes of Primary and Subpecialty pain management, and a healthier Washington State population. Our 2010 Washington State Rules, and our continuing updated revisions and improvements has remained the national model for an evidence-based approach to the role of opioids treating chronic non-cancer and non-palliative/end-of-life pain.[6,7,8]

Why then significantly undo what's proved to be working? The Washington Medical Commission is considering proposed new rules to remove barriers to opioid prescribing so as to ensure that they do not impose unnecessary restrictions. I urge that these revisions ***do not include***:

- "Clarify that stable and compliant chronic pain patients should not have their opioid medications reduced, tapered, or discontinued, as doing so may be harmful and fall below the standard of care."
- "Eliminate predetermined morphine milligram equivalent (MME) guidelines in prescribing decisions, emphasizing that neither Washington State nor federal law mandates specific dose, strength, quantity, or duration limitations."
- Add statement that physician must not refuse to initiate or continue opioids or deny care solely because a *patient is using* or has used opioids: *a major intrusion into medical practice!*
- Add statement that the Medical Practice Act of Washington and Commission rules *supersede any federal guidelines* relating to the practice of medicine or prescribing of opioids for pain control
- Modify "high dose" opioids from 90 MME to 120 MME *for which there is no evidence and worse outcomes.*
- Reduced requirement for use of *Prescription Drug Monitoring Program*, despite patient and community proven life-saving outcomes, due to *incidental opioid prescriptions by multiple providers, misuse, abuse, and diversion related opioid overdose deaths*.
- Prohibit actions against prescribers for "*inappropriate opioid prescribing"* (eg. prescribing solely based upon pain intensity scores) despite persistently poor function, mood and quality of life outcomes, and those with active and/or poorly managed addiction disorders without periodic urine drug testing.
- No requirement for seeking (*whenever available*) expert consultative support *(a basis for good medical judgement re when to consult)*, especially for patients on high-dose opioids and/or challenging dose tapers, those with active or previous addiction disorders and severe refractory painful diagnoses- such as sickle cell, active inflammatory disorders (eg. Crohn's, ulcerative colitis, rheumatoid arthritis), and other medical or post-surgical painful conditions. Experts may offer diagnoses and propose or provide other treatments that may well be available.

Do note that *current rules* currently and explicitly do not apply to cancer-related pain, palliative care and pain at the end-of-life.

Thank you for your attention and efforts to improve the health and lives of our patients.

Most sincerely,

David Tauben, MD

Comment #143

WashPIP proposed changes for 246-919-905: Patient evaluation and patient record – Chronic Pain
March 15, 2026

246-919-905: Patient evaluation and patient record – Chronic Pain:

(d) *Use of a risk assessment tool that is 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.*

Proposed Amendment language (If low, moderate, and high risk categories remain part of the prescribing rules.)

1. Risk assessment tools shall not include scores generated by automated decision-making systems or automated decision support systems.

Definition of Automated decision-making system
Definition of Automated decision support system

Medical Commission,

We are writing this in response to draft suggestions and verbal comments regarding risk assessment for patients on long term opioid therapy.

Risk assessment is already included in section 246-919-985. A risk stratification based on multiple factors, not primarily on dose, has been discussed in our workgroup meetings.

We are reiterating an earlier proposal due to the sudden shift of focus onto risk assessment for chronic pain. Risk for patients on long term opioid therapy remains at less than 1% for developing opioid use disorder. However, colleagues are doubling down.

Our concern lays predominately in the use of Automated Decision-making Systems or Automated Decision Support tools. Systems such as NarxCare pull data from the PMP or STORM sucking data from the PMP and EHR. If these tools are allowed to determine risk among patients, 'less-is-better bias' in opioid risk predictive algorithms will always target patients with complex medical conditions who have higher MEDs, lengthier prescriptions, multiple pharmacies, longer distances travel to providers, treatment with more combinations of medications, and multiple surgical interventions requiring multiple opioid prescriptions. [2]

In the context of the use of risk assessment tools, we ask for automated decision systems and automated decision support systems to be excluded as a valid risk assessment tools. This means any algorithm, including one incorporating machine learning or other artificial intelligence techniques, that use data-based analysis or calculations to support clinical decisions.

When practitioners are required by law to conduct risk assessments for patients in the chronic pain category, and ADS is available to quickly generate a risk score from undisclosed algorithms, it will undoubtedly interfere with provider action and patient health.

"The algorithm is set up to convince clinicians that care of anybody with more serious illness represents the greatest possible liability. And in that way, it incentivizes the abandonment of patients who have the most serious problems."
- Stefan Kertesz, a professor of medicine and public health at the University of Alabama at Birmingham. [3]

When we calculated the numbers a few years ago, according to an independent study on Bamboo's NarxCare algorithm, the false positive rate for high risk was 17%. Those patients were primarily disabled, had poor health, or were deemed as having increased levels of pain and pain interference. In WA, the high risk false positive number would be 70,000 adults with high impact pain denied appropriate care at their provider's office or at the pharmacy.

In order to stave off disaster, we are supporting the above language, or similar language if better stated, to section 246-919-985, Patient Evaluation and Patient Record.

Sources

1. Dosing Discrimination: Regulating PDMP Risk Scores, Jennifer D. Oliva, Feb. 2022
"The proxies that PDMPs utilize to calculate patient risk scores likely produce artificially inflated scores for marginalized patients, including women and racial minorities with complex, pain-related conditions; poor, uninsured, under-insured, and rural individuals; and patients with co-morbid disabilities or diseases, including substance use disorder and mental health conditions."

2. *The Pain Was Unbearable. So why Did Doctors Turn Her Away?* A sweeping drug addiction risk algorithm has become central to how the US handles the opioid crisis. It may only be making the crisis worse, Maia Szalavits, August 11, 2021

3. The ACLU is very concerned about the use of ADS in healthcare. They have written a white paper on the topic accessible through their following page.
Algorithms Are Making Decisions About Health Care, Which May Only Worsen Medical Racism

4. Even the United Nations Human Rights Council has been approached on the issue.
To the United nations Human Rights Council How AI and New Technologies Reinforce Systemic Racism

5. Travis N. Rieder PhD
6, The CA Society of Addiction Medicine wrote to the CA DOJ and CA Medical Board when NarxCare was implemented. They outline concerns about NarxCare from both the patient and provider perspective.
March 15, 2022, California Society of Addiction Medicine to the Medical Board of CA - *RE: Enforcement standards of care for opioid prescribing and management of chronic pain patients*

March 28, 2022, California Society of Addiction Medicine to CA DOJ- RE: *Appriss NarxCare/Bamboo Health PMP Clearinghouse* Implementation in California

8. The Center for U.S. Policy has submitted a Citizen Petition to Protect Patients under the Federal Food, Drug and Cosmetics Act to request the Commissioner of the FDA to deem Bamboo health NarxCare software a misbranded devise and take administrative action to prevent serious, adverse health consequences and death. The Center for U.S. Policy, Citizen Petition to Protect Patients, 28 April 2023.

9. Automated Decision-Making Systems Workgroup Report, Dec. 2021

10. Validation and threshold identification of a prescription drug monitoring program clinical opioid risk metric with the WHO alcohol, smoking, and substance involvement screening test, 1 Nov. 2021.

10. Opioid Prescription Dashboard, Washington Opioid Metrics, 2013-2023.

11. "The DEA would come in and destroy you": a qualitative study of fear and unintended consequences among opioid prescribers in WV, 10 March 2022.

Comment #144

High Impact Chronic Pain Exclusion: An elegant solution for the patients most affected by loss of pain care in Washington State

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Date: August 2, 2026
To: Washington Medical Commission
From: Washington Patients in Intractable Pain
Subject: Defining High Impact Chronic Pain and proposing an exclusion/exemption

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Chronic Pain defined by duration lasting greater than three months does not accurately describe the multidimensional nature of pain and its varying effect on all aspects of life, nor does it differentiate between those with debilitating chronic pain and those with less impactful pain.

A more accurate description would include the additional concept of high-impact chronic pain (HICP), supported by the National Pain Strategy. HICP incorporates both disability (activity limitations/participation restrictions) and pain duration. Those with HICP experience pain most or all days in the past three months and pain that interferes with life or work; activities on most or all days.

High-impact chronic pain is pain associated with substantial restriction of participation in work, social, and self-care activities for six months or more. National Pain Strategy; 2016

Identifying High-impact chronic as a unique type of pain validates special consideration when prescribing long term opioid therapy. The WA opioid prescribing rules should make that update.

The patients represented in the rule making public comments have one thing in common, they describe High-impact chronic pain. They describe loss of function, employment, enjoyment of life and request a return to individualized care.

High-impact chronic pain should

- First, be acknowledged,
- Second, defined
  Examples:

  High-impact chronic pain is associated with substantial restriction of participation in work, social, and self-care activities for six months or more.

  High-impact chronic pain is defined as the presence of pain on at least half of days in the previous 3-6 months with substantial restriction of functional participation in work, social, and self-care activities.

- Lastly, High-impact chronic pain should be added to the list of exclusions. High-Impact chronic pain is the constant in these patients, not the disease process or injury.

Rose Bigham
rosebigham@hotmail.com

Co-Chairs

Cyndi Hoenhous
cynhoenhous@gmail.com

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Steps must be taken for patients to regain their care. We are working from the perspective of "How do we protect these patients from the current culture of tapering, cessation, and inappropriate treatment, or nontreatment, of their pain? How do we encourage physicians to treat patients with complex pain issues like High-impact pain? Exclude High-impact chronic pain.

The National Pain Strategy has already created a one-page document to differentiate between patients with chronic pain, and those with high impact pain that is easy to use.

Patients who are benefitting from opioid therapy, compliant, and have no adverse reactions will not be "dangerous" to exempt. Science does not support the idea that large portions of patients on long term opioid therapy develop opioid use disorder or are overdosing.

Now that the data is clear, how do we repair the damage already done and prevent further inappropriate care? Can we have a meaningful discussion around exempting High-impact chronic pain?

Sources:

Prevalence and Profile of High-Impact Chronic Pain in the United States

Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023

Pain Management Collaboratory High Impact Chronic Pain (HICP) Recommendations

National Pain Strategy

© Washington Patients in Intractable Pain 2026

Comment #145

August 4, 2026

Washington Medical Commission

Re: August 10, 2026 Workshop Comments

Dear Members of the Washington Medical Commission,

Thank you for the substantial work accomplished throughout this rulemaking process. I appreciate the Commission, staff, physicians, patient representatives, and stakeholders who have dedicated significant time and effort to improving Washington's opioid prescribing rules.

The June 3 revisions and the August 10 workshop materials reflect meaningful progress toward individualized, patient-centered care. The evolution of these draft rules demonstrates that patient safety and individualized treatment are complementary goals. Many of the revisions adopted throughout this process better reflect current medical practice by recognizing that numerical dosage thresholds cannot substitute for sound clinical judgment. I particularly appreciate the Commission's recognition that stable patients should not be tapered solely to satisfy dosage thresholds and that treatment decisions should remain clinically individualized.

After reviewing the August 10 workshop materials, I have limited these comments to the provisions scheduled for discussion and the related issues that directly affect their implementation.

To avoid repeating the same recommendation across multiple WAC sections, I have organized these comments around the underlying clinical principles they address rather than by individual rule section. Where appropriate, I have included suggested regulatory language that may assist the Commission during its deliberations.

Patients with Progressive Disease

Applicable to WAC 246-919-900, WAC 246-919-905, and WAC 246-919-930

Patients with progressive, degenerative, incurable, or medically complex conditions may experience worsening pain, declining function, or a need for dosage adjustment because their underlying disease is advancing, not because opioid therapy has failed or become inappropriate.

As the Commission considers revisions to WAC 246-919-905 and WAC 246-919-930, I respectfully request clarification that disease progression should not be interpreted as treatment failure when physicians evaluate ongoing treatment, consultation needs, or clinical benefit.

To promote consistency throughout WAC 246-919-900, WAC 246-919-905, and WAC 246-919-930, I respectfully offer the following:

Suggested Regulatory Language:

"Progressive disease, worsening pathology, or deterioration in function attributable to the natural progression of an underlying medical condition shall not, by itself, constitute justification for tapering opioid therapy, discontinuing treatment, refusing treatment, or requiring specialist consultation."

Individualized Clinical Decision-Making

Applicable to WAC 246-919-900, WAC 246-919-905, and WAC 246-919-930

I strongly support the Commission's recognition that MED/MME values should inform, rather than replace, clinical judgment.

I support specialist consultation when clinically appropriate. However, consultation should be driven by clinical complexity, diagnostic uncertainty, significant safety concerns, evidence of diversion or misuse, active substance use disorder, or a physician's request for specialist input rather than by a numerical MED/MME threshold alone.

I respectfully recommend that this principle be applied consistently throughout consultation requirements, clinical assessments, treatment planning, and ongoing patient care.

Clinical assessments should document demonstrated patient benefits as thoroughly as potential risks. Physicians should consider functional outcomes, quality-of-life improvements, treatment stability, individualized goals, and a patient's response to previous therapies. Documentation requirements should support sound clinical judgment without creating unnecessary barriers to appropriate patient care.

Suggested Regulatory Language:

"A patient's morphine equivalent dose (MED/MME) alone shall not be the sole basis for requiring specialist consultation, altering a treatment plan, tapering or discontinuing opioid therapy, refusing to prescribe, or dismissing a patient from care when the treating clinician determines that continued opioid therapy remains clinically appropriate and the patient is stable and adherent to the treatment plan."

Continuity of Care

Applicable to WAC 246-919-900, WAC 246-919-905, and WAC 246-919-930

I continue to support continuity-of-care protections that ensure patients receiving long-term opioid therapy are provided reasonable notice, appropriate referrals, transition planning, and safeguards against patient abandonment whenever treatment is modified or discontinued.

Physicians who determine that opioid therapy should be modified or discontinued remain responsible for facilitating an appropriate transition of care that protects patient safety and supports continuity of medically necessary treatment.

Suggested Regulatory Language:

"When a physician determines that opioid therapy should be modified or discontinued, the physician shall provide reasonable notice, appropriate referrals when indicated, and a clinically appropriate transition of care to avoid patient abandonment and promote continuity of medically necessary treatment."

Original Request for a Rare Disease Exemption

When I submitted my original petition in 2024, I requested that the Commission consider a rare disease exemption to protect patients from the unintended consequences of rigid opioid prescribing policies.

After reviewing the Commission's June 3 revisions and the broader protections now under consideration, I believe many of those concerns can be addressed through generally applicable safeguards rather than through a separate exemption.

My goal has never been to secure a specific exemption. Rather, it has been to ensure that patients with rare diseases, progressive conditions, high-impact chronic pain, palliative care needs, and other serious medical conditions receive individualized care guided by sound clinical judgment rather than arbitrary numerical thresholds.

I appreciate the Commission's willingness to engage physicians, patients, advocates, and stakeholders throughout this rulemaking process. The progress achieved over the past two years reflects a genuine commitment to developing opioid prescribing rules that protect patient safety while preserving individualized medical care.

The recommendations above are offered in that same collaborative spirit. I hope they assist the Commission as it continues refining these important rules, and I appreciate the opportunity to contribute to this process.

Thank you for your continued dedication to improving pain care for the people of Washington.

Respectfully,

Maria E. Higginbotham

Petitioner, Opioid Prescribing Rule Revision Petition

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Petitioner, Opioid Prescribing Rule Revision Petition

Outlook

Comment #147

Targeted WashPIP language changes for 9/28 WMC Rules meeting: 246-919-851 (Exclusions); 246-919-950 Tapering—Chronic pain

From Rose Bigham <rosebigham@hotmail.com>
Date Mon 9/21/2026 12:19 AM
To Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>
Cc cynhoenhous@gmail.com <cynhoenhous@gmail.com>

External Email

HI there, Amelia! Can you please include the following proposed language changes in the meeting materials you'll be circulating for the 9/28 meeting? Anything highlighted is new verbiage or contains tweaks to existing verbiage.

1. (Page 11): **WAC 246-919-851 EXCLUSIONS** <these other WACs do not apply to>

   1) The treatment of patients with cancer-related pain;
   a) This includes cancer-related pain which may persist past the treatment phase and into the remission phase.
   <…>
   4) **The treatment of patients with chronic non-cancer pain, where the patient is compliant with treatment plans, and treatment plans demonstrate ongoing benefit.**

2. (Page 58): **WAC 246-919-950: TAPERING CHRONIC PAIN**

   Not all patients with chronic pain will need their opioid prescriptions tapered. The decision to taper should be based on compliance with treatment plans and written agreements, patient outcomes regarding pain and function, and a consideration of risk versus benefit.
   1. **If tapering is initiated, the reason for tapering shall be documented in the patient record.**

Please do let us know if you have any questions? Thanks so much!

Respectfully,

- Rose Bigham, Co-Chair, Washington Patients in Intractable Pain
- Cyndi Hoenhous, Co-Chair, Washington Patients in Intractable Pain

WashPIP is a patient advocacy group which liaises between state healthcare/policy organizations and patient populations to help improve patient outcomes and the quality of healthcare in Washington state.

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Comments from [Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission]

From April 24 to September 20, 2026

Anonymous (not verified)-*Aug 23, 2026 06:09 PM*

Comment #148

I am a Washington resident who has lived with chronic pain for many years. I am commenting anonymously because, quite frankly, I worry about what could happen to my medical care if I put my name on a public comment about opioid treatment. I have taken prescribed opioid medication responsibly for years. It is not a cure for my pain, but it helps enough that I am able to function and have a better quality of life. Recently I went through a trial reduction of my medication. I learned very quickly what a difference that medication was actually making. My pain became much worse, everyday activities became harder, and my quality of life went downhill.When I returned to the dose that had been working for me, I was able to function much better again. What makes this especially frightening is that I am currently facing the possibility of further reductions in medication that is still helping me, even after experiencing firsthand how much worse my pain and function became when it was reduced. I do not know whether treatment that has allowed me to function will continue to be available to me, and living with that uncertainty has caused a tremendous amount of stress. There is another part of this that I believe the Commission needs to take very seriously. For some chronic pain patients, the consequences of losing effective treatment can go far beyond increased pain.The FDA and CDC have both warned about serious psychological harm associated with rapid opioid reductions or discontinuation, including suicide risk. There are patients who can become desperate when medication they have relied on to remain functional is reduced or stopped. No patient should ever be pushed toward that kind of desperation by a policy that treats everyone the same instead of looking at the individual person. That is one of the reasons I feel so strongly about these rules. I understand that opioids have risks. I am not asking the Commission to ignore those risks or to say that every patient should remain on opioids forever.I am asking you to recognize that patients are individuals, and that reducing medication also has risks. If a patient has been stable, takes their medication as prescribed, is benefiting from it, and is not showing signs that the treatment has become unsafe, why should that patient be forced to reduce it simply because of a number, a clinic policy, or a general rule? Before reducing medication that has been working, I think there should be a very basic question: “What has changed medically with this particular patient that makes staying on the current treatment more dangerous than tapering them?” If there is a medical reason, then of course the doctor and patient should talk about it. But if nothing has changed medically, I do not believe a stable patient should be made to suffer because of an arbitrary dosage

limit or a policy that does not take the individual patient into account. Please make sure the final Washington rules CLEARLY protect doctors' ability to treat chronic pain patients as individuals.Please also protect stable patients from forced or unnecessary tapers when their treatment is working and the benefits continue to outweigh the risks. Doctors should be able to use their medical judgment without being afraid to continue appropriate treatment, and patients should be part of the decision about what happens to their own pain care! People living with chronic pain already have enough to deal with. We should not also have to live in fear that treatment that allows us to function could suddenly be taken away even though we have done everything asked of us. Please listen to the patients who actually live with the consequences of these decisions.

Bree West (not verified)-*Aug 23, 2026 10:12 PM* Comment #149

As a chronic pain patient, I have repeatedly faced the exact problems the Commission is examining: extreme difficulty finding doctors willing to treat chronic pain, forced medication reductions despite stable and responsible use, arbitrary dosage limits that ignore individual needs, and being turned away or abandoned by providers. Nearly every time I transferred care—after moves within Washington and to California and back to Washington—new doctors reduced my medication for no clinical reason, even though I was stable and the prior regimen restored excellent quality of life and function. These barriers flow from the misapplication of the 2016 CDC guidelines as rigid mandates, creating a climate of fear among physicians, pharmacies, and hospitals that continues to harm productive people, including veterans, and leaves many with untreated or inadequately treated pain and its devastating consequences. Washington can lead by explicitly protecting stable, adherent patients from non-consensual tapering, rejecting arbitrary dosage thresholds that override clinical judgment, prohibiting abandonment or refusal of care solely because a patient uses opioids, and ensuring progressive or complex conditions are never used as justification to deny treatment. Please give physicians, pharmacies, and hospitals the clear backing they need to practice patient-centered medicine without fear. The Commission has the opportunity to restore balance, prioritize function and quality of life, and set an example for other states.

Erika Morgan (not verified)-*Aug 23, 2026 11:22 PM* Comment #150

I was on opioids for multiple chronic conditions which, happily, went into remission. I was off for two years, which I did of my own free will, and no side effects. . My primary retired during this time, which meant I had to find a new primary and had no access to my specialists. Pain went up, and I turned to NSAIDs to function. Even with a new primary, I needed to find pain management --nevermind I have a history of duodenal ulcers from NSAiDs. By the time I found a pain management provider, I had a GI bleed. This meant I

couldn't keep my appointment…and things got even worse. I have since been ill and unable to work again for over six months. My diseases are out of control. I do not know when, if ever, we can get things back. I finally found a private pay provider who, following the rules of today, was willing to take me on with my conditions and assist me with pain management, so long as I follow everything needed. If I had not had that bleed because someone else could have helped prevent it with even tramadol, maybe I would still be working while my new specialists try to get my conditions back under control. I am happy to admit that there is a severe problem out there. But something needs to be done for chronic pain patients. Telling anyone to face neverending pain is barbaric. If opioids are off the table, then true, effective management MUST be found as a dire emergency. The lower level meds arent safe, either. Tylenol can get your liver. NSAIDs can make you bleed to death and fry your liver. I could have still been working with a little more support. But it wasn't there. And I've lost my independence in one fell swoop.

Jacqueline (not verified)-*Aug 24, 2026 12:24 AM* Comment #151

I had adequate pain relief when I lived in Texas. Because of this i had a job, friends, a nice home, I could garden, take walks, cook visit with friends, had a husband. Then in 2018 I moved home to Washington state to get medical care and be closer to family. That was the beginning of the end! I have multiple injuries, birth defects and illnesses. The medical field in Washington destroyed my life. I was no longer able to get the adequate pain relief medication I was in for over 10 years. I was unable to get adequate treatment for my lung issues and other issues!! I was treated worse than a dog and at best like I was a mentally ill drug addict. I have no mental illness! I have never taken illegal drugs of any kind. I don’t even drink. Or smoke! I have always been natural in treating my conditions until they got so bad that I needed medial intervention. Prescription pain medicine. Since I haven’t been able to get adequate pain relief I was unable not work part time. My husband of 20 years left me because I was in so much pain I could not function like before. I lost my home, my husband, friends, family, my pets and I am homeless now. When I couldn’t take care of everyone and everything I was useless to the people around me. My body deteriorated so fast and so bad that I now have multiple other serious health issues from the untreated pain!! I have lost muscles mass from not being able to get out of bed most days because the pain and weakness my injuries and disabilities cause since my lain medication was discontinued. I am 30 lbs underweight now. I’m 5’4 and weigh 86 lbs!! I have uncontrolled high bp and inappropriate sinus tachycardia, due to untreated pain!! Heart problems now. Advanced osteoporosis from not being able to move and use my body. The lack of care has aged my body beyond belief!!! I could go on and on how devastating it has been for me. The doctors are cruel and abusive!!! They try to dismiss, ignore, minimize, and bully. They give free drugs to people in the street but will not allow a person who has been responsible and

shown honest true character to have their lifesaving medicine. It’s sick and disgusting what doctors are doing to pain patients. It’s sick and disgusting what the dea and cdc have done to doctors and then pain patients!!!

Stephanie (not verified)-*Aug 24, 2026 01:29 AM* Comment #152

Legit. MultiCare just shut down their medical pain management department in Kent, Tacoma, and Gig Harbor on 8/12. Thousands of chronic pain patients trying to find new providers, who will actually prescribe what they need, in an already overburdened system. Absolutely terrible timing. I've been unmedicated for pain since the end of April for the first time in 14+ years. The only thing my PCP will prescribe is Meloxicam and Baclofen, which isn't enough. I tried Suboxone and Buprenorphine patch and they caused urinary retention and hesitancy so I had to quit. I was on 5-325 mg Norco for years but eventually it's not effective anymore unless you up the dose, which no one ever wants to do. So basically you have to keep switching meds every few years ago you don't build a tolerance, but then they label you as drug seeking when you just want to take the edge off the pain. Went to Olympia Orthopedic Associates and they only prescribe pain meds if you're in end stage cancer or just had surgery and only for 6 weeks if you just had surgery. Still waiting on referrals to be approved from my primary and now my pain management clinic is closed. *sigh* Something needs to change.

Pamela Taylor (not verified)-*Aug 24, 2026 01:39 AM* Comment #153

Thank you for this opportunity to share about my experience trying to treat chronic pain. Have several back issues on top of lupus and couple of nasty auto accidents that have left me in chronic pain. I am frightened every month that I see my pain management specialist that it'll be the last visit. Yes it is they are the last pain management practice in Pierce County. Every time that a pain management practice closes down this drives people out to the street to seek pain management this is what's feeling the overdoses that we are seeing. Well there once was an issue with people over prescribing the pendulum has swung so far to the Other extreme that we have people who are having knee replacements hip replacements and other major surgeries and they're being denied pain management! Instead they're told it's Tylenol only you're not in that much pain and suck it up not only is this dangerous but some of these various people involved in pushing this message are also being reimbursed by big pharma. When you're out on the pressure that most of our mega conglomerate healthcare systems put on top of doctors and other prescribers to not prescribe any opiates at all will you have even more people that are going out to the black market to treat their pain. This is in direct violation of various studies that were done that showed in treating people's pain they had less inflammation they had less risk of suffering a heart attack or stroke from the stress of the constant pain that they were suffering and

instead now we've gone back to here's a nice packing suck it up buttercup. Well someone who literally requires these medications so I can function it's frightening to see what's happening there doesn't seem to be any one who cares or wants to listen to The chronic pain patient. I don't have millions of dollars to contribute to anyone's campaign but I'll tell you this my life matters just as much as everyone else's and if I don't have these medications I cannot work if I can't work I can't keep a roof over my head if I can't keep a roof over my head I'll be out pushing a shopping cart. So I implore you please act today to preserve pain management is obtainable in every single County in Washington state because that is currently not the case I'm a member of a pain management advocacy group and every single day in our group we have hundreds of people coming who are looking for a new provider because they're provider either was pushed out of the practice or as was the case recently MultiCare decided to close their pain management practice in Tacoma and Lakewood which will now push all of those patients into my pain Management's provider's office and as it is I can barely get an appointment. Oh but that's not where the fun ends because once you need to go get your prescription filled that starts a whole another chaotic process you may have a pharmacist who doesn't want to fill your prescription or better yet the manufacturer isn't manufacturing your medication and then I also had United that was consistently harassing myself and my doctor and asking for additional notes and other mumbo jumbo needless things before they would okay the coverage of my prescription. This is unacceptable as I was left in bed for upwards of a week or more in agony and I'm not exaggerating I'm talking about living at a pain level 9 where I did not sleep I could not eat and all I could do was sit around and cry my eyes out and then call everyone to see if somebody bothered to get something faxed in so I can get some pain relief no one should have to live like this!!! As I pointed out to United healthcare if I was a diabetic who required insulin they would have gone to jail for what they did to me. But it's perfectly acceptable to rest pain patients we get ignored we get put on forced papers we get kicked out of practices.. or the practices completely shut down the level of suicides because of this occurring is sky High. I'm begging you to please listen to us and think about the people who are suffering. I have been in pain management for over 8 years and I have never once gone up on my dose not once. I've never lost my medication. I've never ever ever mis used my medication. So please stop penalizing me. I'm already waking up in my own personal hell everyday, it's called chronic pain!!

John Kaufmann (not verified)-*Aug 24, 2026 05:42 AM*

Comment #154

I am 62. When I was 20, driving to work a truck pulled in front of me on us 101. I was crushed to death, my heart stopped on impact, my right leg mangled with the bone sticking out of my jeans. CPR got my heart started again! I was airlifted to Seattle where they did a nine hour surgery to try to save my leg. Despite developing a blood/ bone infection, I kept

my leg. And after three surgeries and three years I taught myself to walk again (while enduring extreme poverty!). I have lived with constant pain for over 40 years. For many of those years I suffered. My family suffered our finances suffered. My dignity as a man suffered. When seeking help, I was stripped of what dignity I had left. Suffering seemed the only sure course! Then I found a doctor who could see my agony and understood the toll of constant pain, not only on the brain, body and spirit but on the trajectory and potential in life. Mine had been stunted! I was an ideal patient — compliant in all respects. I was stable for nearly TWO DECADES. He retired and the nightmare began. Being treated as if my humanity meant less somehow due to my suffering. Having to "prove" my pain is akin to a rape survivor having to prove they did not "ask for it"! Then came bi- weekly appointments AT MY EXPENSE and inconvenience. Pill counts. Ridiculous refill schedules with NO MARGIN OF ERROR (with withdrawal always looming). The anxiety around this was devastating. The pill counts. The urine tests (AT MY EXPENSE — imagine being in pain, a degraded, devalued human PAYING to prove you are worthy to not SUFFER!). Then came the reductions. First one med, then another. Then the forced taper. I am no longer a foster dad. I am no longer working at Habitat for Humanity, helping disabled people stay in their homes through the critical repair program that I was the lead repair tech for. I no longer volunteer. I no longer sing in church, lead children's church. I cannot play my guitar even. I am waiting to die. I lost my faith and no longer function in any productive function. What good am I? What is my value? Can you answer any of those for me, please? Can you look me in the eye and deny my humanity?

Comment #155

Kari Lehman (not verified)-*Aug 24, 2026 06:12 AM*

As a chronic pain patient managed on stable opioid medication for over a decade, I been repeatedly mistreated by various medical professionals, and as of last year had my treatment discontinued without warning or any tapering by the new owner of the clinic I'd been at for six years, who was NOT my normal provider and knew nothing about my medical history, solely based on his personal opinion that it wasn't appropriate for my age. It took me months to find another provider willing to maintain my stable dosage, during which I had minimal quality of life or ability to function. This type of judgemental behavior from healthcare professionals with no basis in medical facts causes irreparable patient harm and loss of trust, and should not only be advised against but carry consequences for providers who violate known best practices based on available evidence. Furthermore, there should be a return to primary care providers having more latitude for ongoing pain management, as they are by definition intended to be the primary clinician coordinating all aspects of patient care with the best understanding of the patient's full history and conditions. Corporate pain clinics operate on cookie cutter protocols with little empathy nor comprehensive view of the full situation. Referrals to specialists are appropriate when

interventional procedures are required, not for simple medication continuation, and no provider should ever be forced to choose between the best available care for their patients or protecting their own license to practice.

Stephanie L (not verified)-*Aug 24, 2026 06:50 AM* Comment #156

Pain patients and people that have surgery shouldn't be denied pain medications. Those that have chosen to go into the medical field take an oath, which includes do no harm. Denying pain meds to chronic pain patients is doing harm. Trying to function through the day in so much pain is cruel, trying to do daily tasks that cause severe pain then be judged by medical professionals when asking for medication that allows one to just live to be denied or accused of being a "drug seeker" shows a lack of education and empathy. Also showing our government and those sitting behind a desk are clueless to what chronic pain patients go through on a daily basis. "Tying" the hands and threatening medical professionals to help their patients IS cruel punishment for both. As the saying goes, a few bad apples ruin the rest.

Adrienne (not verified)-*Aug 24, 2026 07:29 AM* Comment #157

I was forcibly tapered off of my pain management regimen in 2013, after 8 years without issue. I have several chronic conditions that cause intractable pain, and because of the abrupt stop in my medications I was forced to deal with the chronic pain. I've been through many different treatments and therapy, but the deformity in my back is not responsive to them and continues to cause severe pain that limits my life, affecting my job, my family, and my overall quality of life. Opiates are safe and effective for treating chronic intractable pain. It is not fair to lump patients like me in with others who are addicted, opiates treat my pain so that I can have a better quality of life. The government regulations over opiates have swung too far, patients rights are being ignored We need to find a better balance where chronic pain patients are treated with dignity and get the care they need and deserve.

Anonymous (not verified)-*Aug 24, 2026 11:41 AM* Comment #158

I have multiple chronic pain conditions, I have had little to no management of my pain since moving to Washington in 2019. I am a disabled combat veteran and have spent the past year in debilitating pain due to delays in treatment options. They now refuse to do IV sedation for ablations, spinal injections which is pure torture, I've been lied to about policy restrictions, dismissed when needing my pain managed. When asking for management of pain, the response is "your treatment is scheduled in 8 months" that is unacceptable, inhumane and the urgent care and er do nothing because I'm a chronic pain patient other than offer medication I've already failed repeatedly. They over state the risks of opioids, which I tolerate well, have no desire to be on anymore than necessary and don't give me a

slew of side effects, while ignoring the risks of not managing my pain. I'm limited on options due to lacking enzymes to process most medications without experiencing severe side effects so my options are very limited. Recently I had to endure test injections and ablation while hypersensitive, nothing but lidocaine which made an already painful procedure exponentially worse. To top it off, they blame my hypertension and activity level on me despite post procedure demonstrating a significant drop relative to my pain. How am I supposed to stay active when I am incapacitated by pain? These are not personal failings, it's a deliberate choice to ignore my suffering for sake of a problem I am not participant to nor has anything to with. The lack of dignity, the gaslighting, the outright disdain that is shown towards people in my position is disgusting.

Kelly Elson (not verified)-*Aug 24, 2026 01:24 PM* Comment #159

At one time I would say I am speechless the idea that you folks would stop working on this rule at the end of 2026. I guess for those in charge, to ask that the people who are in charge of changing/making amendments to this rule would be actual Chronic Pain Patients who actually walk the walk 24/7 living with chronic pain and how your decision making affects every aspect of our lives would be to easy. I have been a pain patient since 2008 in NC until moving to Washington in 2022. At that time working in the Healthcare field, I had no earthly idea what a "pain mgmt provider was" before being thrown into that world as a chronic pain patient after a life altering injury. I soon realized it was a very profitable business for anesthesiologist. The stigma associated with taking pain medication along with the stigma associated to the scarlet letter of being a CPP has not changed. We are treated as 2nd class citizens, labeled as drug seekers, found acceptable that after outpatient surgery to be discharged in severe pain where as other patients the nursing staff strives to get their pain score around 5-6 before sending them home. I have yet to find a provider who is not an anesthesiologist to manage my pain meds. Despite voicing my concerns repeatedly about taking buprinorphine long term and not providing adequate pain relief, they always send in the same prescription month after month, now they charge my insurance $250 for a 10-15 minute appt every month, and triple that amount for the UDS. What other kind of patients are treated the way we are by providers just to get a refill on our meds. They threaten you with pill counts, then randomly once or twice a year when they call you and say you need to come in today for UDS/pill count and if you can't in their time frame you are discharged, if you dont' agree to an epidural/SCS, then you are seen as a non-compliant patient and they will stop prescribing to you. Chronic pain patients desperately need an Advocate in our Corner, please live up to that Hippocratic Oath you swore to and continue to work in this rule

Kathy Jo (not verified)-*Aug 24, 2026 01:43 PM*

Comment #160

8.24.2026 - My son has profound disabilities and a rare genetic disorder. He went to one of the pain clinics locally. They basically forced needles and procedures onto him vs treating his pain. They counted pills and because he couldn't urinate on command in a cup they forced us to wait hours until somebody could draw his blood or we had to drive 45 minutes to another clinic for the blood draw. This pain clinic was more like a law enforcement agency. There was no empathy. The NP we saw pulled out a NarxScore and was totally rude and mean about his medications and his score. He is 32 and has generalized tonic clonic seizures. He takes Onfi For seizures and has VALTACO for a GTC over 3 minutes. The pain clinic treated us horribly. We were guilty and given no chance to be innocent. We were 1 pill short once and at the same time were another 1 pill over. She acted as if we had committed a felony. When medications are administered through a gastrostomy tube or Jejunostomy tube there can be accidents and there was and we had 2 staff initial and document this. The 60mL en fit syringe was stuck and to eliminate the bubbles all the meds were pushed out onto the floor. Accidents 1 time were unacceptable. This is incompatible with humans- as we always make mistakes as there are no perfect humans. The pharmacy forced us to get Narcan that has never been used. We are constantly waiting for Walgreens to get the medications in because there are always "Out Of Stock". Even palliative care - doesn't want to take my son because he is using opioids to treat his pain. PALLIATIVE CARE !!!!! They don't want to use opioids in palliative care. People in pain are being treated horribly from all fronts. Please stop allowing doctors and nurses and pharmacists from hurting and harming patients. It's a sad time when doctors want to prescribe assisted suicide because you're in pain- BUT NOT- effectively treat your pain with opioids. Please fix this issue. Thank you -

Brenda Dunn (not verified)-*Aug 24, 2026 03:43 PM*

Comment #161

I have been in chronic pain for over 25 years. My pain was being controlled post Covid then all of a sudden I was cut off everything I almost unalivemyself. I was in horrible shape. No one would prescribe no doctors no neurologist no pain clinic nothing I suffer every day. Cannot live. Cannot do for myself. It is not fair. When opioids can control the situation, please do something to help us million of pain patients. I end up having back surgery. I have rods and screws and now one of the screws is broken and still no doctor will take me seriously of how much pain I am in. Please overlook our situation. We are not addicts. We only want to live a normal pain-free life. Thank you.

LD (not verified)-*Aug 24, 2026 05:47 PM*

Comment #162

I've been stable for years with my existing treatment. I get a new pain management doctor and he has decided to redo my entire treatment plan. I barely function as it is but I have

been getting to choose 6 hours a day with manageable pain to work, care for my home and family, and to sleep at night. He said I'm not allowed to have any sleep medication at all, and that with my injections, "hopefully" I'll slowly be able to sleep again in the future. I specifically requested non-hypnotic not controlled medication to assist with sleep to avoid asking for an increase in my pain medication. It was clear it was about control and liability, instead of patient care. I have had 5 surgeries, 20+ injections over 20 years, 3 x radio frequency ablations, nerve blocks, and a spinal cord stimulator that malfunctioned, was removed, and made my chronic condition exponentially worse. In my first spine surgery, I got MRSA from the hospital that caused subsequent revisions and heavy scarring. I've done pain psychology and while it has its place in hope, it does not replace compassionate and adequate care. My medical history is completely disregarded and am being told I now have to have more injections and not sleep to continue the subpar care I currently receive. The alternative is to discharge where I'm being treated poorly and like a criminal on probation or suffer. That might end up not being able to maintain gainful employment and daily functioning. All research shows sleeping and eating healthy contributes to less inflammation. A physician wants me to decompensate physically so he can say I'm not high risk? I'm also aware of the prescription tracking. Last month I was told to find someone else to address sleep, so I did, but apparently the discouragement by suddenly stopping medication was supposed to be a deterrent for the "risk" that is suddenly a "concern." I was told I cannot get sleep addressed at all and I had to agree to the current treatment plan or receive no treatment at all. I asked my primary to take over, they declined. It's not a matter of competence but it is a lot of extra work required to simply treat someone and it risks their license despite my MME is 12 per month. I'm not physically dependent on my medication but with the new scare tactics, policy is mistaking quality of life for addiction. I depend on medication for going to work full time, caring for my family and my home. Which is the entire point of pain management. Don't sleep but feel better with more steroid and lidocaine injections? I asked him how long it will last and he didn't even respond. He waved his hand at me because he was using dictation software and didn't disclose it. Physicians typically tell you when you come in. Being disrespectful sets a tone. I have had these conditions starting in 2006. So 20 years of regular healthcare and I've never been treated so poorly as I have the last three months. Many people have experienced this at pain management patient mills with adverse reactions to "treatment" but are told it's their own fault. For what? To control agonist opioids for an overdose epidemic that is actually caused by illicit street fentanyl? Harming patients has not had a significant impact on the houseless or addicted populations, giving naloxone had a better effect. Trauma informed care and actually listening to people is not that hard. It's also not hard to follow the archaic discriminatory practices that are in place without treating people like they are less than human. We don't need to return to high MME to ensure people

receive adequate care with spine injuries, hospice patients, cancer patients, palliative care patients, and not subject them to forensic monitoring, humiliation, and scare tactics that has just subjected people to undue suffering. I'm afraid to get older in Washington state. I am afraid that I'm going to be in worse pain than I'm in now and won't be able to function anymore in my life. I don't even know what to do as I've never experienced this level of gaslighting and disdain. Does reporting people to the medical commission even do anything? I'm guessing that it won't change how this person treats me or other patients. Besides a policy change, messaging around care needs to get to physicians as everyone is afraid right now and you've given bad actors the e means to abuse patients under the premise of care.

Lilith (not verified)-*Aug 24, 2026 08:06 PM* Comment #163

I reported to the medical commission about an er doctor on a different topic (left a lot of my complaints and symptoms out of the chart, and basically excused me but still provided the antiviral medication I requested) It's almost useless...most pain clinics have the interventional doctors now. I got lucky my interventional pain doctor never pushes for a repeat of an esi or anything...but he doesn't prescribe pain medicine. I got lucky with a clinic in Idaho that treated me okay, though we had to stay around the 40-45mme... But I got tired of the hour long drive there and back every month. My doctor put me on the butrans patch, which minimally helped but any acute injury or flare I had I was treated like a drug seeker and given toradol and steroids on top of the copious amounts of Tylenol and ibuprofen I was taking. Mind you I have medullary sponge kidney and nsaids really take a toll on my kidneys, I am now experiencing more kidney and ureter spasms. After my second neck surgery (revision from ADR to ACDF) my neurosurgeon had me on and XR twice a day and immediate release every 4 hours. I was up to a 75mme and stayed there until pain management dropped me to 52.5 me, and I was tired of swallowing all the pills. It's one big vicious cycle. I didn't even get treatment (outside of Tylenol, Ibuprofen and a medrol dose pack) after I had general anesthesia to pull all 13 teeth I needed pulled at once, due to being on the butrans patch. For those of us truly in chronic pain, opioids even in smaller doses can make a huge impact on our lives, we are able to get out of bed, play with our kids, take care of ourselves and our families....some are even able to maintain their jobs. Not everyone benefits from buprenorphine, ssri's, gabapentinoids, esi injections, or basic Tylenol and ibuprofen. Most of us have co-morbidities they are contraindited for nsaids, and sometimes Tylenol for that matter. We shouldn't be left behind, to suffer, commit suicide, resort to anything we can find to help the pain so we can function like every one else. We have rights to.

Alex (not verified)-*Aug 24, 2026 09:20 PM*

Comment #164

I moved to WA recently and started a career as a caregiver. I was hoping to restart my life on my own after escaping an abusive situation. I have chronic pain from arthritis and hypermobility. I also have a lot of GI issues and can't do NSAIDs. I have been through countless rounds of PT and all sorts of procedures. The best thing that has controlled my pain is a synthetic opiate at the lowest dose. It is not addictive and I've used it for years, often skipping days with no issues. I get no "high" from it, only pain relief. My previous pain management docs had no problem prescribing it to me because it worked well with no side effects. It was a lifesaver. After moving here I cannot find a doctor to prescribe it. I can't even find a pain clinic that will accept me, because my case is "too complex". I'm in pain all the time. I have had subluxed ribs for months. I'm burning out and may have to move back to the Midwest soon because I can't get the medication that helps me through my worst pain flares so I can function and stick to my PT routines. I've accepted that I'll never be pain free; I just want my pain reduced enough to be functional so I can work and support myself. The state I'm in and have been forced to be in because of the arbitrary rules here is inhumane and barbaric.

Michelle VanDeSteeg (not verified)-*Aug 24, 2026 10:47 PM*

Comment #165

As a 33yr chronic pain patient, I've had 1 primary care dr move out of state, a 2nd decide I was over medicated & sent me to a pain clinic who reduced & changed my medication without even discussing it with me, my pharmacist did, i ended up in the er from withdrawals, had an a horrible allergic reaction. I spent 4 day's in rhe hospital, pain medication was changed back to my original medication. I went back to the pain center at my next appointment to have my medication cut in half and changed again.. this happened at the next 6 appointment's, i went once a month, 9 medication changes, dose cut in half only to end up in the hospital 7 months in a row did they finally put me back on oxicotton. I found a new primary care dr who took over my pain medication when the pain center closed in 2016 at the beginning of the so called opioid crisis... once again I was sent to a different pain center with the promise that she would explain what i went through at the last pain clinic. We'll the same thing happened only this time my medication was charged, 1 dose taken away & the other 2 cut in half, that's just 1 medication the other 2 were completely taken away, now 10yrs later i don't have the same quality of life i did 10yrs ago. I'm really tired of the government overstepping in my medical care, that should be between me & my Dr... i used to have a job, i don't now, i can't walk for more than 45min to 1hr, sitting is just as bad... can we just please get treated as a person

Rebecca (not verified)-*Aug 25, 2026 12:43 AM* Comment #166

I live with degenerative disc disease, lumbar foraminal stenosis, cervical spondylitis with a bone spur, Ehlers-Danlos syndrome/hypermobility, pelvic tilt, and significant chronic hip pain with popping, catching, and a suspected labral tear from a previous wreck. These aren't vague aches and pains. They are structural and connective-tissue problems that can make ordinary daily activities hurt. There are days when something as basic as standing long enough to brush my teeth, making myself something to eat, showering, cleaning my house, or simply trying to participate normally in my family's life becomes difficult because of pain. And yes, I've tried other things. I'm currently taking Cymbalta for chronic pain. I've been prescribed muscle relaxers, but I hate the way they make me feel. I've also gone through injections that were extremely painful themselves and, in my experience, didn't provide meaningful relief. Yet people with chronic pain are increasingly treated as though asking a doctor for effective pain control automatically makes them drug-seeking. There has to be a middle ground. I am not advocating reckless prescribing, pill mills, or handing opioids out without appropriate medical oversight. I'm advocating individualized medical care. If someone has documented painful conditions, has tried reasonable alternatives, understands the risks, is appropriately monitored, and their physician believes an opioid medication improves their ability to function, why should politicians, blanket policies, stigma, or fear prevent that doctor from treating their patient? Addiction is real and deserves compassionate treatment. Chronic pain is real too. Protecting one group should not require abandoning another. Pain patients shouldn't have to prove their morality every time they say, "I hurt." We shouldn't have to live at an unbearable pain level simply because a medication that may help us can also be misused by someone else. The goal of medicine shouldn't be "no opioids at any cost." It should be the safest, most effective treatment for the individual patient, with appropriate safeguards and informed consent. Some of us aren't asking to be high. We're asking for enough relief to get out of bed, take care of ourselves, make dinner, spend time with our families, and have some quality of life again. There is a difference between preventing opioid abuse and preventing legitimate pain treatment. We need to be able to talk about that difference without treating every chronic-pain patient like a potential criminal.

Vanessa Howell (not verified)-*Aug 25, 2026 03:35 AM* Comment #167

I have been chronically in increasing pain for the last 8 years or so. I have CRPS, fibromyalgia, rheumatoid arthritis, back problems, and a lot of health issues. I have seen the immense damage done to patients when they are wrongly labeled a drug seeker for asking for help, as well as the continued war on production of pain medication. It is much less effective than a few years ago. Doctors are scared to lose their license and often don't

have enough pain management training. Last year, my gallbladder was so full of stones and I was so symptomatic. I had episodes of severe malnutrition and vomiting etc. The ER turned me away 3 times without any help and by the time I got it out 5 weeks later it was near rupture and I could have died. Hospice patients, people with sickle cell, and cancer desperately need access to pain medication, as do the rest of the population who need it and get cared and evaluated properly. The war on drugs has done nothing but make them worse and legitimate patients are suffering deeply. I will literally euthanize myself if access to my pain medication is stopped because I can barely function as it is. Pain control allows me to eat, sleep, be there for my children, sometimes do household chores, and self care. Please increase the supply and efficacy of pain medication to where it used to be, and stop ridiculous guidelines on how much someone is supposed to take. Please stop the DEA from going after doctors who work in good faith. And please focus your energy on relieving suffering, not causing more. The rules at my pain clinic are extremely strict and if there were issues, I'd likely be discharged. I'm on parole without doing anything. Please have compassion for us- we are parents, children, the elderly, disabled people, people with chronic illnesses, etc. Life is hard enough without worrying about every monthly refill, insurance issues, prior authorizations, etc. Thank you.

Jackie Melcher (not verified)-*Aug 25, 2026 11:41 AM* Comment #168

I'm a chronic pain patient. Patients are suffering from lack of individual treatment where their outcomes matter. We are being forced into "one size fits all" treatment and our outcomes and our health and function are no longer important. Different people metabolize and absorb meds differently. Please return our care. Please track the outcomes for patients.

Debra Nolan (not verified)-*Aug 25, 2026 12:24 PM* Comment #169

We have normalized the Barbaric treatment of one health care condition. Stigma, unreasonable rules and regulations for patients to get treatment. This must stop. It is blatant discrimination. People in pain are human beings that have a body that is broken. They live in constant pain. No reputable professional would ever tell someone that requires insulin what maximum dose they can have. That they must agree to invasive procedures to get insulin or do urine screens to make sure they are taking their insulin. We have normalized the suspicion towards people that need Opioid medications to live. All patients have been looped in as " addicts" ins9 of pain patients. This madness must stop. People are unaliving themselves. It is causing PTSD in patients just trying to get treatment. There are rules at the doctors office, the pharmacy, non FDA approved epidural injections are for Ed on pain patients. We are not a cash cow we are human beings. When did we normalize torture? Discrimination? When did the sacred doctor patient relationship become a parole

interview and testing? This must stop. Not one of these draconian rules and regulations have done anything to lower addiction rates. Yet it has terrorized patients. Doctors are afraid to treat us because of fear of losing their license. When will some adults rise up and stand up to the addiction medicine industry that has tried to loop every patient as addicts? When will we stand up to discrimination and remove the criminalization of pain treatment. It isn't a crime to have CRPS, fibromyalgia and many other painful diseases. Yet you treat it as a crime. It's time to stop it before more people die or are harmed. People are being harmed. Yet don't physicians take an oath to " do no harm"? You can't in say they are protecting the public from addiction because study after study proves pain patients under a doctor's care have a very , very low chance of becoming addicted. Stop the madness. It isn't a crime to be in pain. It shouldn't be a crime for our doctors to treat pain. Stand up to the rogue DEA and the rogue addiction medicine industry

James Edwards (not verified)-*Aug 25, 2026 12:25 PM* Comment #170

Every doctor, healthcare professional, DEA agent, DOJ agent, or anyone else who has participated in this as I call it this legalized premeditated murder campaign against good Americans many through no fault of their own r being systematically marked for death and everyone involved should be doing life in the deepest darkest prison known to man! I personally have had my jaw slashed open 6 times and the only medication that helped it was a mild dose of a benzodiazepine called lorazepam!! But, try getting it prescribed by a doctor! They r all scared to death and I've been told this personally to my face by 2 doctors that said they were afraid of losing their license!!! Someone needs to stop this! What freaking country am I living in today when 25 yrs ago I was given both lorazepam and oxycodone together! Try getting that today and you r lucky u dont wind up in freaking jail! YOU, r drenched in the blood of Americans that have offed themselves because of their inability to get proper pain treatment!! This is a scam just like the covid pandemic was and everyone keeps their mouths shut except for those of us that r fighting for quality of life!! You all should be ashamed and shunned from society as far as I'm concerned!! But don't worry, they're coming for u and your family members real soon!!!

kasey hadd (not verified)-*Aug 25, 2026 12:29 PM* Comment #171

"Will you introduce or support a Washington State version of Illinois HB 5373 / Public Act 103-1064 to protect chronic pain patients and allow doctors to use individualized medical judgment instead of rigid opioid dosage limits?" I do think people in pain deserve care, dignity, and doctors who are allowed to use their judgment. I am writing to urge you to support patient-centered healthcare policies that prioritize compassion, evidence-based treatment, and harm reduction programs for individuals living with substance use disorder (SUD) and those who face dependency challenges. Every person deserves the dignity of

care that meets them where they are—not where we wish they were. Too often, patients are forced into systems that stigmatize, punish, or deny them adequate treatment. This approach does not heal people, it harms them. Dependency and SUD are complex medical conditions, not moral failings. Just as we would not shame a cancer patient for needing chemotherapy, we should not shame or abandon patients who require medication-assisted treatment, pain management, or other forms of support. Why harm reduction matters: • Harm reduction programs save lives by preventing fatal overdoses, reducing the spread of infectious diseases, and connecting people to healthcare and recovery pathways. • They do not "enable" drug use—they enable survival. Without survival, there is no opportunity for healing. • Communities that embrace harm reduction see cost savings in emergency services, reduced incarceration rates, and healthier families. Why patient-centered healthcare is essential: • Patients thrive when their care is tailored to their unique needs, values, and goals. • Trust between patients and providers is strengthened when treatment is collaborative, not coercive. • Evidence shows that when people feel respected and heard, they are more likely to remain engaged in treatment and achieve long-term stability. As a community, we must choose policies that save lives, reduce suffering, and honor the humanity of every patient. Harm reduction and patient-centered care are not just strategies—they are lifelines. When we invest in these approaches, we invest in stronger families, healthier neighborhoods, and a future where healing is possible for all. I respectfully ask that you support legislation and programs that expand access to harm reduction services, ensure adequate pain and dependency care, and promote patient-centered practices across healthcare systems. The lives of our neighbors, our friends, and our families depend on it. Thank you for your time, your leadership, and your commitment to creating a healthier, more compassionate world. Will you introduce or support a Washington state version of Illinois HB 5373 / Public Act 103-1064 to protect chronic pain patients and allow doctors to use individualized medical judgment instead of rigid opioid dosage limits?" Thank you for your support of this bill Kasey Hadd she/her Pain & harm reduction advocate

Shelley (not verified)-*Aug 25, 2026 04:08 PM* Comment #172

My name is Shelley and even though this isn't very enjoyable for me to write this out because I feel it will be just like every other time Ive spoke about the pain I live with 24/7 and 365 day a year, since Jan 5th 2009. That's the day I slipped on ice. The day my life as I knew it left me! I'm a registered nurse and was doing private duty at the time after working in the hospital many years. I lost everything I went to college and worked so hard for that day! Because what followed was nothing shy of absolute torture!!! Excruciating and unlivable pain. I had a er visit but the ct machine didn't pick up the badly herniated disc in my neck. It seen a brain contusion and that's it. I wasn't even sure what was happening to

me at the time. The pain grew and kept getting worse. We had just relocated to this area so I didn't know any of the doctors here or hospital systems. I finally landed on some help 3 years later. The MRI showed a badly herniated disc in my neck, which looked like I was already paralyzed. The surgery helped take the pain from a 9 or 10 daily to a 2. Which was heavenly until I fell and the plate twisted in my spine. I had another spine surgery And this time I needed all the discs in my neck fused. I remained in pain after that. I was on opiates for about a year and a half and doing fairly well. Until the Dr at the time told me the pain was all in my head! That he was losing my dose asap buy one whole pill per day! I was just barely getting by the way it was. I was so terrified to be at the mercy of this uncaring arrogant man and quack of a Dr to be so heartless!!! I found a pain clinic and went there approximately 8 years and finally met a Dr who had compassion and gave me almost a proper dose. I was still in a lot of pain but it was better than being cut off. This place went bankrupt and never told any of the patients! Called one day and numerous times thereafter and no answers at all. I learned they went bankrupt in the news!!!!! That's when I decided to go to a sud clinic and try Suboxone! And it did and does work very well for me. I now am able to get meds from my family doctor with no issues. But now I'm having trouble walking and need a spine surgery again. I'm in a lot of pain again. It seems to be the story here and I know I wouldn't wish this nightmare on anyone! It's horrible to be in this much pain. It sucks everything out of you! I've done my best to try and make a life but all in all I can only do what this pain allows me to do. I'm nervous about another surgery and have waited as long as I possibly can. But I'm risking becoming paralyzed not doing anything. It's not a good place to be and feel comfortable. That's all I have to say for now. I hope this can help to change things for people in this much pain! I don't get why we have to be made to suffer in this country!??? It's a hopeless place to be! It really is and no one cares one bit!!5[6]>

Anonymous (not verified)-*Aug 25, 2026 06:44 PM* Comment #173

Restricting full agonist opioids for pain is cruel and inhumane.We need to bring back safe scientific pain medication and allow Doctors who have been trained to prescribe to do so.These medications are very necessary for patients who suffer severely in pain daily due to a injury/illness..Prescribing a pain medication does not cause one’s addiction .Just because one is prescribed a pain medication does not mean they will go on to become a addict.This theory is false.Pain prescribing is down and addiction is up...what does that say?A lot.Chronic and acute pain patients deserve to be treated .They deserve to live their best life while here.This needs to change because this has gone too far!We need to bring back science because what we are working with is false narratives and unscientific propaganda!!!

Kayleigh Merlino (not verified)-*Aug 25, 2026 09:47 PM* Comment #174

Having been diagnosed with Rheumatoid Arthritis at a young age as well as other joint deteriorating conditions has really taken away my quality of life. The one thing that has helped me be able to work and live semi normal is my pain medication. However, this doesn't come easy or without multiple hoops and problems that the guidelines prescribers feel they are supposed to abide by have caused. I have been on pain medication for 10+ years as pain escalates and my condition worsens Iam not able to receive a raise in medicine due to these guidelines. I want to be clear Iam not on a high dose Iam below the 90MME threshold. Around 3 years ago my provider retired who was prescribing and I was left to scramble. It's not only extremely hard to find anyone to prescribe but the amount of physicians who will are overloaded with patients. They also feel as if they are stuck to these extremely unfair strict rules set forth by these guidelines. If I had a serious emergency or a surgery (which I have had) because I'm already taking medication I wouldn't be able to receive anymore to cover the emergency or surgery. This is unfair and unethical in so many ways. My mother recently entered hospice and she isn't the only family of loved one I've witnessed this happening with but the only time you will see proper pain care if when someone is dying. This should not be how things are. My mother fought in pain with a fractured hip for many years prior and had no quality of life no mobility. All because of these guidelines. My mother is now weeks or days away from death and finally comfortable in her final days. But why couldn't she be comfortable in her better days? It saddens me and angers me. Things should not be like this. She even said it for herself "to bad I have to be dying to be comfortable " . It broke my heart. Please help us all out here struggling. We are not seeking a illicit drug high we are seeking a more normal life, to do more than we can without pain medication. Please I beg you. This is more to me than just a prescription this is fighting for what is right and I hope you will to!

Camryn Searls (not verified)-*Aug 26, 2026 03:01 PM* Comment #175

I am a patient with multiple chronic illnesses who is medically complex I have never once in my 31 years of life received competent or helpful medical care despite seeing many providers, many specialists, and visiting many clinics across the entire greater Puget Sound region. I believe the treatment of patients like myself suffering from chronic pain and medically complex conditions without obvious or immediate solutions have been left behind and abandoned by the medical system. The constant gaslighting and negligence along with outright refusals of care, abandonment, and even malpractice have forced me into a position where I no longer feel safe seeking medical care at all.

Mrs. Michael Good (not verified)-*Aug 26, 2026 07:36 PM*

Comment #176

Please do not continue making patients suffer. All of the restrictions and inhumane restrictions are causing severe harm. All we are asking is to be treated for medical conditions that we did not create. It's a matter of being a productive part of society. We want to live and participate in life. Being treated with proper medication and finding a dr to treat is our livelihood. Removing medication and providers is on the verge of selective extermination don't you think? Don't take away ours lives. Don't take away our ability to function outside our homes. We are not criminals seeking a high. This is not how to treat your fellow humans. Punishing millions of patients and providers is a medical issue, not a government one. We are not drug seeking. We want to be a participant in daily life.

Anonymous (not verified)-*Aug 27, 2026 06:44 PM*

Comment #177

Fifteen years ago in another state, after a diagnosis of several debilitating and painful conditions, the United States government determined I was permanently disabled and unable to work. After trying many medications, procedures, and treatments through doctors and pain management, opioid medication was the treatment that provided the best control of my chronic pain. My PCP here in WA has continued and managed that treatment for the past 9 years. Today at appointment, my PCP told me that she is no longer going to prescribe opioids for most, but not all, of her chronic-pain patients, and that she intends to taper me completely off opioids, which are currently the only medications I take. I asked why I am not one of the patients she is choosing to continue prescribing to, and I was not given a patient-specific medical reason. In one step, she reduced my opiate prescriptions by 20%. I was also given no complete taper schedule. I don't know what the next reduction will be, how frequently the reductions will occur, or how long this will continue. I was simply told that I have to call every month for another prescription. I also gave her a written history showing the substantial reductions I've already had over the years and the corresponding increases in my documented pain levels, and I asked that it be placed in my medical record. The Washington Medical Commission's current proposed guidance says that stable long-term patients should not be tapered solely to meet guidelines, policy limits, or dosage thresholds, and that destabilizing a clinically stable patient can create undue risk. I told her this, but she didn't care. CDC guidance also says that tapering should be individualized to the patient. For patients who have been on opioid therapy for a year or longer, a taper of approximately 10% per month or slower is generally better tolerated, and depending on the individual patient and the length of treatment, tapering may need to take months or even years. She didn't care. I asked her to continue providing the chronic-pain treatment she has provided to me for the past 9 years, but she refused, and told me I would need to find another Dr. or she could refer me to pain

management in another city over an hour from where I live. She said pain management doctors at her clinic do not prescribe opiates. Can you imagine a pain management dr that does not proscribe a medication that has been used for pain relief for thousands of years?! I have been stable on these medications, they have provided meaningful pain relief, and I have not been given a patient-specific medical reason why continuing this treatment has suddenly become inappropriate for me. If she is going to continue this non-individualized and potentially harmful taper despite my request to continue treatment, I asked that this first reduction be limited to 10%, but she reduced it by 20%. And after this month she will continues to taper me every month. I asked that any further reductions be no more than approximately 10% every three months, rather than every month. I have been taking these medications for 15 years. I need time for my body to adjust, time to determine what each reduction does to my pain and my ability to function, and time to find another doctor which is highly unlikely because doctors in this state apparently are no longer willing to evaluate and treat my chronic-pain with the only drug that has ever relieved my torturous day in and day out pain. It is extremely difficult now to find doctors willing to prescribe opioids for chronic pain, even though this is the only medication in 15 years that has ever provided meaningful relief for me. So my first request was that she continue the treatment she has provided to me for the last 9 years. She refused to do that. I said well at a minimum I am asking for a slow, individualized, medically appropriate taper that gives my body time to adjust and gives me a reasonable amount of time to find another physician. She did not respond to this. I asked to speak to her supervisor so he could review my case, and help me understand why I was selected for complete discontinuation, and why she will no longer continue the treatment she has provided me for NINE YEARS. The supervisor did not call me. So now I am joining the 100s of thousands of WA state residents and US citizens that have been cruelly and abusively taken off of the opiates that allow me some semblance of life. While drug addicts on the street are given free needles and safe places free from law enforcement, to shoot up their illegal drugs. I am lost and have no idea what I'm going to do. Can someone please help me make sense of this insanity?

Anonymous (not verified)-*Aug 28, 2026 09:05 PM* Comment #178

Something needs to change when pain meds started getting cut they took my moms oxytocin away cold turkey said FDA says no more pain meds , My mom lived another year after that in horrible pain she could not get to the bathroom cuz it hurt to move so she would pee on the floor from her bed to the bathroom all due to the pain she was in she had a couple neck surgeries and fibromyalgia and arthritis, pain causes depression and that gets worse when there is no pain relief. My mom was cut off 2 pills a day I feel this helped her to an early grave she was 68 years old and couldn't get to the bathroom 20 steps away , however when she had pain meds she functioned and did every day task loaded dishes and

cooked for herself as well as other daily living task there was still pain with medication but she could manage by taking breaks to rest . I do agree people need to be screened by a therapist and pharmacy computers should be linked so there is no doctor shopping, but everyone deserves adequate pain relief and doctors should not be scared to loose there l8cemce for prescribing pain medication, and pharmacies should not be able to deny filling a prescription that your doctor has written ! My dad had a triple heart bypass they gave him 10 pain pills and the pharmacy refused to fill it , he had just bern discharged from the hospital the last thing he should have to deal with is fighting a pharmacy for pain medication that was prescribed by the doctor.

Anonymous (not verified)-*Aug 28, 2026 09:23 PM* Comment #179

I have had chronic pain since I was 18 years old i am now 53 . I had pain medication that was adequately working . I could maintain daily life shower , cooking, clean a little I would rest in between it started with my pain doctor saying the FDA has new rules we need to reduce your medication that made my daily life task reduce too I would fix food mostly frozen and take a shower 1 time a week clean very little then my doctor retired for fear of FDA coming down on him cuz he was a pain management doctor he prescribed pain medicine. It took me 8 months to find a new pain management doctor and I had to find a way to pay cash as by this time I had to leave my job cuz I could bearly get up to get food never mind work 8 hours as a customer service person on the phones which sounds easy but its not your brain needs to function so you can comprehend what your being told and type those concerns and know whete to find the answer to thier questions . I was lucky to feed my self 2 times a day ! I was on medicaid and they do not cover pain management doctors so cash it was i was very lucky to find a doctor that would get the insurance authorization so they would pay for my prescription. Most people cannot pay cash for the doctor I had some help so I was blessed , I realize people have Opioid issues but when we are prescribed the medication by a doctor the insurance or pharmacy should not be able to question , the doctors have been trained to see people who are addicted or ones who sell the drugs . Please stop making doctors scared to prescribed it stop regulating our pain medication we all deserve to be treated humain we deserve to live with some pain relief. If I had adequate pain relief I may have been able to work longer . We sign pain contracts we pee in acup to prove we are taking our medication as prescribed, we use the same pharmacy ever month so we can show we are not getting medication for any other doctors and I am fine with that but we should not be looked at like drug addicts when we fill our prescription and we should not have to live in pain 24 - 7 because there is some people who dont use it right .

Anonymous (not verified)-*Sep 02, 2026 02:46 PM* Comment #180

You cannot drug test patients legally, unless you get their permission. You do this by requiring them to sign Pain Contracts. Contracts are invalid when you use blackmail to get them. You cannot withhold treatment based upon someone using an illicit drug anyway! Why do you not require Emergency Room patients to get tested? And deny them treatment and prescriptions because they have an illicit substance in their system? I call your attention to: DEPARTMENT OF JUSTICE Office of the Attorney General 28 CFR PART 35 Nondiscrimination on the Basis of Disability in State and Local Government Services AGENCY: Department of Justice. ACTION: Final rule. Paragraph (b) of {35.131 Illegal use of drugs. provides a limited exception to the exclusion of current illegal users of drugs from the protections of the Act. It prohibits denial of health services, or services provided in connection with drug rehabilitation to an individual on the basis of current illegal use of drugs, if the individual is otherwise entitled to such services. A health care facility, such as a hospital or clinic, may not refuse treatment to an individual in need of the services it provides on the grounds that the individual is illegally using drugs, but it is not required by this section to provide services that it does not ordinarily provide. For example, a health care facility that specializes in a particular type of treatment, such as care of burn victims, is not required to provide drug rehabilitation services, but it cannot refuse to treat a individual's burns on the grounds that the individual is illegally using drugs. Public hospital districts are governmental entities established by Washington State statute. Thank You,

Patricia Dunn (not verified)-*Sep 13, 2026 02:42 PM* Comment #181

FORMAL WRITTEN SUBMISSION TO THE WASHINGTON MEDICAL COMMISSION Date: September 13, 2026 Subject: Public Comment on Proposed Rulemaking: Chapter 246-919 WAC (Opioid Prescribing — General Provisions) Target Section: WAC 246-919-850 (Intent and Scope) — October 26, 2026, Workshop Item [DB1] To the Commissioners of the Washington Medical Commission: I am writing to provide critical feedback regarding the proposed language for WAC 246-919-850. While I strongly support the Commission's explicit recognition that "tolerance and physical dependence from long-term opioid use are normal and distinct from opioid use disorder," the current administrative structure of the rule still allows defensive medicine to severely harm compliant, stable chronic pain patients. To ensure that patients in Washington maintain safe, legal, and affordable access to FDA-approved treatments, the final rule must explicitly address the following real-world systemic failures: 1. Staff Vacancies, Interventional Coercion, and Forced Non-Agonist Therapy (Case Study) The primary driver of patient suffering in Washington is the "chilling effect," which forces clinics to use staff turnover and corporate policies to abandon stable patients. Consider this real-world chronological shift in a patient's medical records and

care continuity within a single Washington practice: • Visit 1 (Baseline Stability under ARNP Jenna Beh): The patient is maintained on a conservative, highly functional regimen of Hydromorphone (40 MME). The provider explicitly charts: “Washington state PMP and most recent UDT were reviewed and found to be consistent with the treatment plan. The patient continues to report significant improvement of pain and function secondary to opioid therapy that is not otherwise achievable.”The Clinic Turnover and Gatekeeping: Prescriber Jenna Beh subsequently left the practice at Mt. Baker Pain Clinic. Upon being transferred to the next available physician, Dr. Nolin, the patient was informed by the front desk receptionist that "Dr. Nolin does not treat medication-only patients; he only wants to treat interventional cases."The Ultimatums and Coercion: At the next appointment, Dr. Nolin's charting abruptly shifted to declare the patient was “likely at the limit of reasonable opioid therapy,” heavily pushing invasive procedures (spinal cord stimulators and DRG trials) that the patient had already safely and legally declined. When the patient refused to have her care returned back to the only other remaining prescriber in the office, Hannah Jaster, PA-C—who categorically refused full-agonist therapy and tried to force a transition to buprenorphine with escalating doses against the patient's wishes (she repeatedlt requested dose reductions, which were met with documented plan of care for dose increases, with discontinuations of her full agonists hydromorphone. Buprenorphine repeatedly caused the patient incapacitating headaches documented over several years — the clinic structures effectively trapped the patient. While the patient fiercely self-advocated and was ultimately granted a return of care to her original, safe provider, Kyle Rickards, this crisis highlights an unacceptable administrative loop. Because of local clinician refusals in her immediate area, the patient is now forced to drive from Arlington to Bellingham just to protect her access to life-functioning opioid prescriptions. Stable, compliant patients should not be forced to travel long distances across counties, endure traumatic clinical standoffs, or issue absolute practitioner refusals (such as rejecting Dr. Nolin or Hannah Jaster, PA-C) just to maintain a baseline of medical continuity. The Policy Flaw: This is clear interventional coercion. Clinics are using internal staff vacancies to push stable, perfectly compliant 40 MME patients off effective, FDA-approved medications solely because a doctor prefers high-billing interventional procedures or fears regulatory oversight. Forcing a patient onto a medication (buprenorphine) that causes severe adverse effects like incapacitating headaches ignores the proposed text of WAC 246-919-850, which mandates that patients have access to appropriate pain relief and explicitly protects the use of traditional opioid agonists. 2. The Flaw of Algorithmic Safeguards (NarxScore & Epic Integration) By stating that "Physicians are expected to incorporate safeguards… including monitoring prescriptions," the rule forces reliance on highly flawed, automated software. Peer-reviewed data shows that proprietary scoring tools like Bamboo Health’s NarxCare (NarxScore) carry a 17% false-positive rate and poor diagnostic validity. These

"black box" algorithms routinely misclassify complex care coordination—such as seeing multiple specialized clinicians or using different pharmacies due to medication shortages—as "doctor shopping." When these scores are integrated visually into Electronic Health Records like Epic, they create an immediate visual bias. Ill-informed PCPs instantly refuse care or force tapers based on a flawed mathematical projection, rather than conducting an individualized clinical assessment. 3. The Crisis of "Partial Abandonment" Due to regulatory anxiety, Primary Care Providers (PCPs) are increasingly offloading stable patients to high-priced pain management specialists. While transferring a controlled substance script is permissible, PCPs are using this handoff as a loophole to completely refuse any basic, non-controlled pain evaluations or routine care. Forcing a patient to seek expensive specialized clinicians for minor, everyday pain-related issues constitutes partial patient abandonment and creates an unjust financial barrier to care. REQUESTED AMENDMENTS TO WAC 246-919-850 To protect Washington residents from defensive medical abandonment, I request the Commission incorporate the following explicit protections into the final rule text: 1. Formally Codify Interpretive Statement INS2025-03: Embed the protections of INS2025-03 directly into the rule text, explicitly stating that denying, delaying, or withholding standard medical care or routine primary evaluations solely based on a patient's chronic pain diagnosis or history of controlled substance therapy constitutes a departure from the standard of care. 2. Explicitly Prohibit "Partial Abandonment": Add a clear clause stating that referring a patient to a specialized clinic for controlled substance management does not absolve a primary care provider from their legal and ethical duty to manage non-controlled therapies, handle routine pain complaints, and maintain overall continuity of care. 3. Protect Right to Traditional Agonists Over Forced Alternatives: Add explicit language stating that practitioners shall not force stable, compliant patients to switch from traditional opioid agonists to partial agonists (such as buprenorphine) or interventional treatments if the alternative therapies have previously failed, caused severe adverse effects (e.g., incapacitating headaches), or are clinically inappropriate for the patient's individual diagnosis. 4. Clarify "Expected" vs. "Discretionary" Safeguards: Amend the text to read: "Physicians are encouraged to utilize clinical safeguards based on an individualized risk-benefit assessment, while recognizing that automated data metrics (e.g., PDMP scores) are auxiliary tools and shall not override a clinician's documented evaluation of patient compliance and functional improvement." Thank you for your dedication to creating a balanced framework that protects the health, dignity, and wallets of Washington's chronic pain patients. Respectfully submitted, [Partricia Dunn, former RN / "A Concerned Washington Resident and Patient Advocate"]

Outlook

Fw: Public Comment Regarding Proposed Opioid Rules – Buprenorphine and Patient Choice

From WMC Medical Rules <Medical.Rules@wmc.wa.gov>
Date Mon 9/21/2026 5:28 PM
To Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>

From: [redacted]
Sent: Sunday, August 9, 2026 1:38 PM
To: WMC Medical Policy
Subject: Fw: Public Comment Regarding Proposed Opioid Rules – Buprenorphine and Patient Choice

Comment #182

External Email Dear Washington Medical Commission, My name is Mims Gordon, and I would like to submit this comment regarding the opioid prescribing rules currently under consideration in Washington State. I have attended several of the recent workshops. Unfortunately, during the workshop in which Dr. Stanos's proposed language regarding buprenorphine was discussed, I became ill and had to leave before I could fully participate. I would therefore like to submit my concerns in writing. My first question is a basic policy question: Why should buprenorphine—or any particular medication—be specifically identified in the rule at all? Would it not be more patient-centered and clinically appropriate for the rule to state that physicians should consider all treatment options available to them, including opioid agonists and partial agonists, when medically appropriate, based upon the individual patient's condition, treatment history, risks, benefits, and preferences? Most importantly, when a change from one opioid medication to another is being considered, that decision should occur in collaboration with the patient rather than as a consequence of regulatory preference or pressure. I raise this concern based upon my own experience as a patient with severe chronic pain. I have received specialized pain care for Complex Regional Pain Syndrome (CRPS) since a routine ligament repair injured a nerve in my ankle in 2016. Since that time, I have undergone an extensive range of treatments. These have included numerous medications, multiple forms of physical therapy, cognitive behavioral therapy with a licensed psychologist, repeated nerve blocks, a spinal cord stimulator, a neurectomy at Swedish Hospital, and participation in an FDA clinical trial involving bisphosphonate infusions. I am currently enrolled in an invasive deep brain stimulation research trial. This treatment involves substantial intervention and carries risks including infection, bleeding, seizures, and other complications. I have agreed to these treatments because I have continually been expected to demonstrate that other options have been attempted before adjustments to my opioid therapy will even be considered. At some point, however, patients and clinicians must be permitted to recognize when a treatment is providing meaningful benefit. Patients with serious chronic pain should not be required to continually undergo increasingly invasive, burdensome, expensive, or unsuccessful treatments merely to justify continuing or appropriately adjusting a medication that is already helping them. This issue is not theoretical for me. Buprenorphine has not merely been presented to me as one possible treatment option. I have experienced pressure from physicians to replace my existing opioid agonist medication with buprenorphine, despite the fact that my current treatment has repeatedly been evaluated, I have not been diagnosed with opioid use disorder, and my treatment has provided

meaningful benefit without adverse effects that outweigh those benefits. I have also undergone repeated assessments regarding my risk of addiction and overdose and have consistently been considered low risk. For me, therefore, the concern about specifically naming buprenorphine in regulation is not opposition to the medication itself. Buprenorphine can be an appropriate and valuable medication for patients for whom it is clinically indicated and who choose it in consultation with their clinician. My concern is what happens when regulatory language gives one medication preferred status. What may be written as a suggestion to "consider" buprenorphine can become something very different in clinical practice: pressure on physicians to prescribe it, pressure on patients to accept it, or an expectation that patients receiving full opioid agonists must attempt buprenorphine before their existing therapy can be continued or adjusted. For a stable patient who is benefiting from an existing therapy, such a transition should not occur merely because buprenorphine is perceived as preferable from a regulatory standpoint. My treatment history also illustrates why individualized care is so important. Before opioid therapy was considered, I was prescribed numerous other medications. Some produced severe adverse effects, including cognitive impairment, vomiting, migraines, loss of function, and ultimately a medication reaction involving Stevens-Johnson syndrome. At the time, my ability to work as a Licensed Mental Health Counselor at Joint Base Lewis-McChord deteriorated because I could no longer reliably drive, concentrate, or function professionally due both to uncontrolled CRPS pain and the adverse effects of the medications being used to treat it. I eventually lost my ability to continue working and became increasingly isolated and homebound. Opioid therapy was considered only after extensive attempts with other treatments. For me, it has ultimately been one of the most effective and tolerable components of my pain treatment. That experience is why I am concerned about a regulatory framework that could unintentionally create another treatment hierarchy—this time one in which patients receiving full opioid agonists are expected to transition to buprenorphine regardless of whether their existing treatment is stable, effective, and medically appropriate. The goal of these rule revisions should be to restore individualized clinical decision-making and protect patients from inappropriate forced tapering, discontinuation, or abandonment. Replacing pressure to taper with pressure to convert patients to another opioid would not accomplish that goal. I respectfully ask the Commission to consider using medication-neutral language rather than specifically elevating buprenorphine in the rule. For example: "The clinician should consider all clinically appropriate treatment options, including opioid agonists and partial agonists, based on the individual patient's diagnosis, treatment history, clinical response, risks, benefits, and preferences. Changes in opioid therapy should be individualized and undertaken collaboratively with the patient. A patient who is stable and experiencing meaningful benefit from an existing opioid regimen should not be required to transition to another opioid medication solely because of medication class, dosage, or generalized regulatory preference." This language would preserve buprenorphine as an important clinical option without turning it into a regulatory expectation. I am not asking the Commission to restrict physicians from recommending buprenorphine. I am asking the Commission to protect the distinction between offering a treatment option and creating pressure to accept it. For patients like me, that distinction matters enormously. After years of unsuccessful medications, invasive procedures, surgeries, psychological evaluations, clinical trials, and other treatments, patients should not have to continually prove that they deserve access to a medication that is helping them. Treatment decisions should remain individualized, evidence-informed, and made between the patient and the clinician. Thank you for considering my comments and for the work being undertaken to revise Washington's opioid prescribing rules. Respectfully, [redacted]

[redacted]

[redacted]

[redacted]

August 3, 2026

Comment #183

Terry Murphy
Washington Medical Commission
111 Israel Road SE
Tumwater, WA 98501

Dear Chair Terry Murphy, MD, and Members of the Commission:

The undersigned organizations and signatories appreciate the Washington Medical Commission's thoughtful work to modernize its opioid prescribing rules for allopathic physicians and physician assistants. We recognize the significant time and effort that has gone into this process and share the Commission's commitment to promoting safe, evidence-based opioid prescribing while ensuring patients continue to have access to appropriate pain management.

We understand that the Commission's principal objective in reopening these rules is to improve access to appropriate pain management, and we strongly support that objective. We also recognize that the opioid prescribing rules that took effect in 2019 reflected the seriousness of the opioid epidemic and were developed to strengthen safeguards around opioid prescribing. However, those rules have had unintended clinical consequences by creating a regulatory framework that many physicians have found to be complex, difficult to navigate, and administratively burdensome. That complexity has contributed to, in some cases, hesitation to prescribe opioids when clinically appropriate—creating unnecessary barriers to patients accessing needed pain management. We understood the Commission's decision to reopen this rulemaking as an opportunity to simplify that framework while maintaining appropriate patient protections. Based on the Commission's work to date, however, we are concerned that the current trajectory of the rulemaking may inadvertently move in the opposite direction by further expanding and complicating the regulatory requirements.

Successive drafts have largely reorganized and expanded the existing regulations rather than simplifying them, creating an increasingly complex framework that blends enforceable legal requirements with clinical recommendations and best practices. The current approach risks compounding that complexity instead of reducing it. Although each individual provision may be well intentioned, the cumulative effect is a regulatory scheme that is increasingly difficult to navigate and challenging for physicians to operationalize in everyday practice.

We respectfully urge the Commission to pivot from its current approach and instead bifurcate this effort into two complementary projects:

1. **A concise opioid prescribing rule** that clearly identifies the actions physicians are legally required to perform when prescribing opioids, including requirements established by statute and those regulatory provisions the Commission determines are necessary to protect patient safety and establish minimum standards of professional practice; and

2. **A Washington Medical Commission opioid prescribing guideline** that contains clinical recommendations, best practices, explanatory information, examples, and other guidance intended to assist physicians in exercising sound clinical judgment.

This approach would not diminish patient protections. Rather, it would make regulatory expectations clearer, improve physician compliance, reduce physician concern about being coerced into over- or under-prescribing, and allow the Commission's clinical recommendations to evolve alongside medical evidence without requiring repeated rulemaking.

At its core, this proposal is grounded in a simple principle: physicians should be able to readily understand what the law requires of them. A physician should be able to answer one straightforward question: "What am I legally required to do every time I prescribe an opioid?" Today, answering that question requires navigating dozens of pages of regulatory text, multiple exceptions, and provisions that often blur the distinction between mandatory legal requirements and recommended clinical practices.

Regulations should establish the minimum standards that carry the force of law. Guidance should assist physicians in delivering the highest quality care beyond those minimum standards.

Separating these functions would produce several important benefits.

First, it would improve regulatory compliance. Physicians are far more likely to consistently follow requirements that are concise, clearly written, and easy to understand. Regulatory complexity can itself become a barrier to compliance and clinical care, particularly when physicians struggle to distinguish legal obligations from recommended best practices.

Second, it would provide physicians with greater confidence in appropriately treating patients with pain management needs. Physicians should not have to worry that they may have inadvertently overlooked one of dozens of regulatory provisions before appropriately prescribing an opioid. When legal requirements are clearly articulated and separated from clinical recommendations, physicians can focus on exercising sound medical judgment rather than navigating regulatory complexity. Increased confidence in understanding one's legal obligations will help reduce unnecessary hesitation to prescribe opioids when clinically appropriate, thereby improving patient access to pain management while maintaining appropriate safeguards. We believe this directly advances the Commission's stated purpose for reopening this rulemaking.

Third, it would better distinguish between legal requirements and evolving standards of care. Medical evidence, national guidelines, and best practices continue to evolve. A Commission guideline can be updated far more efficiently than administrative rules, allowing physicians to benefit from current clinical recommendations without requiring continual regulatory amendments.

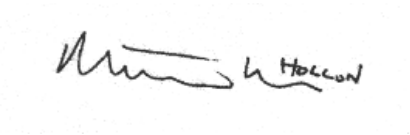
This approach is also consistent with the Legislature's direction. The Legislature has directed the Commission to adopt opioid prescribing rules for physicians, while providing broad authority regarding the content of those rules at RCW 18.71.800. At the same time, Washington law has long

recognized an important role for clinical guidance in supporting physician practice. For example, in directing the Commission's earlier rulemaking on chronic pain management, the Legislature expressly contemplated guidance on matters such as specialty consultation, tracking clinical progress, and monitoring opioid use at RCW 18.71.450. We believe the Commission can fully satisfy its statutory responsibilities while presenting physicians with a clearer, more accessible regulatory framework that distinguishes enforceable legal requirements from clinical recommendations.

Should the Commission adopt this framework, the undersigned are committed to partnering with the Commission to educate physicians on the revised regulatory structure. We would welcome the opportunity to help physicians understand both their legal obligations under the rule and the accompanying Commission guidance so that implementation is successful from the outset. We believe a simplified regulatory framework, coupled with coordinated physician education, will improve compliance, increase physician confidence, and ultimately improve patient access to safe, appropriate pain management.

We appreciate the Commission's willingness to engage stakeholders throughout this rulemaking and respectfully request that it consider reframing this effort around a streamlined, enforceable rule paired with a comprehensive clinical guideline. We look forward to continuing to work collaboratively with the Commission to achieve our shared goal of promoting safe opioid prescribing while ensuring Washington patients continue to have access to evidence-based pain care.

Sincerely,



Matthew Hollon, MD, MPH, MACP
President-Elect
Washington State Medical Association

Timothy H. Dellit, M.D.
CEO, UW Medicine
Executive Vice President for Medical Affairs
Paul G. Ramsey Endowed Dean of the School of Medicine
University of Washington

Nathan Schlicher, MD, JD, MBA
Chief Clinical Officer
Better Prescribing Better Treatment

David J. Tauben, MD, FACP
Clinical Professor Emeritus
Medicine and Anesthesia & Pain Medicine
University of Washington

Victoria Fang, MD
Medical Director
UW Medicine Primary Care

Joe Merrill, MD, MP
Penny LeGate and Craig Tell Term Professor in Addiction Medicine
University of Washington

Jared W. Klein, MD, MPH
Medical Director, Pioneer Square Clinic and Downtown Programs
Harborview Medical Center

Sonal Patel, MD, MPH
President
Washington Academy of Family Physicians

Chelene Whittaker
Senior Vice President, Government Affairs
Washington State Hospital Association

Additional supportive state medical societies

- Washington State Psychiatry Association
- Washington State Oncology Society
- Washington Academy of Eye Physicians and Surgeons

Comments from [Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission]

From September 21, 2026 to October 20, 2026

Marge (not verified)-*Sep 23, 2026 03:31 PM* Comment #184

My pain management provider retired and his replacement has initiated a forced taper of my narcotic medications by one third of my prior dose. No reason was given for this only stating they didn't prescribe above 120MED. Every patient at this clinic currently above 120MED will be forced to taper to this dose. Also the provider is a certified pain specialist. This certification gives him the ability to prescribe over this dosage. I have also been threatened with discharge from this clinic for trying to discuss this with my provider. I have read and understand the WAC'S and what the Washington Medical Commission says and is doing. What is it going to take to get the providers to follow these rulings! I have been forced tapered before when the 2016 guidelines were instituted and that was just horrible both physically and psychologically! And it is happening again!

Marge (not verified)-*Sep 23, 2026 03:35 PM* Comment #185

My pain management provider retired and his replacement has initiated a forced taper of my narcotic medications by one third of my prior dose. No reason was given for this only stating they didn't prescribe above 120MED. Every patient at this clinic currently above 120MED will be forced to taper to this dose. Also the provider is a certified pain specialist. This certification gives him the ability to prescribe over this dosage. I have also been threatened with discharge from this clinic for trying to discuss this with my provider. I have read and understand the WAC'S and what the Washington Medical Commission says and is doing. What is it going to take to get the providers to follow these rulings! I have been forced tapered before when the 2016 guidelines were instituted and that was just horrible both physically and psychologically! And it is happening again!

Ashley (not verified)-*Oct 06, 2026 01:05 PM* Comment #186

I am a patient who has a rare disease that causes severe pain. When I was treated with opiate pain medication I was able to work full time and be a contributing member of society. I was able to be a better parent to my young child, was more social, was able to move around and get things done etc. I was forced off of my pain medication that I was stable on and since then I am unable to work, am financially doomed, am essentially bed bound at this point. Some of us need these medications to live. I need these medications to live. My chronic intractable pain is never going away and will probably get worse. I am unable to get the care I need because of the current rules. Doctors are afraid to treat. There is a crisis in WA state right now, people in pain are suffering and choosing to not live

because they can not stand the pain! Please implement new rules. Specifically, releasing MME restrictions in stable pts and especially adding RARE disease to the list of exemptions. People with rare disease do not have many options for care due to there not being many studies and/or medications to treat their conditions. Until there are, we should not have to suffer. We should be able to treat our pain appropriately until there is a better option for us. Please dear God, implement these rules ASAP!!!!!!!

Mariah Riggsby (not verified)-*Oct 09, 2026 01:55 PM* Comment #187

I am writing to share my experiences as a chronic pain patient and ask for meaningful attention to the barriers patients face when trying to access pain care in Washington. I have officially been a chronic pain patient since 2023. Managing chronic pain has been one of the hardest things I have ever dealt with, and navigating the healthcare system has added significantly to that burden. I have experienced stigma from multiple pain providers, been denied care, and repeatedly felt that assumptions about my medications mattered more than understanding my condition, reviewing my information, or helping me find an appropriate path forward. I understand that medications require careful assessment and that not every treatment is appropriate for every patient. What I am asking for is individualized care, respectful communication, and decisions based on a meaningful review of the whole patient. My PCP and behavioral-health providers have shown me what collaborative care can look like: listening, involving me in decisions, and communicating with one another. My concern is the breakdown in that collaboration across specialty care, referrals, and pharmacies. Patients should not have to rebuild their story and prove their daily limitations at every handoff. At multiple appointments, I have brought concrete symptom and pain tracking data that providers did not meaningfully review. Instead, I have felt that conclusions were already formed from limited paperwork sent before the visit, before I had the opportunity to explain my experience. Records are important, but they should support a conversation, not replace listening to the patient. Accurate documentation is another essential part of access to care. A recent specialist's note listed lamotrigine as an active medication even though I have not taken it for years. Patients need a clear, accessible process for requesting corrections and having disputed information reviewed, so future decisions are not based on inaccurate or unresolved information. I have also experienced isolated recommendations without a coordinated plan to investigate underlying problems, manage symptoms, or support me over time. I recognize that not every condition can be cured, and symptom relief is an important goal. However, patients still deserve an effort to understand what is happening, address what can be addressed, and explain what comes next. Being denied care without a workable alternative leaves patients carrying both the pain and the responsibility for finding another option. In my surgical care, I have experienced what I would describe as tunnel vision, where I felt my

concerns and changes in my condition were not being fully considered. I had to repeatedly push for additional imaging, which subsequently showed worsening in my back. Patients should not have to fight to have their concerns meaningfully assessed or changes in their condition investigated. I am also concerned about gender bias and whether women's reports receive the same attention without a male partner present. During one phone appointment, my surgeon unexpectedly asked whether my partner was present, without explaining why. In my interactions with him, I have felt that he showed more interest in my boyfriend's involvement than in listening directly to me and addressing my concerns. I cannot know his intent, but the impact was that I felt less heard as the patient. My account of my symptoms and limitations should carry weight whether or not my partner attends an appointment. For patients covered by Washington Apple Health, access can be especially limited. In my experience, finding pain providers who accept my coverage and are willing to consider my care has been difficult. Having insurance does not necessarily mean having a realistic route to treatment. The process described to me as an insurance "exemption" has created another barrier. I have encountered situations where a clinic will tell a referring provider or insurer that it will consider such an arrangement, but will not make that option clear to the patient. Meanwhile, the patient is still expected to identify potential clinics and gather their names, addresses, and contact information so the provider or insurer can reach out. An option that is difficult to discover and requires extensive patient coordination is not easily accessible. Patients need clear information about available coverage arrangements and practical help navigating them. More broadly, too much of the work of finding and coordinating care is placed on patients. In my experience, including with my surgeon's office, I have been left responsible for finding care and navigating next steps that I needed help arranging. Chronic pain is not just pain. It can also involve fatigue, brain fog, and difficulty managing basic daily activities. Researching clinics, making repeated calls, gathering information, and coordinating between offices takes capacity that patients may not have. Having to perform the coordination work of a medical office adds significant stress and uses the limited energy we need for everyday life. Patients need practical referral assistance and communication between providers, not simply instructions to find care on their own. Specialists should also consider the purpose and benefit of treatments managed by other clinicians. At my most recent pain-management intake, I was told that I would need to halve my pain medication and discontinue my anxiety medication before the provider would consider taking me on as a patient. I was ultimately denied care. My behavioral-health treatment was treated as a barrier, rather than something to discuss with the clinicians who know me and manage that care. When medication concerns could determine whether a patient receives care, there should be direct clinician-to-clinician consultation with the patient's established providers, with the patient's involvement and ideally before the specialist visit. Patients should not be left to relay complex clinical

information or navigate conflicting treatment demands alone. I am asking for coordinated assessment of risks, benefits, and alternatives, not for legitimate safety concerns to be ignored. Treatment that helps manage my behavioral health should be considered as part of my overall care, not leave me without a path to pain care. Patients need their providers to work together rather than address one part of their health in isolation from the rest. Pharmacy communication has also been a recurring concern. I have experienced prescribed medications being held, with poor communication about the reason or what needs to happen to resolve the issue. From the patient's side, these decisions can feel rigid, without consideration of individual circumstances or a clear route to clarification with the prescriber. I understand that pharmacists have legal and clinical safety responsibilities. My concern is not that those responsibilities exist. It is that patients can be left without clear explanations, timely coordination, or a workable resolution when access to a needed medication is interrupted. Medication-related concerns should be handled through respectful communication and coordination, not leave patients feeling judged or caught between a pharmacy and a prescribing office. There also needs to be a clear, safe pathway for urgent care during severe pain flares. In my experience, my PCP's office directs me to the emergency department, but emergency visits have not provided meaningful relief or a workable plan. Instead, I have experienced being treated as drug-seeking and sent home with advice to use Tylenol. If Tylenol were sufficient to manage the flare, I would not be seeking additional help. I am not asking for a particular medication or for safety assessments to be bypassed. I am asking for timely assessment, respectful treatment, and an individualized plan when my pain exceeds what I can manage at home. Patients should not be passed between primary care and emergency care with neither setting providing a realistic path to help. We need an accessible urgent-care pathway for chronic pain flares, with coordination and follow-up rather than stigma and dismissal. These experiences have made me concerned that chronic pain patients face recurring gaps in access, communication, and accountability. I can speak directly to my own experiences, and I am asking the Department and this panel to examine whether these barriers are affecting other patients as well, particularly those with limited insurance options or limited capacity to advocate for themselves. I would like to see attention to the following changes: - Better access to pain providers for Washington Apple Health patients, including clear information and practical support for coverage exceptions or other arrangements that may allow access to care. - Meaningful review of patient-provided information and individualized assessment, rather than assumptions based on medication use or limited pre-visit paperwork. - Accessible processes for correcting outdated or inaccurate records and reviewing disputed diagnoses. - Whole-patient assessment, including consideration of established behavioral-health treatment and its role in the patient's wellbeing. - Direct consultation with established prescribers when medication concerns may lead to changes

being demanded or care being declined. - Clear explanations when care is declined, along with appropriate referral guidance and support so patients are not left without a path forward. - Greater responsibility for referral coordination and communication between medical offices, rather than placing that work entirely on patients. - Clear, timely pharmacy communication about medication holds, including what is needed to resolve them and coordination with the prescriber. - Attention to medication-related stigma and gender bias, including ensuring that patients are heard directly regardless of whether a partner is present. - An accessible, clearly defined pathway for urgent assessment and management of severe chronic pain flares when routine outpatient care is unavailable or insufficient. I am speaking up because these barriers cannot be addressed if patients' experiences are not heard. Patients should not need medical-system expertise, repeated complaints, or energy they do not have simply to access respectful care. Please consider this letter as patient input for the relevant public meeting or panel discussion. I would appreciate information about how these concerns can be reviewed, what steps may be taken to address them, and whether there is an opportunity for me to provide further written or spoken public comment. If any of these concerns fall outside your authority, please direct me to the appropriate agency or body. Thank you for your time and consideration.

Aubrey (not verified)-*Oct 13, 2026 03:51 PM*

Comment #188

To: Washington Medical Commission Medical.commission@doh.wa.gov Dear Washington Medical Commissioners, I am submitting the following public comments regarding Washington State's proposed opioid prescribing rule revisions for physicians and physician assistants. I am a Washington State resident living with multiple documented chronic pain conditions and disabilities. I am sharing my lived experience navigating pain treatment and the healthcare system. I strongly support responsible prescribing, overdose prevention, and appropriate safeguards against addiction. However, patient safety must also include protection from undertreatment, discrimination, and the harm caused when patients are afraid to discuss their pain openly. Throughout my medical history, I have been prescribed opioid pain medications to manage documented medical conditions. Although these medications helped control my pain, I disliked the side effects. When I was staying home and could manage with less medication, I often chose to take less than the prescribed amount. When I needed to leave the house, I generally took the full prescribed dose because I needed that level of pain relief to function outside my home. My experience illustrates why individualized pain management matters. A patient's medication use may vary depending on their functional needs, activity level, and tolerance of side effects. Taking less medication does not necessarily mean the patient does not experience significant pain or that the prescribed treatment is unnecessary. Despite objective medical findings supporting my conditions, I have also struggled to have my symptoms and

treatment needs taken seriously. These experiences have contributed to what I describe as white coat PTSD. Medical appointments can feel less like collaborative healthcare and more like being cross-examined. I have established a personal rule that I never attend medical appointments without a trusted support person or advocate. I ask the Commission to consider the following principles in its revised rules. 1. Individualized Care Treatment decisions should reflect each patient's medical conditions, functional limitations, clinical history, treatment response, and individual risk factors. Blanket restrictions should not replace clinical judgment. Patients with the same diagnosis may have different symptoms, functional limitations, treatment histories, and medical needs. A diagnosis alone should neither automatically qualify nor disqualify someone from consideration for a particular treatment. 2. Recognition of Undertreatment The rules should clearly recognize that failing to appropriately evaluate and treat pain can cause harm, just as inappropriate prescribing can. Patient safety should include the consequences of inadequate pain relief, including reduced mobility, loss of function, sleep disruption, and diminished quality of life. A policy intended to prevent one form of harm should not unintentionally create another. 3. Trauma-Informed Communication Patients should be able to discuss opioid medications and other pain-treatment options without automatically being treated as suspicious or presumed to have a substance use disorder. Clinical discussions should be respectful, collaborative, and free from unnecessary stigma. Patients should not have to fear that honestly describing their pain or asking about available treatment options will damage their relationship with their healthcare provider. For patients who have experienced years of medical dismissal or discrimination, these interactions can have lasting consequences for their willingness to seek care. 4. Distinguishing Physical Dependence From Addiction I encourage the Commission to ensure that its prescribing rules and clinical guidance clearly distinguish between physical dependence, opioid use disorder, and appropriate therapeutic use of prescribed opioid medications. Physical dependence is a physiological adaptation that can develop with repeated medication use. It is not, by itself, evidence of addiction. Opioid use disorder involves a problematic pattern of use that causes clinically significant impairment or distress. These are different medical concepts and should not be treated as interchangeable. Not every patient who takes prescribed opioids will experience physical dependence or develop an opioid use disorder. In my own experience, I have taken prescribed opioid pain medications for documented medical conditions and have never experienced withdrawal symptoms when reducing or discontinuing them. I recognize that other patients may have different experiences, but mine should not be dismissed simply because it differs from common assumptions about opioid use. I ask that the Commission's rules encourage individualized clinical assessments rather than assumptions based solely on whether a patient has been prescribed opioids, how long they

have taken them, or whether they require ongoing pain management. 5. Fear of Professional Discipline and Criminal Prosecution I am concerned about the effect that fear of professional discipline, investigation, or criminal prosecution may have on physicians' willingness to discuss or prescribe opioid medications when they are medically appropriate. I recognize that prescribing oversight and accountability are necessary to protect patients. However, when clinicians believe that discussing or prescribing an opioid could place their license, livelihood, or freedom at risk, that fear may influence clinical decisions even when a patient has a legitimate medical need. From the patient's perspective, this can create a healthcare environment in which both parties are afraid to speak openly. Patients may hesitate to describe the severity of their pain, while physicians may hesitate to consider the full range of appropriate treatment options. I ask the Commission to make clear that responsible, evidence-based prescribing within accepted standards of care should not automatically be treated as suspicious or inappropriate simply because an opioid medication is involved. The rules should provide clear expectations for appropriate documentation, clinical judgment, monitoring, and individualized risk assessment. They should also distinguish legitimate medical practice from reckless or unlawful prescribing. Protecting patients from unsafe prescribing is essential. Protecting access to medically appropriate treatment is also part of patient safety. 6. Safe Treatment Changes Decisions to taper or discontinue medication should involve meaningful patient participation, appropriate clinical assessment, and planning to avoid preventable harm or abandonment. Patients should not be subjected to abrupt or involuntary changes in treatment solely because of generalized fears, rigid numerical thresholds, or administrative pressure when those changes are not supported by an individualized clinical assessment. When a treatment must be changed for clinical safety reasons, patients should receive a clear explanation and an appropriate plan for continued care. 7. Disability Accessibility and Patient Participation Patients should be supported in bringing advocates or caregivers to appointments, and people living with chronic pain and disabilities should have meaningful representation in developing and evaluating prescribing policies. The Commission should consider how prescribing policies affect people with mobility limitations, neurological conditions, chronic illness, and other disabilities whose ability to participate in daily life may depend on adequate pain management. Policies should account for communication needs, mobility limitations, and reasonable accommodations rather than creating additional barriers to care. Patients with lived experience should be included not only when policies are being drafted, but also when their real-world effects are evaluated. 8. Consistent Statewide Standards for Pain Management Clinics I ask the Washington Medical Commission to address the lack of consistency patients may encounter between pain management clinics across Washington State. Patients should not face entirely different standards of care simply because they

attend a different clinic. One clinic may consider opioid treatment appropriate for a particular documented medical condition, while another may refuse to prescribe opioid medications for that same condition regardless of the patient's individual circumstances. I am particularly concerned about differences in clinic policies regarding patient eligibility, treatment agreements, medication monitoring, and dismissal from pain management programs. Patients should not be dismissed from care based on arbitrary, unclear, or inconsistently applied requirements. Dismissal from a pain management program can have serious consequences for patients with chronic pain, particularly when alternative providers are difficult to find. I recognize that individual physicians must retain the ability to exercise clinical judgment and that not every patient will require or benefit from the same treatment. However, clinical judgment should operate within consistent, evidence-based standards rather than entirely different rules established independently by each clinic. I ask the Commission, within its regulatory authority and in coordination with other appropriate licensing boards, to consider establishing or clarifying statewide minimum standards that address: * Consistent, medically appropriate criteria for evaluating opioid treatment. * Clear and transparent patient treatment agreements. * Fair, evidence-based criteria for discontinuing medication or dismissing a patient from a pain management program. * An opportunity for patients to understand and respond to concerns before dismissal, when clinically appropriate. * Appropriate continuity-of-care planning and referrals when a clinic ends treatment. * Protections against discriminatory or arbitrary treatment decisions based solely on diagnosis, disability, or the type of medication being considered. My goal is not to require every clinic to prescribe opioids or to remove physicians' clinical discretion. My goal is to ensure that patients throughout Washington receive fair evaluations, clear expectations, and consistent protections regardless of which pain management clinic they attend. A patient's access to fair and appropriate pain management should not depend on which clinic's front door they walk through. Conclusion I am not asking for unrestricted opioid prescribing. I am asking for a healthcare system in which safety and compassion coexist, where physicians can exercise responsible clinical judgment, and where patients with documented pain conditions are evaluated without stigma. I encourage the Commission to ensure its final rules protect patients from unsafe prescribing practices while also preserving access to appropriate, individualized pain treatment. Patients should not be afraid to ask for help, and physicians should not be afraid to provide medically appropriate care. Thank you for considering the perspective of patients whose lives are directly affected by these decisions. Sincerely, Aubrey Jones Washington State Resident Disability Advocate

Outlook

Comment #189

Public Comment on prescribing rules

From Shawn Rees <ssrtum1@gmail.com>
Date Tue 10/13/2026 7:54 PM
To WMC Medical Rules <Medical.Rules@wmc.wa.gov>

External Email

To Whom It May Concern:

I believe the pendulum has swung way too far towards making doctors fearful of lawsuits and monitoring rules regarding opioid use. I believe it has made patients like me left out and told to take gabapentin and tolerate pain. I believe we need to work on educating adults on opioids rather than pretending they no longer exist for people with real pain.

I'm just a normal school teacher that developed chronic abdominal pain that is thought to be from the fascia around my abdominal muscles. The treatment given helps, but I still live with pain every day; so much so that I use a heating pad at work.

I ask that deference be given to patients like me that have found themselves stuck in chronic pain during this post opioid world. There has to be a balanced way for people like me with pain to use opioids responsibly while also addressing the health concern for people with addiction problems. Maybe it's time to give more responsibility to adults by educating them, reform tort law to make it harder to sue doctors, and encourage doctors to use opioids for chronic pain when it is appropriate rather than be fearful of using them.

Thank you for your consideration. You may use my letter in any way you see fit. Thank you for what you do because I know it's not easy but it could help people like me live with less pain.

Shawn Rees
Puyallup, WA

Comment #190

From: Mariah Riggsby <m.riggsby92@gmail.com>
Sent: Wednesday, September 30, 2026 10:17 AM
To: DOH Secretary's Office <DOH.Secretary@DOH.WA.GOV>; DOH HSQA Customer Service Center <hsqa.csc@doh.wa.gov>; WMC <Medical.Commission@wmc.wa.gov>
Subject: Patient Advocacy: structural challenges and care continuity for pain patients

External Email

To the Washington State Department of Health and members of the panel

I am writing to share my experiences as a chronic pain patient and ask for meaningful attention to the barriers patients face when trying to access pain care in Washington. I have officially been a chronic pain patient since 2023. Managing chronic pain has been one of the hardest things I have ever dealt with, and navigating the healthcare system has added significantly to that burden.

I have experienced stigma from multiple pain providers, been denied care, and repeatedly felt that assumptions about my medications mattered more than understanding my condition, reviewing my information, or helping me find an appropriate path forward. I understand that medications require careful assessment and that not every treatment is appropriate for every patient. What I am asking for is individualized care, respectful communication, and decisions based on a meaningful review of the whole patient.

My PCP and behavioral-health providers have shown me what collaborative care can look like: listening, involving me in decisions, and communicating with one another. My concern is the breakdown in that collaboration across specialty care, referrals, and pharmacies. Patients should not have to rebuild their story and prove their daily limitations at every handoff.

At multiple appointments, I have brought concrete symptom and pain tracking data that providers did not meaningfully review. Instead, I have felt that conclusions were already formed from limited paperwork sent before the visit, before I had the opportunity to explain my experience. Records are important, but they should support a conversation, not replace listening to the patient.

Accurate documentation is another essential part of access to care. A recent specialist's note listed lamotrigine as an active medication even though I have not taken it for years. Patients need a clear, accessible process for requesting corrections and having disputed information reviewed, so future decisions are not based on inaccurate or unresolved information.

I have also experienced isolated recommendations without a coordinated plan to investigate underlying problems, manage symptoms, or support me over time. I recognize that not every condition can be cured, and symptom relief is an important goal. However, patients still deserve an effort to understand what is happening, address what can be addressed, and explain what comes next. Being denied care without a workable alternative leaves patients carrying both the pain and the responsibility for finding another option.

In my surgical care, I have experienced what I would describe as tunnel vision, where I felt my concerns and changes in my condition were not being fully considered. I had to repeatedly push for additional imaging, which subsequently showed worsening in my back. Patients should not have to fight to have their concerns meaningfully assessed or changes in their condition investigated.

I am also concerned about gender bias and whether women's reports receive the same attention without a male partner present. During one phone appointment, my surgeon unexpectedly asked whether my partner was present, without explaining why. In my interactions with him, I have felt that he showed more interest in my boyfriend's involvement than in listening directly to me and addressing my concerns. I cannot know his intent, but the impact was that I felt less heard as the patient. My account of my symptoms and limitations should carry weight whether or not my partner attends an appointment.

For patients covered by Washington Apple Health, access can be especially limited. In my experience, finding pain providers who accept my coverage and are willing to consider my care has been difficult. Having insurance does not necessarily mean having a realistic route to treatment.

The process described to me as an insurance “exemption” has created another barrier. I have encountered situations where a clinic will tell a referring provider or insurer that it will consider such an arrangement, but will not make that option clear to the patient. Meanwhile, the patient is still expected to identify potential clinics and gather their names, addresses, and contact information so the provider or insurer can reach out. An option that is difficult to discover and requires extensive patient coordination is not easily accessible. Patients need clear information about available coverage arrangements and practical help navigating them.

More broadly, too much of the work of finding and coordinating care is placed on patients. In my experience, including with my surgeon’s office, I have been left responsible for finding care and navigating next steps that I needed help arranging.

Chronic pain is not just pain. It can also involve fatigue, brain fog, and difficulty managing basic daily activities. Researching clinics, making repeated calls, gathering information, and coordinating between offices takes capacity that patients may not have. Having to perform the coordination work of a medical office adds significant stress and uses the limited energy we need for everyday life. Patients need practical referral assistance and communication between providers, not simply instructions to find care on their own.

Specialists should also consider the purpose and benefit of treatments managed by other clinicians. At my most recent pain-management intake, I was told that I would need to halve my pain medication and discontinue my anxiety medication before the provider would consider taking me on as a patient. I was ultimately denied care. My behavioral-health treatment was treated as a barrier, rather than something to discuss with the clinicians who know me and manage that care.

When medication concerns could determine whether a patient receives care, there should be direct clinician-to-clinician consultation with the patient’s established providers, with the patient’s involvement and ideally before the specialist visit. Patients should not be left to relay complex clinical information or navigate conflicting treatment demands alone.

I am asking for coordinated assessment of risks, benefits, and alternatives, not for legitimate safety concerns to be ignored. Treatment that helps manage my behavioral health should be considered as part of my overall care, not leave me without a path to pain care. Patients need their providers to work together rather than address one part of their health in isolation from the rest.

Pharmacy communication has also been a recurring concern. I have experienced prescribed medications being held, with poor communication about the reason or what needs to happen to resolve the issue. From the patient's side, these decisions can feel rigid, without consideration of individual circumstances or a clear route to clarification with the prescriber.

I understand that pharmacists have legal and clinical safety responsibilities. My concern is not that those responsibilities exist. It is that patients can be left without clear explanations, timely coordination, or a workable resolution when access to a needed medication is interrupted. Medication-related concerns should be handled through respectful communication and coordination, not leave patients feeling judged or caught between a pharmacy and a prescribing office.

There also needs to be a clear, safe pathway for urgent care during severe pain flares. In my experience, my PCP's office directs me to the emergency department, but emergency visits have not provided meaningful relief or a workable plan. Instead, I have experienced being treated as drug-seeking and sent home with advice to use Tylenol. If Tylenol were sufficient to manage the flare, I would not be seeking additional help.

I am not asking for a particular medication or for safety assessments to be bypassed. I am asking for timely assessment, respectful treatment, and an individualized plan when my pain exceeds what I can manage at home. Patients should not be passed between primary care and emergency care with neither setting providing a realistic path to help. We need an accessible urgent-care pathway for chronic pain flares, with coordination and follow-up rather than stigma and dismissal.

These experiences have made me concerned that chronic pain patients face recurring gaps in access, communication, and accountability. I can speak directly to my own experiences, and I am asking the Department and this panel to examine whether these barriers are affecting other patients as well, particularly those with limited insurance options or limited capacity to advocate for themselves.

I would like to see attention to the following changes:

- Better access to pain providers for Washington Apple Health patients, including clear information and practical support for coverage exceptions or other arrangements that may allow access to care.

- Meaningful review of patient-provided information and individualized assessment, rather than assumptions based on medication use or limited pre-visit paperwork.

- Accessible processes for correcting outdated or inaccurate records and reviewing disputed diagnoses.

- Whole-patient assessment, including consideration of established behavioral-health treatment and its role in the patient's wellbeing.

- Direct consultation with established prescribers when medication concerns may lead to changes being demanded or care being declined.

- Clear explanations when care is declined, along with appropriate referral guidance and support so patients are not left without a path forward.

- Greater responsibility for referral coordination and communication between medical offices, rather than placing that work entirely on patients.

- Clear, timely pharmacy communication about medication holds, including what is needed to resolve them and coordination with the prescriber.

- Attention to medication-related stigma and gender bias, including ensuring that patients are heard directly regardless of whether a partner is present.

- An accessible, clearly defined pathway for urgent assessment and management of severe chronic pain flares when routine outpatient care is unavailable or insufficient.

I am speaking up because these barriers cannot be addressed if patients' experiences are not heard. Patients should not need medical-system expertise, repeated complaints, or energy they do not have simply to access respectful care.

Please consider this letter as patient input for the relevant public meeting or panel discussion. I would appreciate information about how these concerns can be reviewed, what steps may be taken to address them, and whether there is an opportunity for me to provide further written or spoken public comment. If any of these concerns fall outside your authority, please direct me to the appropriate agency or body.

Thank you for your time and consideration.

Mariah Riggsby

10/17/2026

Comment #191

Re: The WMC is consideration of amending the opioid prescribing rules: MD WACs 246-919-850 through 246-919-985 and PA WACs 246-918-800 through 246-918-935.

To Washington Medical Commission:

As medical leaders and practicing clinicians within a Federally Qualified Health Center (FQHC), we appreciate the intent to ensure that patients with chronic pain, including patients receiving long-term opioid therapy, are treated with dignity and have access to appropriate care. Our clinicians care for populations that have historically experienced substantial barriers to healthcare and that have also been disproportionately affected by the harms associated with opioid prescribing and the opioid epidemic. This experience informs our belief that policies addressing opioid prescribing must balance access to appropriate pain treatment with the safeguards necessary to protect patients and communities from medication-related harm.

We are also concerned about the balance of perspectives represented in the development of this guidance. We have observed that much of the input appears to be coming from clinicians specializing in pain management, while a substantial portion of the practical impact will fall on primary care clinicians. Pain specialists bring essential expertise to this discussion, but their practice environment, resources, clinical focus, and patient population differ significantly from those of primary care.

This distinction is particularly important because guidelines commonly recommend specialty consultation or referral when a patient's treatment needs become unusually complex or extend beyond the parameters of routine prescribing guidance. In other words, pain specialists are, by the nature of their role, the clinicians to whom patients are referred when care approaches or exceeds the boundaries contemplated for generalist practice. Primary care clinicians, meanwhile, must determine whether they have the expertise and infrastructure to initiate or assume such treatment, often while simultaneously managing multiple other acute and chronic conditions. We therefore believe that primary care representation should be substantial in both the development of these recommendations and the assessment of their real-world consequences.

First, the implication that all licensed medical providers should be prepared to assume management of high-dose or otherwise complex opioid therapy is misguided. Licensure establishes the legal authority to prescribe; it does not mean that every clinician has the

training, experience, clinical infrastructure, or systems of care necessary to manage every form of high-risk prescribing safely.

Complex chronic pain management and high-risk opioid prescribing require more than the ability to write a prescription. Safe care may depend upon established prescribing protocols, appropriate monitoring, access to consultation, reliable follow-up, and systems for identifying and responding to medication-related risk. A clinician practicing without those supports should not be pressured to provide care outside the scope in which they believe they can practice safely.

Difficulty locating clinicians willing and qualified to manage complex chronic pain is an important access-to-care problem. However, that access problem cannot be solved by implying that every licensed clinician is therefore qualified or obligated to assume that care. Doing so shifts a systemic access problem onto individual clinicians without addressing the clinical infrastructure necessary to provide that care safely.

We strongly recommend explicit language affirming clinicians' ability to define their scope of practice. This is not simply a patient-by-patient prescribing decision; it is also a legitimate scope-of-practice decision. Clinicians should be supported when they clearly and consistently identify services that they are not equipped to provide safely.

Second, we are concerned that the proposed approach does not sufficiently preserve the autonomy and responsibility of the individual prescriber. We agree that treatment decisions should be based upon an individualized assessment of each patient. However, that principle must apply equally to a clinician who concludes that continuation of an existing regimen is appropriate and to one who, after independent assessment, concludes that modification of the regimen is necessary.

This is particularly important for patients sometimes characterized as “legacy” patients. A new prescriber should carefully consider the patient's history and the rationale for previous treatment decisions, but prior prescribing decisions cannot bind a subsequent clinician to the same treatment plan. Requiring a clinician to effectively justify disagreement with a predecessor's prescribing decisions risks substituting one arbitrary standard for another. Individualized care cannot simultaneously mean that the current prescriber must exercise independent clinical judgment while also implying that the prescriber should presumptively continue decisions made by others.

Finally, controlled-substance prescribing carries responsibilities extending beyond the immediate clinician-patient interaction. The potential for misuse, diversion, overdose, and other harms means that appropriate risk-mitigation strategies must remain available to prescribers. Guidance should not discourage clinically appropriate medication monitoring,

including toxicology testing, when the clinician determines that such monitoring is relevant to safe prescribing.

We recommend language along the following lines:

“Although diversion of controlled substances can be difficult to address within the medical setting, responsibility for mitigating diversion and other medication-related risks cannot rest solely with the prescriber. Safe prescribing may reasonably require patient participation in risk-mitigation measures, which may include shorter prescription durations, closer follow-up, medication monitoring, and clinically appropriate toxicology testing. Controlled substances carry significant potential risks, and clinicians must retain the ability to employ reasonable measures intended to reduce those risks.”

Our overarching concern is that efforts to protect patients from inappropriate discontinuation of opioid therapy should not inadvertently create a competing mandate that pressures clinicians to prescribe controlled substances outside their competence, established scope of practice, or independent clinical judgment. As an FQHC serving patients who have experienced both barriers to appropriate care and significant consequences from unsafe opioid prescribing, we believe strongly that improving access must not come at the expense of prescribing safety.

A sound policy should protect patient access and continuity of care while preserving clinician judgment, appropriate scope-of-practice boundaries, and reasonable safeguards for controlled-substance prescribing. It should also be developed with substantial input from the primary care clinicians who will be responsible for implementing it in everyday practice. We therefore recommend revising the proposed language to explicitly recognize these principles while ensuring that patients receiving long-term opioid therapy are treated respectfully, individually, and without abandonment.

Sincerely,

Ricardo Jimenez, MD
Philip Reilly, MD
Ellen Rak, MD
John Okrent, MD
Tony Stupski, DO
David Johnson, DO

Medical Leadership
Sea Mar Community Health Centers

PETITION FOR ADOPTION, AMENDMENT, OR REPEAL OF A STATE ADMINISTRATIVE RULE

Print Form

In accordance with RCW 34.05.330, the Office of Financial Management (OFM) created this form for individuals or groups who wish to petition a state agency or institution of higher education to adopt, amend, or repeal an administrative rule. You may use this form to submit your request. You also may contact agencies using other formats, such as a letter or email.

The agency or institution will give full consideration to your petition and will respond to you within 60 days of receiving your petition. For more information on the rule petition process, see Chapter 82-05 of the Washington Administrative Code (WAC) at http://apps.leg.wa.gov/wac/default.aspx?cite=82-05.

CONTACT INFORMATION *(please type or print)*

Petitioner's Name Maria Higginbotham

Name of Organization

Mailing Address 17118 South Vaughn Rd NW

City Vaughn State WA Zip Code 98394

Telephone `253-381-1783 Email maria98335@comcast.net

COMPLETING AND SENDING PETITION FORM

- Check all of the boxes that apply.
- Provide relevant examples.
- Include suggested language for a rule, if possible.
- Attach additional pages, if needed.
- Send your petition to the agency with authority to adopt or administer the rule. Here is a list of agencies and their rules coordinators: http://www.leg.wa.gov/CodeReviser/Documents/RClist.htm.

INFORMATION ON RULE PETITION

Agency responsible for adopting or administering the rule: Washington Medical Commission, Washington Dept of Health

☐ **1. NEW RULE - I am requesting the agency to adopt a new rule.**

☐ The subject (or purpose) of this rule is: _____

☐ The rule is needed because: _____

☐ The new rule would affect the following people or groups: _____

2) AMEND RULE-I am requesting the agency to change an existing rule

List rule number (WAC) if known: WAC 246-919-850 through 246-919-990 and WAC 246-918-800 through 246-918-835

a) I am requesting the following change:

Add the following language: Not all chronic pain patients should or must have their prescription opioid medications reduced, tapered, cut, or otherwise decreased. If a patient is stable on opioid therapy and has been compliant with their treatment plan: any such reductions are a violation of State policy, and destabilizing the patient, by decreasing their medication, is below the standard of care and a violation of state law. Treatment plans should not be altered or changed unless a violation occurs

b) This change is needed because:

Physicians fear regulatory scrutiny. Abandoned or undertreated pain patients are often forced to suffer agonizing pain. Destabilizing these patients often forces patients to choose to seek relief illicitly, using dangerous and deadly street drugs. Due to psychological distress, tapering creates a mental health crisis of being abandoned, many have overdosed or committed suicide. In the event of a violation of a treatment contract, the treating practitioner should investigate to determine whether a purported violation is accurate and assess its severity level. The investigation should always include a face-to-face meeting with the patient to discuss potential violations, and, as appropriate, to remediate them

c) The effect of this rule change will be:

To define the standard of care and stop unnecessary patient harm. WAC 246-919-850 WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. According to the CDC the misapplication or use of inappropriate policies and being inflexible on opioid dosage and duration, discontinuing or dismissing patients from a practice, tapering stable patients has caused significant patient harm

d) The rule is not clearly or simply stated:

There is no upper MME/MED limit or ceiling limit in Washington State or federal law. Washington State does not have an upper limit for opioid prescribing. The rules call for a consult with Pain Management at 120 MME

2) AMEND RULE-I am requesting the agency to change an existing rule

List rule number (WAC) if known: WAC 246-919-850 through 246-919-990 and WAC 246-918-800 through 246-918-835

a) I am requesting the following change:

Add the following language: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by specific morphine milligram equivalent (MME) guidelines. Neither the State of Washington nor federal law require dose, strength, quantity, or duration limitations on prescription opioids. In addition, Washington does not have an "upper limit" for opioid prescribing.

b) This change is needed because:

Many physicians and medical personnel are unaware that there is NOT a maximum MME dose in Washington State. The 2016 CDC Opioid Prescribing Guidelines have been misapplied and have caused direct harm to the pain community. If a patient is stable and has been compliant with their treatment plan then forcing tapers of stable patients to a specific MME aka MED, is a violation of the state law and below the standard of care. Abruptly tapering or discontinuing opioids may cause serious patient harms including severe withdrawal symptoms, uncontrolled pain, psychological distress, and in rare instances, suicide.

c) The effect of this rule change will be:

To stop practitioners from setting dosage limits aka MME or MED, inferring to patients that they are required to set such limits and/or tapering a patient's medication, reminding them to view pain management as a part of standard medical practice for all patients, and becoming knowledgeable about assessing pain and effective treatments to avoid destabilizing patients

d) The rule is not clearly or simply stated:

There is no upper MME/MED limit or ceiling limit in Washington State or federal law. Washington State does not have an upper limit for opioid prescribing. The rules call for a consult with Pain Management at 120 MME

Also, there are so many different rules and or guidelines for prescribers. They find it confusing which forces them to make the decision to either taper stabilized patients or completely stop prescribing opioids. This has left thousands of patients without care.

For example:

The Washington State Health Care Authority states on their website:

Pharmacy Opioid Quick Reference Guide:
Opioids are limited to 120 Morphine Milligram Equivelent (MME) per day
Pharmacy claims for opioids will reject if a single prescription or a combination of prescriptions exceed the MME limit

2) AMEND RULE-I am requesting the agency to change an existing rule

List rule number (WAC) if known: WAC 246-919-850 through 246-919-990 and WAC 246-918-800 through 246-918-835

a) I am requesting the following change:

ADD EXEMPTION: RARE DISEASES-Patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National Institutes of Health (NIH) are Exempt from these guidelines and/or policies.

b) This change is needed because:

According to the NIH there are over 10,000 rare diseases affecting more than 30 million US citizens of which 90% are without treatment. A rare disease is a disease or condition that affects less than 200,000 people in the United States. Many are life threatening and most do not have treatments.

c) The effect of this rule change will be:

Adding Rare Disease as an Exemption ensures that ALL Americans suffering from Rare Diseases receive adequate pain treatment. Sickle Cell Disease is but 1 of 10,000 rare diseases that cause intractable pain. Many patients search for 8-10 years for a diagnosis. According to the NIH, misdiagnoses delay specialty care. Often these delays cause the disease to progress uncontrollably and to increase in severity, especially in terms of persistent and worsening chronic pain.

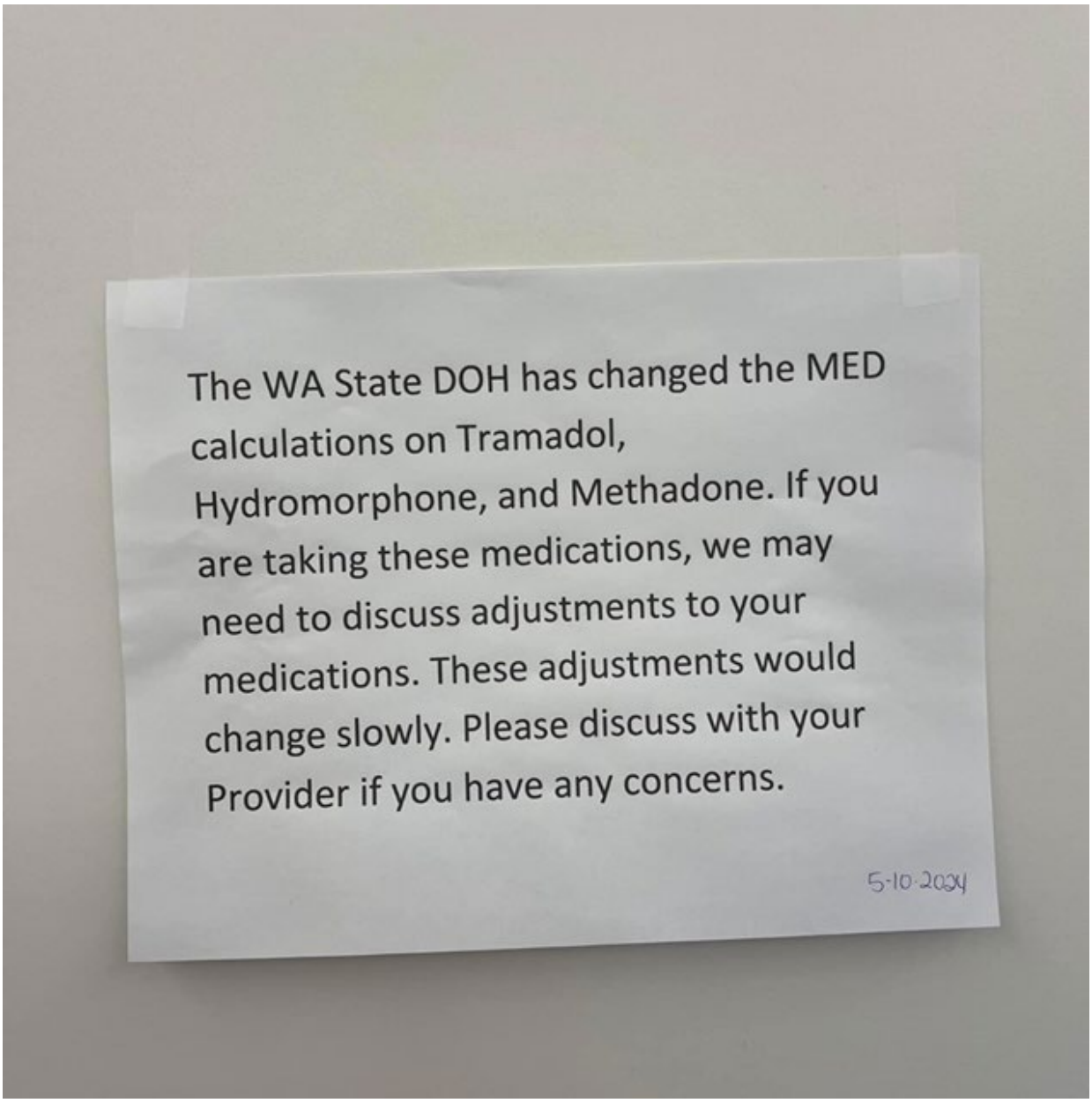
d) The rule is not clearly or simply stated:

From: Maria
To: Boyd, Amelia (WMC)
Subject: Notice in doctors office
Date: Monday, July 15, 2024 9:55:01 AM

External Email

This just one pain practice, the other clinic has 15 offices. It's so very alarming.

Regards
Maria Higginbotham



Sent from my iPhone

Pulled from the following on July 15, 2024: Pain Patients Feel Abandoned by U.S. Healthcare System — Pain News Network

Pain Patients Feel Abandoned by U.S. Healthcare System

January 12, 2024

By Pat Anson, PNN Editor

Many pain patients feel abandoned by the U.S. healthcare system and say it's increasingly difficult to find a doctor or obtain opioid analgesics, according to a large new survey by Pain News Network. Some patients have turned to other substances – both legal and illegal -- for pain relief, and almost a third have contemplated suicide.

Nearly 3,000 pain patients or their caregivers participated in PNN's online survey in the final weeks of 2023.

Over 90% of those with opioid prescriptions said they faced delays or problems last year getting their prescriptions filled at a pharmacy. Nearly a third were hoarding opioids because of fear they'll not be able to get them in the future. And over 40% rated the quality of their pain care as "bad" or "very bad."
"I've given up hope of getting help for chronic, severe pain in this country. I'm planning to move to where I can receive humane treatment," one patient told us.

"The hoops in which I have had to jump through to get the minimal help that I have gotten throughout the years is ridiculous," said another. "I have a very extensive and very well documented history of mental and physical trauma, but I am still treated as a drug seeker. I am currently unable to get any form of medication."

"Every pain patient worries, from one month to the next, if their doctor will cut them off opioids or force taper them to such low levels that there is NO pain relief," another patient wrote.

HOW WOULD YOU RATE THE CURRENT QUALITY OF YOUR PAIN CARE?

- Very Good
- Good
- Adequate
- Bad
- Very Bad

“I’ve spent the last 8 years explaining my inadequate pain control and lack of sleep that has fallen on deaf ears. I’ve tried so many different doctors and now feel like no one cares at all. Honestly feel as though they would rather see me die and be rid of me,” said another.

‘Impossible to Find Help’

About one in every four patients said they were tapered to a lower dose or taken off opioids — but only a small number were referred to addiction treatment. Less than one percent of those who stopped opioid treatment said it improved their pain and quality of life.

One in five patients couldn’t find a doctor to treat their pain. Many were abandoned by a physician or had a doctor who retired from clinical practice.

- 20% Unable to find doctor willing to treat pain
- 14% Doctor retired or left their practice
- 12% Abandoned or discharged by a doctor
- 27% Tapered to a lower dose or taken off opioids
- 3% Received a referral for addiction treatment
- 0.6% Stopped opioids & pain and quality of life improved

“My primary retired. Then my rheumatologist moved to another state. Now most doctors don't prescribe and it's impossible to find help,” a patient wrote.

“Every pain management office in my area were nothing but nightmares waiting to happen. And every person I talked to… were solely concerned with either

getting people off of pain medication or reducing the amount of medicine by over half," said another.

"Doctors I talked to said they felt like they had a gun to their head and that they are being watched, so they won't prescribe or prescribe very little," a patient wrote.

"My insurance just capped opioids to 7 days a month, so I have to choose whether to buy the other 3 weeks and cut back on my food budget, or take to my bed for 3 weeks a month," said another.

"I am unable to find a new doctor to treat pain. A couple of years ago I was tapered from a previously working amount of pain med, so now I have daily severe pain and too many sleepless nights from pain. But the doc doesn't care. It seems my clinic system only sees me as an addict," wrote another pain patient.

Risky Choices

With pain care increasingly difficult to find, nearly a third of patients said they considered suicide in the past year because their pain was so severe. Others adopted risky behaviors, such as hoarding opioid medication, obtaining opioids from another person, buying illicit substances off the black market, or using alcohol, cannabis and other substances for pain relief.

- 29% Considered suicide
- 32% Hoarded opioid medication
- 30% Used cannabis for pain relief
- 14% Used alcohol for pain relief
- 11% Used kratom for pain relief
- 11% Obtained prescription opioids from friend, family or black market
- 4% Used heroin, illicit fentanyl or illegal substance for pain relief

"I was taken off my prescription opioid twice and attempted suicide twice because the other prescriptions were not effective," one patient told us.

“I have a therapist that has been helpful, because I have considered taking my life. He is concerned that I'm not getting adequate pain relief,” said another.

“Since suicide is against my faith, I prayed for death,” one patient wrote.

“I know so many people that have stopped going to doctors and started buying heroin off the street. They say it’s easier and cheaper,” another patient said.

“The obscenely high cost of medical marijuana made me suffer so much financially that I have been unable to make use of the compassion center’s offerings,” wrote another patient. “Why on earth do we let plants be illegal in the first place, then let them be sold for so much money that they are almost impossible to afford on a disability income?”

“We desperately need to get away from the denial of opioids as a way to deal with this crisis. So far, the results of these laws on opioids have been an abject failure. Deaths have not been reduced, but actually increased due to chronic pain patients having to resort to suicide,” said another.

“I hope that all the people who are in charge of this will one day feel what I do and have some grasp of the pain situation people are forced to live through. They take care of their dogs and cats better than human beings,” a patient said.

“I have considered suicide multiple times over the past few years. These laws, while meant to curb illicit abuse of these medications, are harming legitimate patients like myself,” another patient wrote. “The worst part is that, for the time being, it looks like things are going to get much, much worse for me and the millions of others like me.”

PNN’s online survey was conducted from November 13 to December 31, 2023. A total of 2,961 U.S. pain patients or caregivers participated. We’ll be releasing more results in the coming days.

From: Maria Higginbotham
To: Boyd, Amelia (WMC)
Subject: Study done by Health Affairs Scholars
Date: Monday, July 15, 2024 10:30:53 AM

External Email

Abstract

Changes in chronic noncancer pain treatment have led to decreases in prescribing of opioids and increases in the availability of medical cannabis, despite its federal prohibition. Patients may face barriers to establishing new care with a physician based on use of these treatments. We compared physician willingness to accept patients based on prescription opioid, cannabis, or other pain treatment use. This study of 36 states and Washington, DC, with active medical cannabis programs surveyed physicians who treat patients with chronic noncancer pain between July 13 and August 4, 2023. Of 1000 physician respondents (34.5% female, 63.2% White, 78.1% primary care), 852 reported accepting new patients with chronic pain. Among those accepting new patients with chronic pain, more physicians reported that they would not accept new patients taking prescription opioids (20.0%) or cannabis (12.7%) than those taking nonopioid prescription analgesics (0.1%). In contrast, 68.1% reported willingness to accept new patients using prescribed opioids on a daily basis. For cannabis, physicians were more likely to accept new patients accessing cannabis through medical programs (81.6%) than from other sources (60.2%). Access to care for persons with chronic noncancer pain appears to be the most restricted among those taking prescription opioids, although patients taking cannabis may also encounter reduced access"
Full study in link below:
https://academic.oup.com/healthaffairsscholar/article/2/6/qxae086/7691431?login=false

Health Affairs Scholar, 2024, **2**(6), qxae086
https://doi.org/10.1093/haschl/qxae086
Advance access publication: June 12, 2024
Brief Report

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Access to care for patients with chronic pain receiving prescription opioids, cannabis, or other treatments

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Abstract

Changes in chronic noncancer pain treatment have led to decreases in prescribing of opioids and increases in the availability of medical cannabis, despite its federal prohibition. Patients may face barriers to establishing new care with a physician based on use of these treatments. We compared physician willingness to accept patients based on prescription opioid, cannabis, or other pain treatment use. This study of 36 states and Washington, DC, with active medical cannabis programs surveyed physicians who treat patients with chronic noncancer pain between July 13 and August 4, 2023. Of 1000 physician respondents (34.5% female, 63.2% White, 78.1% primary care), 852 reported accepting new patients with chronic pain. Among those accepting new patients with chronic pain, more physicians reported that they would not accept new patients taking prescription opioids (20.0%) or cannabis (12.7%) than those taking nonopioid prescription analgesics (0.1%). In contrast, 68.1% reported willingness to accept new patients using prescribed opioids on a daily basis. For cannabis, physicians were more likely to accept new patients accessing cannabis through medical programs (81.6%) than from other sources (60.2%). Access to care for persons with chronic noncancer pain appears to be the most restricted among those taking prescription opioids, although patients taking cannabis may also encounter reduced access.

Key words: access to care; prescription opioids; opioid analgesics; cannabis; medical marijuana; survey; primary care; chronic pain.

Introduction

The treatment landscape for chronic noncancer pain, which impacts more than 1 in 5 Americans,[1] has undergone significant shifts over the last decade. Treatment with prescription opioids has broadly declined in response to changing clinical guidelines and other policies designed to curb opioid misuse,[2] and the use of cannabis for chronic pain management has increased with state legalization of cannabis for medical conditions.[3] Contemporary guidelines emphasize the use of nonopioid, non-cannabis options as first-line treatment for chronic noncancer pain.[4-6] Anecdotally, there is stigma around prescription opioid use for chronic pain.[7] As physicians move away from treating pain with opioids, they may be less willing to accept new patients using prescription opioids to manage pain. Physicians may also be uncomfortable managing patients using cannabis, given that its use is not guideline-concordant and remains prohibited under federal law.

Consequently, patients with chronic noncancer pain may face barriers to initiating treatment with a physician if they use prescription opioids or cannabis for pain management. While caring for patients with chronic pain has been cited as one of the most difficult issues encountered by physicians, no studies have examined how access varies based on patients' use of different types of pain treatments.[8] To address these gaps, this investigation analyzed a national survey of US physicians treating patients with chronic noncancer pain in states with active medical cannabis programs in 2023. This study assessed physicians' willingness to accept new patients with chronic pain using prescription opioids, cannabis, and nonopioid prescription analgesics.

Data and methods

In this cross-sectional web survey, we examined a national sample of physicians practicing in the 36 states and Washington, DC, with active medical cannabis programs in July–August 2023. Ipsos fielded the survey using the SurveyHealthcareGlobus physician survey panel. This opt-in panel includes approximately 800 000 US physicians (~75% of active US physicians) recruited from the American Medical Association (AMA) Masterfile, hospital directories, and other verified medical directories of physicians. For this study, physicians with specialties that commonly treat chronic noncancer pain (family medicine, internal medical, general medicine, anesthesiology, neurology, physical medicine,

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and rehabilitation) were included in the survey sample if they reported spending 50% or more of their professional time caring for patients, if they cared for 100 or more patients in the past year, and if they cared for any patients with chronic noncancer pain in an outpatient clinical setting in the past year. A screening survey identified eligible physicians, who were then invited via email to participate in a survey on "chronic non-cancer pain management." The survey was fielded from July 13, 2023, to August 4, 2023 (additional details in the eMethods). Respondents received an incentive between $20 and $30 for their participation in the survey.

We first asked physicians about their behaviors of whether they were accepting any new patients with chronic noncancer pain. Among physicians who responded "yes" to accepting new patients with chronic noncancer pain, we examined responses to the following questions about type of pain treatment: "Do you currently accept new patients with chronic noncancer pain who are managing their pain with [prescription opioids, cannabis, nonopioid prescription analgesics]?" Physicians who reported accepting new patients using opioids were asked about their preferences of whether they would accept patients who take prescribed opioids "on a daily basis" for pain. Physicians who reported accepting new patients using cannabis were asked whether they would accept "patients accessing cannabis through the state medical cannabis program" and/or "patients using cannabis obtained from sources other than the state medical cannabis program." Survey questions only allowed for binary (yes/no) responses. We calculated the proportion responding "yes" to each of these items.

All analyses incorporated survey sampling weights to generate estimates representative of physicians in the 36 states and Washington, DC, included in the sample, with the AMA physician Masterfile data used as the sample weighting benchmark. The variables analyzed in this report did not have missing data. The Weill Cornell Medical College Institutional Review Board approved this study.

Results

Of 1372 physicians identified as eligible, 1000 (73%) completed the full survey (median age [SD], 52 [11.3] years; 34.5% female; 35.9% non-White) (eFigure S1). Most identified as primary care physicians (78.1%), and nearly half of physicians (46.5%) treated a panel with a proportion of patients with chronic pain between 1% and 33% (eTable S1). Only 26.7% of physicians reported completion of their state's authorization process for formally recommending patients for use of cannabis through the state program.

Overall, 82.8% of physicians reported currently accepting any new patients with chronic pain. Among this group, 20.0% (95% CI, 16.8%–23.2%) of physicians were not willing to accept new patients taking prescription opioids and 12.7% (95% CI, 9.9%–15.4%) were not willing to accept new patients taking cannabis. In contrast, 0.1% (95% CI 0.0%–0.2%) of physicians were unwilling to accept new patients taking nonopioid prescription analgesics (Figure 1). Physician characteristics did not differ among those who were not willing to accept patients taking prescription opioids when compared with those who were not willing to accept patients taking cannabis (eTable S2).

The proportion of physicians willing to accept new patients with chronic pain varied based on characteristics of analgesic use (Figure 2). For prescription opioids, while 80.0% (95% CI, 76.8%–83.2%) reported willingness to accept patients using any prescription opioids, 68.1% (95% CI, 64.4%–71.9%) reported willingness to accept new patients taking prescription opioids on a daily basis. For cannabis, physicians were more likely to accept patients accessing cannabis through medical cannabis programs (81.6%; 95% CI, 78.5%–84.7%) than those using cannabis obtained from other sources (60.2%; 95% CI, 56.1%–64.2%).

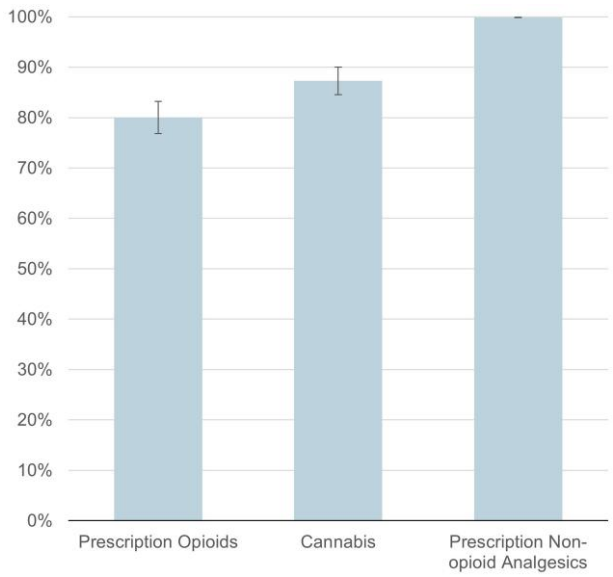

Figure 1. Proportion of physicians accepting new patients with chronic noncancer pain by type of existing chronic pain treatment. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13, 2023, to August 4, 2023, among respondents willing to accept new patients with chronic noncancer pain ($n = 852$). Measures signify the proportion responding "yes" to the question: "Do you currently accept new patients with chronic noncancer pain who are managing their pain with [prescription opioids, cannabis, nonopioid prescription analgesics]?" Error bars show 95% CIs. Results account for sampling weights.

Discussion

Among physicians actively accepting new patients with chronic pain, 20.0% were unwilling to accept a new patient taking prescription opioids, while 12.7% were unwilling to accept a new patient taking cannabis. In contrast, few physicians (0.1%) were unwilling to accept a new patient taking nonopioid prescription analgesics. Physician acceptance of new patients was lower for patients using prescribed opioids on a daily basis and higher for those using cannabis obtained from medical programs compared with cannabis from other sources.

These findings build upon the small number of state-based studies that have uncovered reluctance among physicians to treat new patients taking prescription opioids.[9,10] A phone-based audit survey of primary care clinics in Michigan found that 41% of 79 clinics that were contacted would not accept new patients receiving prescription opioids as a treatment for chronic pain.[10] Study findings also suggest that people using medical cannabis for pain management may face access barriers. This lack of access could inadvertently encourage patients to seek nonmedical treatments for their chronic pain, given that relief of pain is the most commonly reported reason for misuse of controlled substances.[11] In response to concerns

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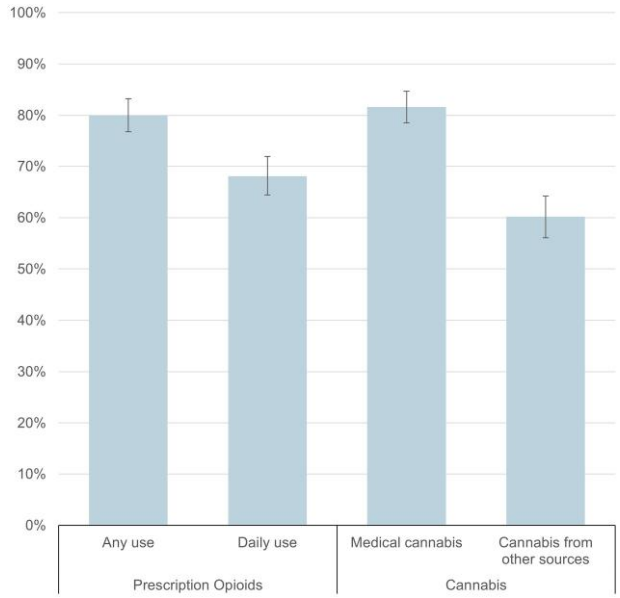

Figure 2. Proportion of physicians willing to accept new patients with chronic noncancer pain by frequency of prescription opioid use and source of cannabis for pain management. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13, 2023, to August 4, 2023, among respondents willing to accept new patients with chronic noncancer pain ($n = 852$). Physicians were asked if they currently accept new patients with chronic noncancer pain who are managing their pain with prescription opioids and, among those who said yes, whether they accepted patients who take prescribed opioids "on a daily basis" to manage their pain. Physicians who reported accepting new patients using cannabis were asked whether they accepted "patients accessing cannabis through the state medical cannabis program" and/or "patients using cannabis obtained from sources other than the state medical cannabis program." Error bars show 95% CIs. Results account for sampling weights.

about difficulty for patients to obtain care, some states have passed legislation that prohibits physicians from denying care to persons who take cannabis, such as California AB-1954.[12]

For both prescription opioids and medical cannabis, gaps exist regarding high-quality studies that critically examine their effectiveness as long-term treatments for chronic noncancer pain, which may contribute to uncertainty regarding their analgesic use.[3,13] Physicians endorse a general lack of knowledge on the clinical risks as well as benefits of cannabis to manage chronic noncancer pain.[14] For prescription opioids, evidence on their long-term effectiveness for chronic noncancer pain remains very limited, while the risk of harm appears to be dose dependent.[15]

Limitations of this analysis include its use of a convenience sample, although the physician panel used includes 75% of active physicians in the United States and analyses were weighted to representative benchmarks. Physicians' responses may be influenced by social desirability bias, a concern we worked to mitigate by use of an anonymous survey. While this analysis examines factors that correlate with some survey responses, examination of factors with all survey responses was not performed. Finally, the inclusion of binary responses to questions asking about actual practices regarding the acceptance of patients may not capture whether providers consider the use of these treatments in their patient acceptance decisions and instead inadvertently lead to reporting of preferences rather than actual practices.

In conclusion, these results indicate that access to care may be the most restricted for patients taking prescription opioids, although patients taking cannabis may also encounter reduced access.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Access to data and data analysis

Dr. Stone had full access to all the data in the study, analyzed the data, and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Data availability

The data will not be shared per the data use agreement with Ipsos, which only allows access by the study team.

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DRAFT

Proposed as of October 22, 2026

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-919-850 **Intent and scope.** The rules in WAC 246-919-851 through 246-919-985 provide requirements and guidance for prescribing opioids to treat pain. They establish that patients in Washington should have access to safe, effective, and appropriate pain relief, and that pain management is an integral part of quality medical care. Physicians are encouraged to be knowledgeable about assessing pain, using both pharmacologic and non-pharmacologic treatments, and understanding the legal and regulatory requirements for prescribing opioids, including traditional opioid agonists and partial agonists.

The rules recognize that tolerance and physical dependence from long-term opioid use are normal and distinct from opioid use disorder. Physicians are expected to incorporate safeguards to reduce the risks of misuse, diversion, and harm, including monitoring prescriptions, using urine drug testing, educating

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patients on safe storage and disposal, and ensuring naloxone availability when appropriate.

A prescription is considered legitimate when issued in the course of professional practice, based on sound clinical judgment, and supported by appropriate documentation of the patient's clinical needs and treatment. Physicians should not fear disciplinary action by the commission for ordering, prescribing, dispensing, or administering controlled substances, including opioids, for a legitimate medical purpose in the course of professional practice.

The Medical Practice Act and commission rules govern the practice of medicine and opioid prescribing in Washington. Physicians should exercise their professional judgment in applying federal and state guidelines to individual patients. Consistent with applicable laws, commission rules take precedence over conflicting guidelines. Applying blanket dosing limits or requiring tapering solely on the basis of federal or state guidelines, without an individualized assessment of the

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patient's clinical needs and circumstances, may fall below the standard of care.

Treatment decisions should be individualized, considering the patient's diagnosis, overall functioning, and clinical needs, rather than relying solely on dosage or quantity limits. A physician should not refuse to initiate or continue opioid therapy solely because a patient is using or has used opioid medications. Such a decision may undermine access to appropriate medical treatment and may fall below the standard of care. Decisions to initiate, continue, modify, or discontinue opioid therapy should reflect clinical need, patient stability, and the physician's professional judgment. Physicians should not deny or taper opioid therapy automatically based on prior or current opioid use without an individualized assessment.

Physicians retain professional judgment to adapt care based on patient circumstances, available resources, and evolving clinical knowledge, with documentation supporting clinical decisions.

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Physicians

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 treatment of patients with sickle cell disease;

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

(4) The treatment of patients with chronic noncancer pain receiving ongoing, individualized treatment based on their clinical needs, and must not be based solely on opioid dosage or changes in dosage. Changes in opioid dosage, including increases or decreases, do not by themselves disqualify a patient from this exclusion. The patient must not exhibit aberrant behavior as defined in WAC 246-919-852.

(5) The provision of procedural medications;

(6) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

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(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

(7) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection (5) of this section.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-851, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71A.800, 18.71.017, and 18.130.050. WSR 22-22-039, § 246-919-851, filed 10/25/22, effective 11/25/22. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

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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) Biopsychosocial assessment means an evaluation that considers the biological, psychological, and social factors that may influence a patient's health status, pain experience, and treatment outcomes. The assessment may include, as clinically appropriate, the patient's medical history, mental health

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status, substance use history, functional status, and social or environmental factors that may affect treatment planning.

(5) "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. Cancer related pain may persist past the treatment and into the remission phase.

(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 pain that persists for more than twelve weeks.

(6) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.

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(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-impact chronic pain" (HICP) means pain that has been present for ninety days or longer and that results in substantial restriction, limitation, or inability to carry out usual life or work activities, such as employment, education, household responsibilities, or social participation, on most or all days during that period.

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

(11) "Hospital" means any health care institution licensed pursuant to chapters 70.41 and 71.12 RCW, and RCW 72.23.020.

Commented [DB1]: This definition is based on the federal standards developed by the U.S. Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). The CDC defines *high-impact chronic pain* as chronic pain (pain on most days or every day in the past three months) that interferes with life or work activities on most or all days during that period. The NIH and National Center for Complementary and Integrative Health (NCCIH) further describe it as pain lasting three months or longer that substantially limits a person's ability to engage in major life activities such as employment, household responsibilities, or social participation.

Commented [DB2R1]: We do not reference this phrase anywhere in this proposed version of the rules.

(12) "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.

(13) "Morphine equivalent dose" or "MED" means a standardized measurement expression the potency of opioids in terms of an equivalent dose of morphine. MED is considered the same as morphine milligram equivalent or MME.

(14) "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.

(15) "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.

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(16) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illnesses.

(17) "Perioperative pain" means acute pain that occurs surrounding the performance of surgery.

(18) "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."

(19) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71, 18.71B or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.71C RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(20) "Refill" or "renewal" means a second or subsequent filling of a previously issued prescription.

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(21) "Subacute pain" is a continuation of pain that is six- to twelve-weeks in duration.

(22) "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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

WAC 246-919-865 Patient notification, secure storage, and disposal. (1) The requirements in this section do not apply to

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the administration of an opioid including, but not limited to, the following situations as documented in the patient record:

(a) Emergent care;

(b) Where patient pain represents a significant health risk;

(c) Procedures involving the administration of anesthesia;

(d) When the patient is unable to grant or revoke consent; or

(e) MAT for substance use disorders.

(2) The physician shall discuss with the patient 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, including the risk of dependence and overdose, possible co-prescription of overdose reversal medication as clinically indicated, as appropriate to the medical condition, the type of patient, and the phase of treatment;

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(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments, whenever reasonable, clinically appropriate, evidence-based alternatives exist;

(c) The safe and secure storage of opioid prescriptions;

(d) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs; and

(e) That the patient has the right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

(3) If the patient is under eighteen years old or is not competent, the discussion required by subsection (2) of this section must include the patient's parent, guardian, or the person identified in RCW 7.70.065, unless otherwise provided by law.

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(4) The physician shall document completion of the requirements in subsection (2) of this section in the patient's health care record.

(5) The information in subsection (2) of this section must also be provided in writing. This requirement may be satisfied with a document provided by the department of health.

(6) To fulfill the requirements of subsection (2) of this section, a physician may designate any individual who holds a credential issued by a regulatory authority under RCW 18.130.040 to provide the information.

[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]

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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. Patient function and quality of life are the paramount concerns when considering treatment alternatives. The physician should consider all aspects of multimodal treatment, when clinically appropriate.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-870, filed 11/16/18, effective 1/1/19.]

WAC 246-919-875 Continuing education requirements for opioid prescribing. (1) To prescribe an opioid in Washington state, a physician licensed to prescribe opioids must complete a minimum of one-hour of continuing education in best practices for pain management. (2) For the purposes of this section, "best practices" includes, but is not limited to, education relevant to the physician's scope of practice and patient population,

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including safe prescribing, pain assessment, risk mitigation, and regulatory requirements.

(3) 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 initial licensure.

(4) The hours spent completing training in prescribing opioids count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

(5) A review of WAC 246-919-850 through 246-919-985 may be counted toward the one-hour continuing education requirement. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]

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

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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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-880, filed 11/16/18, effective 1/1/19.]

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

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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. When a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a seven-day supply of opioids.

Commented [MM3]: Stanos comment requests removal. I do not read this as a hard limit. Question for attendees - is it being read as such? If so, how to alter to communicate intent to show justification?

(4) The physician shall reevaluate the patient's progress and determine 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;

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(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 opioids in combination with other medications, 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 with the exception of buprenorphine.

Commented [MM4]: Does the data still support this? My recollection is that this was a suboxone issue.

(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.

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[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-885, filed 11/16/18, effective 1/1/19.]

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 seven-day supply or less will often be sufficient. When a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a seven-day supply of opioids.

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(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 opioids in combination with other medications, 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 with the exception of buprenorphine.

Commented [MM5]: Does the data still support this statement? For every procedure?

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(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 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.
[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-890, filed 11/16/18, effective 1/1/19.]

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.

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(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:

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(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-895, filed 11/16/18, effective 1/1/19.]

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.

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(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, when a longer duration is clinically indicated and documented in the patient record, the physician may prescribe more than a fourteen-day supply of opioids.

(3) If a prescription results in the patient receiving opioids in combination with other medications, 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

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transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-919-905 through 246-919-955, shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-900, filed 11/16/18, effective 1/1/19.]

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 pharmacologic and nonpharmacologic and their efficacy;

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(d) Relevant behavioral health and psychosocial risk factors, including substance use, that may affect the patient's pain, function, or risk of opioid-related harms; and

(e) Patient goals and treatment expectations.

(2) Appropriate physical examination.

(3) Ancillary information and tools include:

(a) Review of the prescription monitoring program in accordance with the provisions of WAC 246-919-985;

(b) Any pertinent diagnostic, therapeutic, laboratory, or biological specimen test results;

(c) Pertinent consultations;

(d) Use of validated screening or assessment tools, when clinically appropriate, to evaluate pain, function, behavioral health conditions, or risk for adverse outcomes associated with opioid therapy; and

(e) Review of prior treatment records or care plans, when available and clinically relevant.

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(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 initiating or continuing chronic opioid treatment in the context of the patient's condition, clinical goals, and prior response to care;

(c) The patient's pain, function, quality of life, and progress toward treatment goals; and

(d) Pertinent concerns identified through PMP review, consultations, or other clinical information.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]

WAC 246-919-910 Treatment plan—Chronic pain. (1) The physician, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop and

Commented [MM6]: Do we need to say this? What practitioner would not have a treatment plan for ANY patient with a condition? Is that not the standard of care?

Commented [DB7R6]: Since we are moving toward a more individualized medical-decision making model with this draft, keeping this section provides a framework for the evaluation, monitoring, reassessment, and consultation provisions we are proposing elsewhere in these rules.

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document an individualized opioid treatment plan appropriate to the patient's needs.

(2) The treatment plan shall include:

(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.]

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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;

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(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]

WAC 246-919-920 **Periodic review—Chronic pain.** The physician shall periodically review the course of treatment for chronic pain. When conducting periodic reviews of patients receiving chronic opioid therapy, physicians must evaluate all relevant clinical factors, including patient adherence, stability, and functional status. Treatment plans should not be altered or discontinued solely due to the patient exceeding morphine milligram equivalent (MME) dose thresholds or other numeric limits if the patient remains stable and compliant with the treatment plan. Any modifications must be justified by

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clinical indications and documented in the patient record to support individualized care and maintain patient safety. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-920, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-920, filed 11/16/18, effective 1/1/19.]

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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-925, filed 11/16/18, effective 1/1/19.]

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WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain. (1) 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.

(2) The physician may consider referral for additional evaluation or treatment when it may support the patient's treatment objectives. Referral may be particularly appropriate for chronic pain patients who:

(a) are under eighteen years of age;

(b) experience declining function or lack of clinically meaningful functional improvement;

(c) require escalating opioid therapy without corresponding improvement in pain, function, or other treatment objectives;

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(d) present elevated risk factors, which may include, but are not limited to:

(i) a history of substance use disorder or overdose;

(ii) concurrent use of sedating medications; or

(iii) lack of clinically meaningful improvement in pain or function;

(e) have diagnostic uncertainty or have not responded to prior treatment approaches; or

(f) present any other clinical circumstance in which additional expertise would reasonably support patient care.

(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

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either the physician or a licensed health care practitioner designated by the physician or the pain management specialist;

(d) Other chronic pain evaluation services as approved by the commission; or

(e) Participation in peer case presentations such as Project ECHO, documented e-consult, or similar. A physician who participates in or observes a case presentation that involves comparable clinical circumstances may document how the consultation informed the patient's treatment plan and may use that participation as meeting the consultation requirement.

(4) A physician shall document each consultation with the pain management specialist.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-930, filed 11/16/18, effective 1/1/19.]

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

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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 non-escalating dosage of opioids.

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[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-935, filed 11/16/18, effective 1/1/19.]

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

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thirty percent of their current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]

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;

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(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 18 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 30 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 a physician assistant, in accordance with WAC 246-918-895.

(3) If a dentist, in accordance with WAC 246-817-965.

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(4) If a podiatric physician, in accordance with WAC 246-922-750.

(5) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

[Statutory Authority: RCW 18.71.017 and 2020 c 80. WSR 24-23-042, s 246-919-945, filed 11/14/24, effective 12/15/24. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-945, filed 11/16/18, effective 1/1/19.]

WAC 246-919-950 **Tapering—Chronic pain.** Not all patients with chronic pain will need their opioid prescriptions tapered. Patients who are stable on long-term opioid therapy and following their treatment plan should not be tapered solely to meet a pre-predetermined policy limit or dosage thresholds. Relying on medical decision making and patient-centered treatment, the physician should consider tapering or referral for a substance use disorder evaluation when requested by the patient or clinically indicated. If tapering is initiated, the reason for tapering shall be documented in the patient record.

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Examples of clinical indications for tapering include but are not limited to:

(1) The patient experiences a deterioration in function or pain;

(2) Other treatment modalities are indicated;

(3) There is evidence of misuse, abuse, substance use disorder, or diversion;

(4) The patient experiences a severe adverse event or overdose;

(5) There is unauthorized escalation of doses; or

(6) The patient is receiving an ongoing escalation in opioid dosage with no improvement or maintenance in their pain or function.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, s 246-919-950, filed 2/18/25, effective 3/21/25. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]

NEW SECTION

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WAC 246-919-951 **Buprenorphine.** Buprenorphine may be used for the treatment of opioid use disorder, management of chronic pain, or tapering, depending on the patient's needs and diagnoses.

(1) Physicians managing patients receiving buprenorphine for opioid use disorder or chronic pain who require additional analgesia for acute pain or a planned surgical or medical intervention must coordinate care with the provider managing the acute pain or intervention.

(2) Physicians must consider the pharmacology of buprenorphine, available formulations, and evidence-based strategies for managing patients receiving buprenorphine for opioid use disorder or chronic pain who require additional analgesia for acute pain or a planned surgical or medical intervention.

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WAC 246-919-955 Patients with chronic pain - establishing a relationship with a new physician. Due to the scarcity of

chronic opioid management prescribers generally, the commission encourages all physicians who are capable to consider taking chronic pain patients into their practice.

(1) When a patient receiving chronic opioid pain medications changes to a new physician, it is normal and appropriate for the new physician to initially maintain the patient's current opioid doses. Over time, the physician may evaluate whether any adjustments in the treatment plan can or should be done. Suggested language from Higginbotham petition: “Treatment plans should not be altered or changed unless a violation occurs.”

Suggested change from Higginbotham redline (comment #111):

The new physician shall:

(1) Review the patient’s record and previous opioid treatment history, including past trials of opioid and non-opioid therapies;

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DRAFT
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Proposed draft language: Treatment plans should not be altered or discontinued unless there is documented evidence that the patient has violated the terms of the treatment plan.

Suggested alternate language to petition proposal: Alteration of treatment plans should not occur outside of the circumstances listed in WAC 246-919-950.

(2) A physician's treatment of a new 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 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 non-escalating;

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

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(d) The patient has documented functional stability, pain control, or improvements in function or pain control at the presenting opioid dose.

(3) Physicians should not deny a patient with chronic pain the opportunity to establish care solely because the patient's established opioid dosage exceeds historical prescribing thresholds. Treatment decisions should be based on an individualized assessment of the patient's current medical needs, treatment history, functional benefit, and clinical circumstances.

(4) 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 if or until the patient qualifies for exemption from these rules under WAC 246-919-851.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]

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OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-919-960 Special populations—Pregnant patients

Physicians 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-960, filed 11/16/18, effective 1/1/19.]

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 any concerns.

(2) A physician providing episodic care to a patient who the physician knows is being treated with opioids for chronic

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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 should coordinate care with the patient's chronic pain treatment practitioner, if possible. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

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;

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(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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]

WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where feasible, 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

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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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-975, filed 11/16/18, effective 1/1/19.]

WAC 246-919-980 **Coprescribing of naloxone.** The physician shall confirm that the patient has access to naloxone or provide a current prescription when clinically appropriate, including circumstances that may increase the risk of opioid overdose, such as concurrent benzodiazepine use, high opioid doses, history of substance use disorder, or other patient-specific factors.

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[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation. The PMP is a powerful tool for clinicians and patients, but its limitations must be understood and accepted. For these reasons, the Legislature has seen fit to limit access to licensees, patients, relevant regulatory authorities, and law enforcement as the data contained within the PMP is not actionable without additional clinical data that is individualized to the specifics of the patient. Use of the PMP must support safe, coordinated, and informed patient care. PMP data must not be used as the sole justification to withhold, taper, or discontinue treatment for patients who are stable and compliant with their treatment plan.

(1) The physician shall register to access the PMP or

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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.

(5) The physician shall ensure a PMP query is performed for any 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

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knows to be receiving opioids for chronic pain, in accordance with WAC 246-919-965.

(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 should be documented in the patient record.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]

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