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# Rules Workshop

## Opioid Prescribing—General Provisions for MDs & PAs

August 25, 2025 – 1 pm to 3 pm

*Teams Webinar*

# Rules Workshop Agenda

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*The Washington Medical Commission (WMC) is providing a virtual option for this meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.*

Virtual via Teams Webinar

***Commissioners and staff will attend this workshop virtually.***

In-person at Department of Health, TC2 Room 153, 111 Israel Rd. SE, Tumwater, Washington

**Monday, August 25, 2025 – 1 pm to 3 pm**

## Opioid Prescribing—General Provisions for MDs & PAs

**Register** for this meeting at: Rules Workshop

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Upcoming workshops are listed on our Rules in Progress page: Rules and Regulations In Progress | Washington Medical Commission


# Opioid Prescribing—General Provisions for MDs & PAs

Rules Workshop

July 30, 2025

# Agenda

- Housekeeping
- Roll Call
- Open workshop
- WMC Statutory Authority Presentation
- Comments presentation
- Time permitting: Discuss draft language
- Next steps
- Close workshop

# Proposed Rule Development Timeline

April 2025: Inquiry CR-101 – Announces possible rulemaking

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

May 2026: request to initiate CR-102 – formal proposal

October 2026: Public hearing and written comments

December 2026: CR-103 – Final rule adoption and Concise Explanatory Statement

Early 2027: Rules effective

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# Next Steps

- Additional workshops
  - 3rd workshop – September 22 @ 1 pm
  - 4th workshop – October 29 @ 1 pm
  - 5th workshop – February 23, 2026 @ 1 pm
  - 6th workshop – March 23, 2026 @ 1 pm

Please feel free to provide written comments to:

medical.rules@wmc.wa.gov

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# Thank you!

# WASHINGTON MEDICAL COMMISSION'S STATUTORY AUTHORITY FOR OPIOID PRESCRIBING RULES

# WMC's General Rulemaking Authority

**RCW 18.71.017**

**Rules by commission—Successor to other boards.**

(1) The commission may adopt such rules as are not inconsistent with the laws of this state as may be determined necessary or proper to carry out the purposes of this chapter. The commission is the successor in interest of the board of medical examiners and the medical disciplinary board. All contracts, undertakings, agreements, rules, regulations, and policies continue in full force and effect on July 1, 1994, unless otherwise repealed or rejected by this chapter or by the commission. ****

# 2010 Legislation – ESHB 2876

**RCW 18.71.450 Pain management rules—Repeal—Adoption of new rules.**

(1) By June 30, 2011, the commission shall repeal its rules on pain management, WAC 246-919-800 through 246-919-830.
(2) By June 30, 2011, the commission shall adopt new rules on chronic, noncancer pain management that contain the following elements:
(a)(i) Dosing criteria, including:
(A) A dosage amount that must not be exceeded unless a physician first consults with a practitioner specializing in pain management; and
(B) Exigent or special circumstances under which the dosage amount may be exceeded without consultation with a practitioner specializing in pain management.
(ii) The rules regarding consultation with a practitioner specializing in pain management must, to the extent practicable, take into account:
(A) Circumstances under which repeated consultations would not be necessary or appropriate for a patient undergoing a stable, ongoing course of treatment for pain management;
(B) Minimum training and experience that is sufficient to exempt a physician from the specialty consultation requirement;
(C) Methods for enhancing the availability of consultations;
(D) Allowing the efficient use of resources; and
(E) Minimizing the burden on practitioners and patients;
(b) Guidance on when to seek specialty consultation and ways in which electronic specialty consultations may be sought;
(c) Guidance on tracking clinical progress by using assessment tools focusing on pain interference, physical function, and overall risk for poor outcome; and
(d) Guidance on tracking the use of opioids, particularly in the emergency department.
(3) The commission shall consult with the agency medical directors' group, the department of health, the University of Washington, and the largest professional association of physicians in the state.
(4) The rules adopted under this section do not apply:
(a) To the provision of palliative, hospice, or other end-of-life care; or
(b) To the management of acute pain caused by an injury or a surgical procedure.

# 2017 Legislation – ESHB 1427

**RCW 18.71.800**

**Opioid drug prescribing rules—Adoption.**

(1) By January 1, 2019, the commission must adopt rules establishing requirements for prescribing opioid drugs. The rules may contain exemptions based on education, training, amount of opioids prescribed, patient panel, and practice environment.

(2) In developing the rules, the commission must consider the agency medical directors' group and centers for disease control guidelines, and may consult with the department of health, the University of Washington, and the largest professional association of physicians in the state.

*See also RCW 18.71A.800 for PAs

# 2019 Legislation – SSB 5380

**RCW 18.71.810**

**Opioid drugs—Right to refuse.**

By January 1, 2020, the commission must adopt or amend its rules to require physicians who prescribe opioids to inform patients of their 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.

*See also RCW 18.71A.810 for PAs


# Opioid Prescribing
# General Provisions for MDs & PAs

## Written Comments Summary & Main Concerns

# Written Comments Summary & Main Concerns

- Over 100 comments received
- 10 overall requests
- 8 main concerns

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# Overall Requests

1. Allow doctors to use professional judgment without fear of punishment or excessive oversight.

Proposed New Section: WAC 246-919-XXX – Clinical Judgment
The commission recognizes that appropriate opioid prescribing requires the exercise of professional clinical judgment. A physician may vary from the specific dosage thresholds or prescribing guidelines in this chapter when such variation is clinically appropriate and supported by documentation in the patient record. A physician who acts in good faith, documents the rationale for their decisions, and meets the standard of care shall not be subject to disciplinary action solely for prescribing outside of the dosage recommendations in this chapter.

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# Overall Requests continued

2. Remove rigid dosage limits (like MME caps) and one-size-fits- all rules to enable personalized pain management.

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# Overall Requests continued

3. Reduce mandatory referrals or forced consultations with pain specialists when patients have stable, effective care with their current providers.

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# Overall Requests continued

4. Ensure access to adequate opioid prescriptions and other pain medications without unnecessary barriers or stigmatization.

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# Overall Requests continued

5. Educate providers about chronic pain management responsibilities and patients' rights to proper treatment.

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# Overall Requests continued

6. Prevent forced travel or burdensome requirements on patients for pain management.

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# Overall Requests continued

7. Recognize chronic pain patients' needs separately from substance use disorder policies to avoid under-treatment.

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# Overall Requests continued

8. Address stigma and mistrust from pharmacies, emergency rooms, and healthcare providers toward pain patients.

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# Overall Requests continued

9. Improve communication and coordination among providers to better support chronic pain care.

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# Overall Requests continued

10. Update rules to balance safety with maintaining patients' quality of life and dignity.

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# Main Concerns

1. Overly rigid dosage limits
    a) Commenters strongly oppose fixed morphine milligram equivalent (MME) caps or thresholds.
    b) They advocate for removing “one-size-fits-all” dosage restrictions and allowing individualized treatment based on patient need.
    c) Many call for trusting providers’ clinical judgment over numeric limits.

# Main Concerns continued

2. Fear of overregulation of physicians
    a) Physicians are reportedly afraid to treat pain due to fear of disciplinary action or DEA scrutiny.
    b) Commenters want WMC rules to protect providers who act ethically and responsibly, and to reduce the chilling effect current policies may have on appropriate prescribing.

3. Patient suffering and inadequate access to care
    a) Numerous comments describe patients being under-treated for pain, especially those with chronic or disabling conditions..
    b) Barriers such as specialist referrals, travel burdens, and mistrust from pharmacists or ER staff are cited as compounding the issue.

# Main Concerns continued

4. Need to Separate Chronic Pain from Substance Use Disorder
    a) Commenters stress that rules intended to address opioid misuse often conflate pain management with addiction treatment.
    b) They ask for distinct approaches that recognize chronic pain as a legitimate medical condition needing different care standards.
5. Preservation of patient dignity and quality of life
    a) There's a recurring plea to ensure policies maintain patients' dignity, autonomy, and quality of life, not just focus on risk reduction.
    b) Many object to policies that result in forced tapering or abandonment of stable, effective care plans.

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# Main Concerns continued

6. Reform of consultation and referral requirements
    a) Several commenters object to mandatory consultations with pain specialists, particularly when a primary provider is successfully managing the patient's care.
    b) They request flexibility to avoid unnecessary delays or hardship.
7. Stigma and discrimination
    a) Pain patients report being mistrusted or dismissed by providers, pharmacies, or emergency departments.
    b) They urge the WMC to acknowledge and counteract stigma in regulatory language and education.

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# Main Concerns continued

8. Improve provider education and coordination

   a) Some ask for better education for providers about chronic pain management and patients' rights.

   b) Others highlight the need for improved communication between providers to avoid fragmented care.

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# Comments from First Workshop

WSMA

- Establish recurring regulatory review of the opioid prescribing rules
- Simplify and reduce complexity of the rules
- Avoid adding more “shall” and “must” requirements.
- Implement simplification opportunities already identified in the draft and explore additional ways to streamline.
- Reconsider or remove the mandatory specialist consultation threshold at 120 MME/day for chronic pain management.

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# Comments from First Workshop

## WSMA continued

- Revise tapering provisions
  - Maintain physician clinical judgment as the ultimate authority.
  - Ensure shared decision-making that considers the patient's experience, unique circumstances, and beliefs.
  - Avoid language or provisions that enable unilateral tapering not based on clinical need.
- Clarify and simplify PMP requirements
  - Provide strong assurances that physicians will not be sanctioned when making good faith efforts to treat clinically complex patients.
- Avoid rules that unnecessarily restrict access to needed opioid therapy for chronic pain patients.

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# Comments from First Workshop continued

Dr. Steven Stanos

- Remove three-day, seven-day, and fourteen-day opioid prescribing supply limits for acute and subacute pain, and instead focus on individualized patient care.
- Eliminate the 120 MME/day threshold for mandatory chronic pain specialist referral, replacing it with an individualized patient assessment approach.
- Update the rules to reflect current science on buprenorphine, including its use for chronic pain and in acute pain treatment for hospitalized patients already stabilized on buprenorphine.
- Include a definition for high impact chronic pain.

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# Comments from First Workshop continued

Rose Bigham representing WashPIP

- Reevaluate opioid prescribing rules using current evidence to determine which guidelines remain appropriate and which should be updated.
- Update rules to better reflect current understanding of long-term opioid use for chronic pain, acute pain, and trauma-related pain.

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# Comments from First Workshop continued

Susan Olsen

- Address how post-surgical pain management is handled for chronic pain patients to ensure prescriptions are written correctly rather than instructing patients to alter existing medication schedules.
- Ensure documentation accurately reflects the intended treatment to prevent misunderstandings or misinterpretation as inappropriate requests for medication.

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# Comments from First Workshop continued

James Hannah

- Clarify how patients can receive needed care when pain management clinics decline involvement, including allowing primary care providers to treat without increased scrutiny.
- Reduce regulatory or administrative barriers that discourage primary care providers from helping patients in these situations.

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# Future Workshops

- Prescription Monitoring Program subsection
- Detailed comments from M. Higginbotham

WMC's Opioid Prescribing Rules Page

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**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

# 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

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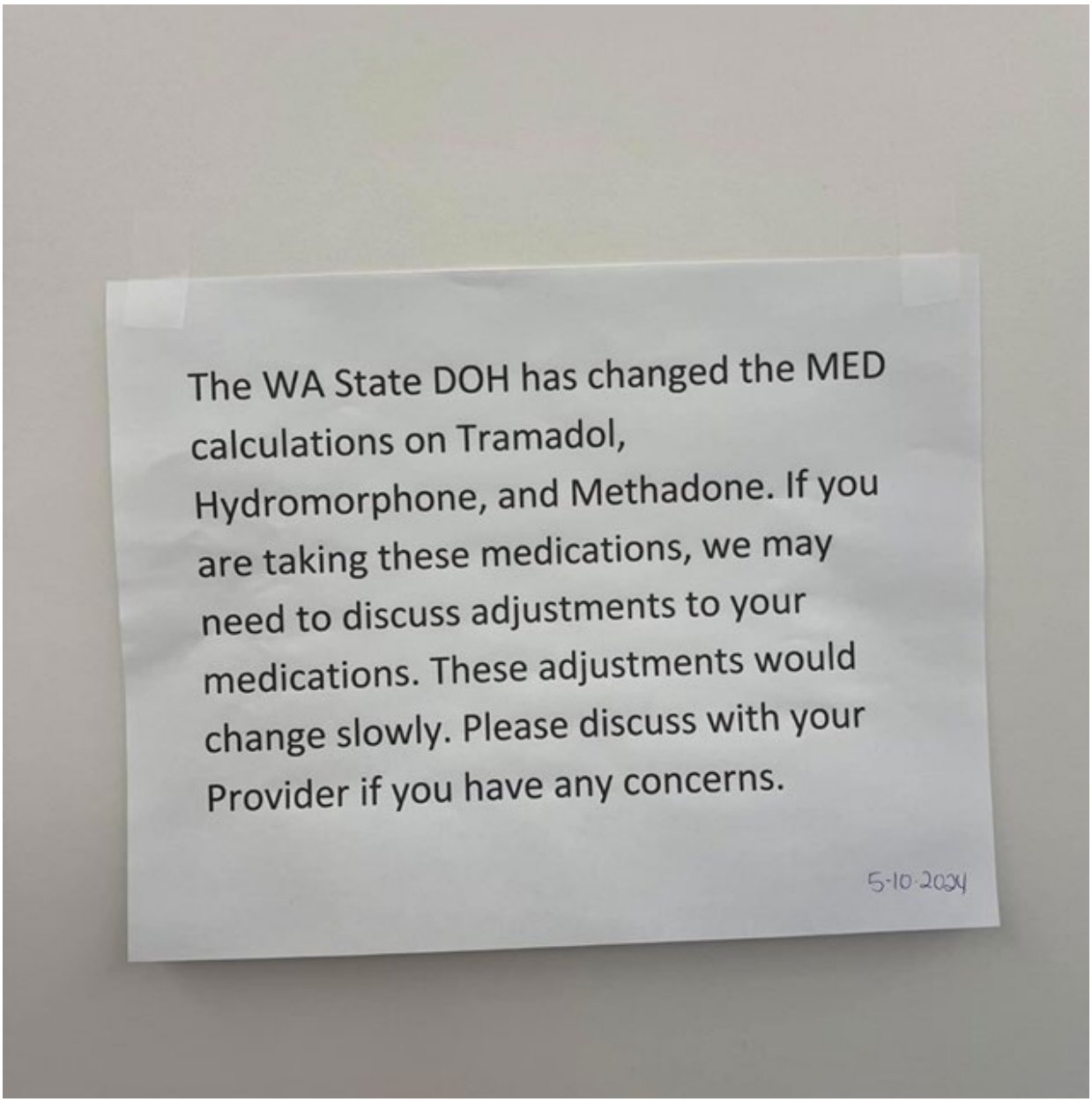
External Email

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



# Abstract

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Full study in link below:
https://academic.oup.com/healthaffairsscholar/article/2/6/qxae086/7691431?login=false

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**Brief Report**

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# 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%).

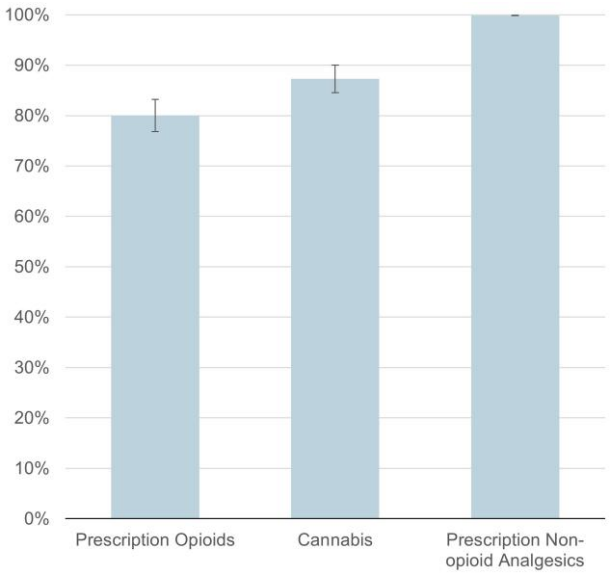


**Figure 1.** Proportion of physicians accepting new patients with chronic noncancer pain by type of existing chronic pain treatment. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13, 2023, to August 4, 2023, among respondents willing 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

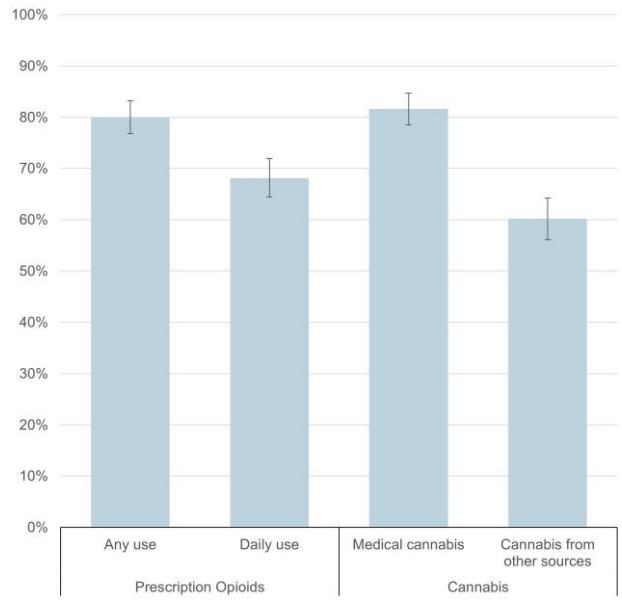


**Figure 2.** Proportion of physicians willing to accept new patients with chronic noncancer pain by frequency of prescription opioid use and source of cannabis for pain management. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13, 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.

## Funding

This study was supported by the National Institute on Drug Abuse (NIDA) grant number R01DA49789. The funder did not contribute to the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

## 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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## OPIOID PRESCRIBING—GENERAL PROVISIONS

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

The Washington ~~state~~ medical ~~quality assurance~~ commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain including acute, perioperative, subacute,

and chronic pain. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioids may be essential in the treatment of acute,

subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by

individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must ~~exist~~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

**Commented [MM1]:** Language from Sierra AGO.

**Commented [DB2]:** Revised from the 7/30 workshop. Needs discussion and decision.

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. NOTE 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, 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.

**Commented [MM3]:** 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.

**Commented [DB4R3]:** This language was not included in the 7/30 draft so it will need review and discussion.

**Commented [DB5]:** Suggested language from Higginbotham petition: "Add the following language: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by the specific morphine milligram equivalent (MME) guidelines."

Also noted in -905.

Possible draft language: Ordering, prescribing, dispensing, administering, or providing controlled substances, including opioids, must not be predetermined solely by specific morphine milligram equivalent (MME) guidelines. MME values are intended to inform, not replace, the clinical judgment of the practitioner.

**Commented [DB6R5]:** See -905

**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

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 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.

[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:

(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 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 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:

**Commented [DB9]:** Should this be in the definitions section?

**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.

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.)

(5) 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."

(54) The provision of procedural medications;

(65) 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.

[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.

(1) "Aberrant behavior" means behavior that indicates current misuse, diversion, unauthorized use of alcohol or other controlled substances, or multiple early refills (renewals).

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. Acute pain is six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of urine, hair, or other biological samples for various drugs and metabolites.

(4) "Cancer-related pain" means pain that is an unpleasant, persistent, subjective sensory and emotional experience associated with actual or potential tissue injury or damage or described in such terms and is related to cancer or cancer treatment that interferes with usual functioning. Cancer related pain may persist past the treatment and into the remission phase.

Commented [DB11]: Approved at 7/30 workshop

(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.

(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,

**Commented [DB12]:** 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 [DB13]:** Suggestion at the 7/30 workshop to eliminate this term from the rules. Nothing in statute requires the WMC to define or use this term.

**Commented [DB14]:** Suggestion from WashPIP (Comment #107): "Change to 120 mg. There is no valid "high dose" definition, as each patient's metabolism, individual risk factors, and patient response dictate that the type and dose of opioids must be individually titrated. But at a minimum, it seems logical to use our own state's referral threshold as the definition for "high dose"; not outdated CDC language which has proven to be a hardship for patients and providers."

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 abuse, aberrant behavior, dose of opioids, or the use of any concurrent central nervous system depressant.

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

(12) "Hospital" means any health care institution licensed pursuant to chapters 70.41 and 71.12 RCW, and RCW 72.23.020.

(13) "Low-risk" is a category of ~~patient~~patients 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~~fifty-milligram morphine equivalent dose per day.

(14) "Medication assisted treatment" or "MAT" means the use of pharmacologic therapy, often in combination with counseling

**Commented [DB15]:** 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 [DB16]:** Suggestion from WashPIP (Comment #107): delete - Level of patient risk should be derived solely on patient history, behavior and comorbidities, NOT on dose. Disproportionate focus on MED has dictated prescribing practices and shifted focus away from individualized care and prescriber expertise and discretion. Patients with no documented risk factors have been losing sufficient pain care since the release of the CDC Guideline.

**Commented [DB17]:** Suggestion from WashPIP (Comment #107): delete - Level of risk should be derived solely on patient history, behavior and co-morbidities, NOT on dose (high OR low).

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. 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

**Commented [DB18]:** Suggestion from WashPIP (Comment #107): delete - Level of risk should be derived solely on patient history, behavior and co-morbidities, NOT on dose (high OR low).

**Commented [DB19]:** Suggestion from WashPIP (Comment #107): delete - Its use is limited in scope and does not set a numerical precedent for prescribing. No single MED indicates a safe dose for individual patients. Likewise, no single MED indicates adequate pain control for individual patients. Bioavailability of various opioids, metabolism, individual risk factors, and patient response dictate that the type and dose of opioids must be individually titrated.

Source of sentence re: individual titration: https://www.ncbi.nlm.nih.gov/books/NBK555200/

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.

(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 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

**Commented [MM20]:** Should be standard practice. Recommend we keep.

**Commented [MM21]:** To follow format established in these rules, exemptions should be listed first.

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~~1~~) 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) 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.]

**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.

[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.

(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~~prescribing 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.]

## 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.]

**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.

Commented [MM22]: 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 who does not follow the expected course of ~~recovery, and~~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~~in combination with other medications, 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 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.]

**Commented [MM23]:** Does the data still support this? My recollection is that this was a suboxone issue.

**Commented [MM24]:** Keep this no matter what. Major intersection between incarcerated population and ED visits discontinuing these medications to their detriment.

**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.

(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.~~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.

**Commented [MM25]:** Does the data still support this statement? For every procedure?

(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.

Commented [MM26]: Keep.

(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 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 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.

Commented [MM27]: 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.

(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 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.

| | |
|---|---|
| Suggested language from Higginbotham petition: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by the specific morphine milligram equivalent (MME) guidelines. | Ordering, prescribing, dispensing, administering, or providing controlled substances, including opioids, must not be predetermined solely by specific morphine milligram equivalent (MME) guidelines. MME values are intended to inform, not replace, the clinical judgment of the practitioner. |
| WMC's proposed revisions to this suggested language: | |

The physician shall include in the patient's record:

(1) An appropriate history including:

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and

(d) Review of comorbidities with particular attention to psychiatric and substance use.

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

(a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;

(b) Any pertinent diagnostic, therapeutic, and laboratory results;

(c) Pertinent consultations; and

(d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.

(4) Assessment. The physician must document medical decision making to include:

(a) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(b) Consideration of the risks and benefits of chronic opioid treatment for the patient;

(c) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids; and

(d) Pertinent concerns discovered in the PMP.

(5) ~~Treatment plan as provided in WAC 246-919-910~~Documentation regarding if or when the patient qualifies for an exemption from the rules.

[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.** 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:~~

**Commented [MM28]:** 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?

~~(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.~~

~~[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:

Commented [MM29]: 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.

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

(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. 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.

**Commented [DB30]:** This additional reiterates that clinical decisions should be based on each patient's unique needs and supports the Commission's goal of promoting safe, evidence-based care that centers on the patient.

**Commented [MM31R30]:** Leaving this and deleting the rest to make the review more flexible and less intrusive on the patient.

~~(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.~~

~~(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.]~~

Commented [MM32]: Either make this mandatory (shall) or we should delete.

Commented [KK33R32]: It should be mandatory, as prescribers must understand the risks of these medications.

**WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain.** (1) The physician ~~shall~~ should consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are

under eighteen years of age or who are potential high-risk patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED per day, a consultation with a pain management specialist as described in WAC 246-919-945 is required, unless the consultation is exempted under WAC 246-919-935 or 246-919-940.

(3) The mandatory consultation must consist of at least one of the following:

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

(b) A telephone, electronic, or in-person consultation between the pain management specialist and the physician;

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

(d) Other chronic pain evaluation services as approved by the commission;

(e) Participation in peer case presentations such as Project ECHO or similar. If the physician observes a case presentation that is substantially similar to the case of their specific patient, they may document that 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;

**Commented [MM34]:** 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 [MM35]:** Keep. Maintains flexibility for practitioner.

(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.

[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 [MM36]: Keep. Maintains flexibility.

(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.**

Commented [MM37]: 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~~A cohort of chronic pain patients will not need their opioid prescriptions tapered or discontinued. Tapering decisions must be individualized, based on clinical indications, and approached collaboratively. The decision to taper or discontinue therapy must be based on clinical judgment, documented rationale, and

**Commented [DB38]:** Suggested language from Higginbotham petition: "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."

**Commented [MM39R38]:** While I don't want to make more requirements on the licensees here, we need to supply them with resources to push back on forced tapering. Suggest we add in for first consideration.

shared decision-making between physician and patient. If a patient is stable on opioid therapy, demonstrates functional stability, and is compliant with their treatment plan, involuntary dose reductions, discontinuation, or tapering must not be undertaken solely for the purpose of meeting policy or guideline thresholds. Such actions may destabilize the patient and may fall below the standard of care.

~~Tapering decisions must be individualized, based on clinical indications, and approached collaboratively. The decision to taper or discontinue therapy must be based on clinical judgment, documented rationale, and shared decision-making between physician and patient.~~

Relying on medical decision making and patient-centered treatment, the physician shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

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

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

(4) Other treatment modalities are indicated;

**Commented [DB40]:** This proposed language is to add clarity and express the intention of these tapering considerations.

**Commented [MM41R40]:** This is one of the spots I think it is appropriate to have this. Suggest limiting to here and the intent section.

**Commented [DB42]:** This proposed language is to add clarity and express the intention of these tapering considerations.

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

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.

(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.

[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~~

**Commented [MM43]:** Is this needed? The adolescent is basic medicine and the geriatric is too. I would consider leaving (2) due to the MAT/pregnancy complication.

~~in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.~~

(1~~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.]

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

Commented [MM44]: Changes to reduce requirements and provide flexibility.

(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~~ 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

Commented [MM45]: Chemistry has not changed so this should stay.

opioids in combination with the following medications without documentation of medical decision making:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics.

(2) If, because of a prior prescription by another provider, a prescription written by a physician results in a combination of opioids and medications described in subsection (1) of this section, the physician issuing the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care.

[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.

(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.]~~

Commented [MM46]: Referenced previously in patient counseling. Delete.

**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.

Commented [MM47]: Placing this to head off PH researchers and SAO issues like we experienced a couple of years ago.

(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.)~~

**Commented [MM48]:** 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~~ should be documented in the patient record.

(10) ~~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. Decisions based on PMP findings must reflect individualized medical decision-making and be documented accordingly.~~

**Commented [MM49]:** 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 [MM50]:** This is standard of care so moving to should in response to comments received.

[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 #1

**From:** Robbins, Beverly A (DSHS/AAA/ALTCEW)
**To:** WMC Medical Rules
**Subject:** RE: Nicotine and Pain Mgmt. Question
**Date:** Tuesday, January 14, 2025 9:42:07 AM

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Hello,
Thank you for your response, you may use my comments. I'm okay with my identity being included as well.
Thank you,

**Beverly Robbins, BSW**
*(she/her/hers)*
Lead Care Coordinator
Aging & Long Term Care of Eastern Washington
1313 N Atlantic St., Ste 3000 | Spokane, WA 99201
**TEL** 509.458.2509 x313 **EXT** 313 | **FAX** 509-458-2003
beverly.robbins@dshs.wa.gov | www.altcew.org

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**From:** WMC Medical Rules <Medical.Rules@wmc.wa.gov>
**Sent:** Wednesday, January 8, 2025 9:58 AM
**To:** Robbins, Beverly A (DSHS/AAA/ALTCEW) <beverly.robbins@dshs.wa.gov>
**Subject:** RE: Nicotine and Pain Mgmt. Question

Hello,

Thank you for reaching out with your concerns regarding nicotine use and its impact on chronic pain management treatment plans. The WMC appreciates your diligence in seeking clarity on this matter.

The WMC's guidelines on opioid prescribing for chronic pain patients do not specifically address nicotine use as a criterion for determining medication levels. However, medical providers may incorporate other clinical considerations, such as overall health and lifestyle factors, into their individualized treatment plans. It is important to note that nicotine use has been shown to negatively affect healing, pain management outcomes, and overall health, which may influence some providers' decisions.

While such policies, like requiring cessation of nicotine use, may not be mandated by law or WMC guidance, they may be implemented by clinics based on their interpretation of best practices or clinical judgment to improve patient outcomes. Providers are expected to engage in shared decision-making with patients, ensuring that any treatment changes are communicated clearly and are based on evidence-based standards.

If you believe patients are being treated unfairly or inconsistently with state laws or WMC guidance, we encourage you to document these concerns and provide specific details for review. You may also wish to consult directly with the clinics involved for clarity on their specific policies or seek legal advice if you believe these practices conflict with applicable laws or regulations.

With your permission, I would like to include your response as part of the comments to be considered in this effort. Please let me know if that would be okay with you. I can redact your identity from the comment if you'd like.

Best,
Amelia Boyd, BAS
Program Manager
Washington Medical Commission
Mobile: (360) 918-6336



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**From:** Robbins, Beverly A (DSHS/AAA/ALTCEW) <beverly.robbins@dshs.wa.gov>
**Sent:** Thursday, January 2, 2025 9:10 AM
**To:** WMC Medical Rules <Medical.Rules@wmc.wa.gov>
**Subject:** Nicotine and Pain Mgmt. Question

Good Morning,
My program has many clients on chronic pain management and I am seeing pain clinics begin to mandate patients cease using nicotine in order to continue to receive their current levels of pain prescriptions. I have clients that have a UA every month to test for nicotine, and when it appears in the results they are prescribed less pills per month.
I am curious why and how this shift in treatment started and if there are any laws concerning

this?
I read the WMC article on Opioid Prescribing for Chronic Pain Patients and didn't see this mentioned.
Thank you,

**Beverly Robbins, BSW**
*(she/her/hers)*
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Comment #2

**From:** THOMAS CLARK
**To:** Boyd, Amelia (WMC)
**Subject:** Chronic pain and the United States
**Date:** Wednesday, July 24, 2024 8:09:09 PM

External Email

DearCommissioners,

I would like to respond to the petition endorsed by Maria Higginbotham. I am not a resident of Washington State-but am a resident of Idaho. It is imperative that we can get clarity and Legislation passed throughout our Nation, as pain patients are struggling to get their much needed pain care without forced opioid tapers. Many chronic pain patients have been abandoned, lose hope, and commit suicide.
Our MD's and other Doctors who continue to treat pain-live in constant fear of overprescribing opioids over 50'MME's to 90 MME's . A "one size fits all " approach to pain care is non-sensical.

I am a former RN, who had to retire early due to being born without ANY left hip socket. I have had numerous Orthopedic surgeries-beginning at age 8-where they took bone from my pelvis to try and create a left hip socket. (I spent 3 Months in the hospital). As an adult, I needed my first total hip replacement surgery at age 25, and had 5 more hip revision surgeries. I have lots of metal, hardware and screws in my left hip. I also sufferf from narrowing of my spine from degenerative osteo-arthritis. I am now needing a right total hip replacement-due to bone on bone wear.
As a former Nurse, we never had to worry about treating patients with proper opioid meds. This helped them to be out of pain, and recover quickly. A trailblazer in Nursing was a woman named Margo McCaffery. She was a promotor of adequate pain management, and believed that pain should be treated-because pain is subjective, and what the patient said it could be. We did not go by MME's to treat pain in the 70's, 80's, or 90's. It is a made up number based on junk science. Each pain patient deserves to not have to suffer daily pain and be tortured. Doctors should not have to be afraid of the DEA. Doctors should be able to prescribe depending on the patients diagnosis. We have an illicit drug problem-NOT a LEGITIMATE DRUG problem.The CDC guidelines of 2016, and the revised guidelines of 2022 still does not clarify what is "overprescribing." That is supposed to be determined through the Doctor/Patient relationship. I am afraid that relationship is currently fractured.
I would like the CDC Guidelines to be rescinded. We need laws to protect compliant pain patients who are in
an establshed pain program. I have been a legacy chronic pain patient for more than 33 years, and all my lab tests are normal. But I was forced tapered off of a stable dose that used to work for me. Now, I have to comply with my pain management program in the State of Idaho.
I wanted to write, to let you know that things have not changed in the State of Idaho.We need ALL 50 States to help get legislation passed. I am on Medicare. It is so tiring, as I have been also trying to be a pain patient advocate. But, many times I am ill.

What will need to happen to help the chronic pain patients?  We need MD's to state on mainstream media-that opioid meds have a place in society-and can be used safely when prescribed. Instead, we have the general Public who have NO knowledge as to what chronic pain is-and we should have the public educated.
I can see from both sides-as a Nurse-(who was passionate about her job, and took pride in it!!! ).
Let's get Hospitals back to treating all pain adequately without judgement-that chronic pain patients are not addicts-because we are not! MD's should have peace of mind to adequately treat pain without Government interference. We need leaders-not cowards.  Thank you for reading my letter.
Sincerely, Kathleen Clark, RN ( retired).

Comment #3

**From:** Vicki Coast
**To:** Boyd, Amelia (WMC)
**Subject:** Opioid limitations
**Date:** Friday, July 19, 2024 11:18:33 AM

External Email

Hello my name is Vicki Sulfaro and I'm a intractable pain patient in washington state. I support the petitions submitted by Maria Higgingbothom. I've been in severe pain since 2000 when i was involved in a severe MVA. I was stopped and a young man from my kids high school hit me at over 50 mph

I've had multiple surgeries which has stabilized my spine but it hasn't the pain until i was put on opioids to help ease the severe pain after trying multiple treatments. I'm also a rapid metabalizer verified by a DNA test that proved i was. My
Meds only lasted a bit until i was put on extended relief with a immediate release for breakthrough pain. In 2009 i was forced into pain management as my dr retired and his replacement refused to treat my pain.

I was immediately told i needed to be reduced because they were told i was on to high a dose. Since 2009 i have been reduced 90% . Before i was reduced i was able to work go on trips go to concerts etc. Now im pretty much stuck in my chair and all because i was reduced by 90 percent.

I've never had any issue with my meds i don't abuse them it just makes my pain .Bearable.

Thank you for taking the time to read this and for all your doing to try and help so many victims who are suffering so badly. You are Appreciated

Best wishes and thank you again

Vicki sulfaro

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Sent from Gmail Mobile

Comment #4

**From:** Seth E Scott
**To:** WMC Medical Rules
**Subject:** Response to guideline suggested change in December update
**Date:** Friday, January 3, 2025 10:39:55 AM

External Email

Greetings,

In response to the December Newsletter, "Opioid Prescribing for Chronic Pain Patients," this was my response to my colleagues, and also my feedback to you:

It's an interesting read, but parts of it seem dumbed-down and lacking nuance, to me.

It's clear from the WMC's tone, that there has been an abundance of quick tapers that have happened without good documentation and rationale supporting rapid taper. And then, probably, a fair mix of

- People not wanting to do the work / documentation, and so tapering,
- People not wanting to assume care of new COT patients (fear of liability, and the amount of work / 'headache' of it)

And so on.

Some of the "comments" the WMC has received probably been from doctors who are in my opinion of the overly-enabling type – the type that will go to bat against state entities on behalf of problematic patients with whom they are entrenched in dangerous prescribing precedent and what I'd view as a non-therapeutic relationship. Some of these comments are probably completely appropriate. How closely does WMC delve into these to decide what the preponderance is? No way for me to know.

**"When a chronic pain patient transitions to a new physician, it is generally appropriate for the new physician to initially maintain the patient's current opioid dose. Over time, the physician can assess whether tapering or other treatment adjustments are needed."**

Some patients on inappropriate regimens will use this to skate from one provider to another, maintaining a sort of prescribing inertia, to avoid change. Not all, but definitely some. You look back on their chart and see that they find a new prescriber whenever their current prescriber reaches a level of discomfort to actually start pushing back on the regimen; then they doctor-shop . Only the strictest / most draconian PCPs will in the first 1-3 months say "this regimen has to go." I think there's a fair minority who just don't push back, or if they do, it takes many months and probably some ER visits with injuries, to gain the necessary conviction.

If I get a new patient, and read all the old records and see that they've been "skating by" in this way when it's clearly an unsafe / bad choice to continue this regimen (and other prescribers have made efforts to taper where that was clinically appropriate), I don't give them 3 months more on my authority to continue. I have the discussion with them about all that has gone before, and set a safer plan going forward on the first or usually second visit (after I've obtained and reviewed records).

**"The CDC encourages clinicians to: • Collaborate with patients to create personalized pain management plans. • Taper only when it is clinically appropriate and aligned with the patient's goals."**

Absolutely no. There are **definitely** cases in which the patient's goals do not "align" with what is clinically appropriate. In some cases there is clearly lack of safe prescribing, appropriate follow up, clear-eyed analysis of risk/benefit and clear boundary-setting; some patients are greatly at risk for harm or have had harm already done, they adamantly don't wish to taper but don't meet strict DSM-V for OUD. Taper for them is necessary and doesn't align with the "patient's goals." I am hopeful that they have language elsewhere in their guideline that specifically calls this out, and that this section of the page is just suffering from brevity by missing this nuance.

Seth Scott MD
Family Medicine Physician
Med Safety Lead (Olympia, Tacoma)
**Kaiser Permanente - Olympia**
700 Lilly Road, Olympia, WA 98501
**Email:** seth.e.scott@kp.org

Comment #5

**From:** Carol Efaw
**To:** Boyd, Amelia (WMC)
**Subject:** Washington Medical Commission - Opioid Prescribing Guidelines
**Date:** Friday, July 19, 2024 11:29:16 AM

External Email

Ms. Boyd,
I would like to add my comments for submission to the Washington Medical Commission. As the commission is reviewing prescribing guidelines, I would ask they support the following:

- Extending exemptions to ALL rare diseases that result in pain - not just sickle cell anemia;
- Ensure that each patient is treated as an individual; do not apply a 'cookie-cutter' approach;
- Never taper ANY patient abruptly;
- NEVER stop treating patients with opioid therapy without their consent;
-

I can share an example regarding my own mother. At the age of 93, she was provided hospice care as death appeared imminent. She had been prescribed opioid medication for severe pain for many years. The hospice doctor, without consulting with her primary care doctor, or agreement with her or her family, discontinued her pain medication 'cold-turkey'. When confronted, the hospice doctor arrogantly stated people with dementia cannot feel pain. Unfortunately, she suffered excruciating pain EVERY DAY for another 18 months until she passed. This is just one example of the terrible things that are happening to chronic pain patients in every state.

Please STOP this type of inhumane treatment of our disabled, elderly, veterans, and chronic pain patients who depend on opioid pain medications to function in their daily lives.
Thank you,
Carol Efaw

Comment #6

**From:** susan franzheim
**To:** Boyd, Amelia (WMC)
**Cc:** SUSAN FRANZHEIM
**Subject:** MARIA HIGGINBOTHAM"S PETITIONS
**Date:** Friday, July 19, 2024 6:31:55 PM

External Email

GOOD EVENING FROM DURANGO, COLORADO.

I SUPPORT THE PETITIONS SENT TO YOU BY MARIA HIGGINBOTHAM.

I AM THE PARTNER OF MARK IBSEN, MD.
HE IS THE QUINTESSENTIAL FRONTLINE WARRIOR IN THE DAUNTING STRUGGLE
OF HIS CHRONIC PAIN PATIENTS.

THE CDC REPORTED BETWEEN 24 AND 126 MILLION AMERICANS FIGHT DAILY FOR THE SEMBLANCE OF A LIFE NOT FILLED WITH BEING INCAPACITATED.

HE PUBLISHED THE BOOK: DR. BISON'S FABLES .. AN ALLEGORY OF THE AMERICAN PAIN REFUGEE CRISIS.

WE HAVE BEEN PETITIONING SITTING US SENATORS AND REPRESENTATIVES FOR SENATE HEARINGS ON PUBLIC PAIN POLICY IN RE TREATMENT.

WE ONLY DEAL IN SCIENCE-BASED DATA ... AS DISINFORMATION IS PERVASIVE OUT THERE.

PLEASE CONTACT ME FOR ANY WAY WE CAN SUPPORT YOUR EFFORTS WITH DATA THAT ARE SUBSTANTIATED - VALIDATED - CORROBORATED.

SYNERGISTICALLY,
susan franzheim

Comment #7

**From:** Viola Von Lindern
**To:** WMC Medical Rules
**Subject:** Upcoming rule changes for chronic pain
**Date:** Monday, August 5, 2024 5:14:57 PM
**Attachments:** image003.png
image004.png

External Email

Hello,
I understand that you are welcoming comments prior to your decisions on rule changes per Maria Higginbotham.
I'd like my initial email to you in this email thread to be of record for the decision making process. As well as the information I'm adding here.
When I wrote you I was actually considering suicide because facing every day in the amount of pain I'm in without pain medicine is not anything I'm able or willing to do.
The Suboxone I was forced on does not treat pain. I had many bad reactions and it made my brain so scrambled I couldn't form sentences. My daughters were literally scared I was coming down with Alzheimer's.
Luckily my 35 year old daughter got so mad at how I was being treated and saw I couldn't even form words to defend myself she called around until she found a clinic that will still prescribe pain medicine.
The new clinic however still won't prescribe above 50mm which doesn't allow me to have any kind of quality life outside my home. It's just an arbitrary number that has no purpose for chronic pain patients.
I know the law says there's not a set limit, but doctors are so scared of losing their license they won't use their professional judgement to care for patients anymore.
There needs to be an end to persecution of doctors who use their professional knowledge to treat pain patients ethically and with empathy.

Also, in the back of my mind I worry about when this doctor might turn their back on me like all the rest have done since my Dr retired in 2021.

Finally, Anyone on permanent disability SSDI should be excluded from all of these rules because it takes a lot to even get approved to start with. I had a neurosurgeon, an occupational doctor, a psychiatrist, a pain management doctor as well as my primary care doctor who documented my pain and the disability it caused. Once that's proven to the government we shouldn't have to have any doctors question our need nor be restricted by the government from having our disability treated.

On Tue, Apr 30, 2024, 10:55 AM WMC Medical Rules <Medical.Rules@wmc.wa.gov> wrote:

> Good morning,

I am so sorry to hear you are dealing with these issues. We have resources for chronic pain patients on our website: Patient Pain Management Resources | Washington Medical Commission

There are no requirements in law (RCW) or rule (WAC) to taper opioid prescriptions for chronic pain patients.

You may want to reach out to Rose Bigham who is the Co-Chair of Washington Patients in Intractable Pain: rosebigham@hotmail.com. This is a link to a presentation Ms. Bigham did a few years ago: Washington Patients in Intractable Pain

Also, the Washington State Medical Association maintains a list of County Medical Societies that may be helpful: County Medical Societies (wsma.org)

To file a complaint against an MD or PA: https://wmc.wa.gov/complaints-actions/file-complaint-against-md-or-pa

To file a complaint against other licensed healthcare providers: https://doh.wa.gov/licenses-permits-and-certificates/file-complaint-about-provider-or-facility

Thank you,

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Amelia Boyd, BAS
Program Manager
Washington Medical Commission
Mobile: (360) 918-6336

Were you satisfied with the service you received today? Yes or No

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**From:** Viola Von Lindern <vvonlindern@gmail.com>
**Sent:** Thursday, April 25, 2024 12:11 PM

Comment #8

**To:** WMC Medical Rules <Medical.Rules@wmc.wa.gov>
**Subject:** Pain clinic took everyone off opioids and put us all on suboxone

External Email

Hello,

I am a chronic pain patient since 2009 on disability.

My provider of 7 years who last provided adequate pain relief with documented compliance of my contract retired June 2021. No one at Valley medical was willing to continue my contract because Valley is no longer prescribing pain medicine. The medicines my previous provider was prescribing was what was working to keep me at a pain level of 3-4 out of 10. For 7 years without negative consequences like addiction or overdose.

I was forced to go to Anesis pain clinic by referral. I assumed since they're a pain management clinic that they would continue to manage my pain.

Anesis' PA I was assigned to at the Renton clinic was Zachary Kile(sp?). Without discussion or consent immediately began tapering me.

My pain, depression and anxiety got worse and worse with every visit.

Based off everything I've read there was never a legal, logical or ethical reason to taper me. No legal rules, regulations nor CDC recommendations required anything to change. I've also read that it's also against regulation of physicians to under treat chronic pain patients.

Suddenly in this past December Zachary was just gone and a doctor from Olympia came to the Renton clinic for the next scheduled visit. I had a total of 15 minute consult where I was not allowed to talk. She had already decided what she was going to do to me.

Although I had followed my pain contract exactly and my contract was still valid, DR Harstrom proceeded to take away all opioids and immediately put me on Suboxone.

I then discovered she has taken opioids away from all patients and put everyone on Suboxone.

Today I live in constant 24/7 extreme pain. I sit or lay in bed all day, every day. My depression and anxiety are at an all time high, my antidepressants are at the highest dose and I now take a separate anxiety prescription.

I was lucky to get an apartment through Catholic community services a year ago. However it's on the top floor with 29 total steps. Apartments I can afford are few so I have no choice right now but to climb those stairs. I am stuck up here. I've only left my apartment about 5 times in the past 2 months because they were mandatory.

Because of the action of this clinic for the past 3 years I no longer have any joy in my life and don't care if I live.  I have nothing to look forward to.

Valley medical quit caring for my pain.  Anesis, a pain management clinic has quit caring for my pain.

My primary care doctor will refer me to another pain clinic but how do I find one who will now put me back on the pain medication that works? Just pull a name out of a hat and hope the next clinic isn't the same as the past two??

And then I'll be told I've been doctor shopping like addicts do.

I'm exhausted and tired of being looked at and treated as if I'm a drug addict. I want to be treated as a patient with empathy, dignity and respect.

Please help me. Give me direction on what to do and where to turn now please.

Thank you in advance for reading this.

Viola Vonlindern

Comment #9

**From:** Amit Desai
**To:** WMC Medical Policy
**Subject:** Regarding policy statement on opioid prescribing
**Date:** Monday, April 7, 2025 4:03:38 PM
**Attachments:** WMC Opiod Prescribing Guidelines.pdf

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External Email

To Washington Medical Commission,

The opioid prescribing guidelines does a good job at restoring patient centered care when there is increasing evidence of discrimination against patients taking opioids. Nevertheless, there remains a concern for possible inappropriate use of opioids for non cancer pain.

While there might be no rigid ceiling at which opioids should not be prescribed there is scarce evidence that higher doses of opioids are as safe as lower doses or that there higher opioid dose are more efficacious for chronic non cancer pain.

As a physician who treats hospitalized patients I am routinely seeing patient at opioid doses that I would be uncomfortable prescribing. Those patients are also on multiple high risk medications like sleep agents, muscle relaxants and benzodiazepines. I am very concerned about opioid overprescribing in our community. A consistent theme in 15 years of my practice is legal opioid prescribing was a major factor to seek illicit opioids in my young patients that I see.

If there are systematic reviews supporting the policy recommendations I would be happy to have access to such evidence.

Thank you so much
Dr Amit Desai

Sent from my iPhone

Comment #10

**From:** STEVE DORLEE SAUVE
**To:** Boyd, Amelia (WMC)
**Subject:** Harm to patients
**Date:** Wednesday, July 24, 2024 8:07:44 AM

External Email

Been advised that you are taking comments about the harm to pain patients and the abandonment of many in regards to treatment involving pain medications.
I won't give a long story, just know that my spine issues have been life long.
I see a Pain Specialist who reduced everyone in clinic in 2016 with the CDC Guidelines. We are again being reduced due to the revisions with the MME calculations.
I no longer recognize myself. My pain is intolerable and everyday is a struggle to stay alive.
It's so unfair when there are medications to help and our doctors are afraid to treat us individually. Not all of us can fit into a box.
We need protection. We need ER doctors to believe us. We need appropriate treatment without government interference.
I've always been proud to live in Washington, in the forefront of everything. Please help us be the first state who protects it's pain patients.
If you need any other info, please contact me.
Thank you and please help.

Sent from my Verizon, Samsung Galaxy smartphone
Get Outlook for Android

Washington State Medical Association
Physician Driven, Patient Focused

Comment #11

October 10, 2024



Kyle Karinen
Washington Medical Commission

**Re: Recommendations for Improving Access to Pain Management**

Dear Mr. Karinen,

On behalf of the Washington State Medical Association (WSMA) and our nearly 13,000 physician members, I write to share with you a copy of our 2024 "Recommendations for Improving Access to Pain Management Treatment in Washington State".

The WSMA recently created a work group, informed by the guidance of experts engaged in and impacted by pain medicine, to identify barriers to appropriate pain treatment and solutions to undertreatment of pain. The overarching goal of the group is to ensure pain is appropriately managed by the right clinician in the right setting, and to alleviate clinician fear of appropriate opioid prescribing through education and advocacy.

I am pleased to share with you the enclosed recommendations that we hope you will consider and utilize when making decisions around pain management. Please never hesitate to consider WSMA a resource and partner in this important work.

Sincerely,

John Bramhall, MD, PhD
President
Washington State Medical Association

**Seattle Office**
1215 Fourth Avenue, Suite 1901
Seattle, WA 98161
*o* / 206.441.9762 *fax* / 206.441.5863
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1800 Cooper Point Road SW
Building 7, Suite A
Olympia, WA 98502
*o* / 360.352.4848 *fax* / 360.352.4303

# Recommendations for Improving Access to Pain Management Treatment in Washington State

Washington State Medical Association
Physician Driven, Patient Focused

## 1. Recommendations for Policymakers

### 1. a. State agencies

*Recommendation to the Washington State Agency Medical Directors' Group*: Update Interagency Guidelines on Prescribing Opioids for Pain.

*Why this is important:* The pain management landscape has evolved considerably over the last decade. Clinical guidance should be reviewed for relevance, ensuring they reflect current clinical practice and do not place unreasonable barriers to appropriate pain treatments. Changes made to the Centers for Disease Control and Prevention's 2022 Clinical Practice Guidelines for Prescribing Opioids for Pain should be considered for inclusion. It is critical that AMDG work with the physicians, health systems, pharmacies, and insurance industry to ensure clinical "guidelines" are not used as the basis for denying appropriate pain management.

*Recommendation to the Washington Medical Commission and Board of Osteopathic Medicine and Surgery:* Conduct recurring regulatory review of opioid prescribing rules with the goal of improving pain management, improving access to care, and aligning with most current clinical practice.

*Why this is important:* Conducting recurring regulatory reviews will ensure Washington's prescribers are following current clinical practices and will improve the quality of pain management care for prescribers and patients

*Recommendation to the Department of Health:* Align all opioid prescribing rules with the Washington Medical Commission.

*Why this is important:* Due to the challenging rulemaking process as directed by the Legislature, the various sets of rules that govern opioid and other controlled substance prescribing by health care professions differ in some key areas. In a team-based care setting, this creates confusion and implementation and compliance challenges. Alignment will improve both the quality of care delivered to patients and coordination of such care.

## Recommendations for Policymakers cont.

*Recommendation to the Department of Health:* Continue to identify grant dollars for the Better Prescribing, Better Treatment program, jointly administered by the WSMA, the Washington State Hospital Association, and the state Health Care Authority, to support programming, report distribution, coaching and consultation services, and the anticipated need to hire additional staff.

*Why this is important:* The Better Prescribing, Better Treatment program is a peer-to-peer, clinician-driven quality improvement program that promotes safe, appropriate prescribing to curb opioid misuse. Continued, stable, and predictable funding for the program will ensure the program has the necessary resources to continue providing the services currently offered and begin offering new supports to meet the needs of prescribers.

*Recommendation to the Health Care Authority:* Continue to identify grant dollars and settlement funds for the Better Prescribing, Better Treatment program to support programming, report distribution, coaching and consultation services, and the anticipated need to hire additional staff.

*Why this is important:* The Better Prescribing, Better Treatment program is a peer-to-peer, clinician-driven quality improvement program that promotes safe, appropriate prescribing to curb opioid misuse. Continued, stable, and predictable funding for the program will ensure the program has the necessary resources to continue providing the services currently offered and begin offering new supports to meet the needs of prescribers.

*Recommendation to the Department of Health:* Ensure low-barrier, "no-wrong-door" access to Washington's prescription monitoring program data via manual checks, OneHealthPort, Bamboo Health PMP Gateway, and EDIE (Emergency Department Information Exchange).

*Why this is important:* The state prescription monitoring program is an important tool that assists with making informed prescribing decisions. Manual access of the database during the limited context of a patient encounter is time consuming and cumbersome. For over a decade, the WSMA has advocated for seamless integration of this clinical data directly into practice electronic health records. Until recently, physicians were only permitted to integrate via the state health information exchange (OneHealthPort). Due to cost and implementation challenges, the WSMA successfully advocated to the Department of Health that it allow for other methods of integration. Despite this permission being granted, we understand the department has not widely promoted or made these tools accessible. As a result, uptake has been low. "No-wrong-door" access to PMP data will ensure all prescribers are compliant with PMP checks and able to safely prescribe medications. Reducing barriers to accessing this data will maximize time spent with patients and reduce administrative barriers to providing timely care.

## Recommendations for Policymakers cont.

*Recommendation to the Department of Health:* Approach ADS (Automated Decision-Making) systems, specifically those which calculate risk-scores, with caution and ensure systems have been validated prior to use.

*Why this is important:* Automated decision-making systems may make inaccurate clinical decisions and may not have the capacity to consider the context behind certain data that is being mined. The Department of Health should use caution when considering permitting these systems to avoid inappropriate or uninformed patient care.

*Recommendation to the Department of Health:* Automatically enroll physicians into the Better Prescribing, Better Treatment program upon licensure. During licensure process, provide an opt-out option.

*Why this is important:* The Better Prescribing, Better Treatment program is a peer-to-peer, clinician-driven quality improvement program jointly administered by the WSMA, the Washington State Hospital Association, and the state Health Care Authority that promotes safe, appropriate prescribing to curb opioid misuse. The current process of prescriber enrollment is administratively burdensome for the WSMA. While the WSMA has been successful in enrolling prescribers at health systems into the program, barriers for small group and independent practice participation remain. Automatic enrollment will ensure all prescribers, regardless of their practice setting, can seamlessly join the program.

### 1. b. Legislature (2025)

*Recommendation to the Legislature:* Provide sustainable funding for the University of Washington's Telepain Program.

*Why this is important:* The University of Washington's Telepain Program provides support to physicians and other health care professionals as they work with patients to improve pain management, function, and quality of life. Sustainable funding for this program will ensure these services remain available to prescribers needing support.

*Recommendation to the Legislature:* Provide sustainable funding for the Better Prescribing, Better Treatment program.

*Why this is important:* Sustainable funding for the Better Prescribing, Better Treatment program is critical to its viability. The program provides prescribing reports to enrolled prescribers, coaching opportunities led by a physician, and educational opportunities. The program is currently funded through grant dollars, which can be unpredictable. Consistent funding will help staff plan long-term for the future of the program and allow prescribing reports, coaching opportunities, and educational opportunities to continue to be services offered to enrollees.

## 2. Recommendations for Medical Schools

*Recommendation to medical schools:* Provide educational overview to medical students explaining the general interplay between state opioid prescribing rules and federal prescribing requirements.

*Why this is important:* Educating the incoming workforce on state opioid prescribing rules and federal prescribing requirements will empower incoming physicians to learn about the state's prescribing rules with which they choose to practice medicine; promote compliance with federal regulations; and ensure patients receive consistent, accurate care.

*Recommendation to medical schools:* Provide comprehensive education to medical students on pain management.

*Why this is important:* Education on pain management, to include both pharmacological and non-pharmacological modalities, should be considered essential to a medical student's education. Educating the incoming workforce on pain management through all phases of education and training will empower incoming physicians to treat pain; decrease stigma associated with pain; and improve access to pain management services.

## 3. Recommendations for Residency Programs

*Recommendation to residency programs*: Provide comprehensive education to physician residents on Washington state's opioid prescribing rules.

*Why this is important:* Educating incoming physicians on Washington state's current opioid prescribing rules will empower incoming physicians as they prescribe; promote compliance with regulations; and ensure patients receive consistent, accurate care.

## 4. Recommendations for Physician Employers

*Recommendation to hospitals and large employers:* Develop opioid stewardship programs (modeled after antibiotic stewardship programs) that systemize pain and opioid policies, such as required prescription monitoring program checks, guidelines and rules, and training sessions and continuing medical education opportunities. Hospitals may also consider implementing the below practices in their opioid stewardship programs:

- Develop system to indicate whether a patient is on long-term opioid therapy to ensure appropriate pain management, such as visual chart tags similar to drug allergy flags.
- Amend standard dosing guidance for post-operative patients requiring opioids to provide dosing flexibility for patients on long-term opioid therapy.
- Create and utilize education tags that educate care teams about standard guidance for post-operative opioid dosing, **specifically how the guidance may be insufficient for patients on long-term opioid therapy**.
- Provide education for the administration of Narcan for patients on long-term opioid therapy to avoid withdrawal and increased pain.
- Provide education on the pharmacology of suboxone, to include the interplay between naloxone and opioids.
- Provide education on the administration of buprenorphine for pain.

*Why this is important:* Implementing programs and systems that assist care teams in managing patients' pain is imperative to ensuring patients of all demographics (to include those who are on long-term opioid therapy) receive high-quality, individualized pain management. Such programs and systems will support care teams as they provide care and will decrease confusion or uncertainty about guidelines and policies. Providing training sessions and CME opportunities for physicians and health care professionals will encourage participation and help clinicians stay current on their education.

## 5. Recommendations for Health Insurance Carriers

*Recommendation to health insurance carriers:* Provide adequate coverage and reimbursement for:

- Spinal manipulation services
- Integrative treatments such as physical therapy services, massage therapy, etc.
- Interventional treatments
- Acupuncture treatments
- Behavioral health services to include psychiatric services
- Social work and peer support services
- All buprenorphine formularies: Long-acting injectable, transdermal patch, buccal films

*Why this is important:* Sufficient reimbursement for services that can reduce or assist with a patient's pain will promote the treatment of pain with the correct modality. Ensuring reimbursement is sufficient will ensure patients receive individualized care relevant to their diagnosis or condition, which is critical to a patient's care experience and recovery or management of their pain.

## Recommendations for Health Insurance Carriers cont.

*Recommendation to health insurance carriers:* Eliminate policies that apply non-clinical hard dose limits to prescription drugs, including buprenorphine.

*Why this is important:* The Centers for Disease Control and Prevention's 2022 Clinical Practice Guidelines for Prescribing Opioids for Pain cautioned against the application of rigid opioid dosage thresholds. Eliminating policies that promote rigid dose thresholds will ensure prescribers are prescribing opioid doses respective to the patient's needs.

## Opioid Prescribing Work Group Next Steps

1. **Consider introducing policy to WSMA House of Delegates opposing dose limits for opioid prescriptions for chronic pain.** The Centers for Disease Control and Prevention's 2022 Clinical Practice Guidelines for Prescribing Opioids for Pain cautioned against the application of rigid opioid dosage thresholds. Eliminating policies that promote rigid dose thresholds for all patients will ensure prescribers are prescribing opioid doses respective to the patient's needs, such as patients who experience long-term pain and require higher doses of medication.

2. **Consider introducing policy to WSMA House of Delegates demonstrating WSMA's support of the administration of buprenorphine formularies to treat pain.** Buprenorphine's effectiveness in treating pain is not widely understood in the medical field. The misconception is that buprenorphine is designated to treat opioid use disorder, despite its development in 1966 as an alternative pain reliever to morphine. Supporting the administration of buprenorphine to treat pain provides more treatment options for physicians and patients and may serve as the best option for patients experiencing challenges with opioids or other pain management treatments.

3. **Distribute recommendations to impacted stakeholders.**

## Opioid Prescribing Work Group Members

The WSMA Opioid Prescribing Work Group comprises five physicians representing various clinical perspectives:

**Katina Rue, DO**, chair, family medicine physician
**Nathan Schlicher, MD, JD**, emergency physician
**Teresa Girolami, MD**, primary care physician
**Tony Quang, MD, JD**, oncologist
**Karen Domino, MD, MPH**, medical commissioner, Washington Medical Commission

## Special Thanks

The WSMA Opioid Prescribing Work Group could not have conducted its work without the guidance of experts engaged in and impacted by pain medicine:

**Judy Chen, MD, FACS, FASMBS**, Washington Chapter – American College of Surgeons
**Garrett Jeffrey, DO**, Washington Osteopathic Medical Association
**Gregory Rudolf, MD**, Washington Society of Addiction Medicine, Swedish Health Services
**Steven Stanos, DO**, pain medicine specialist, Swedish Health Services
**Mark Sullivan, MD, PhD**, psychiatrist, University of Washington
**David Tauben, MD**, pain medicine specialist, University of Washington
**Gregory Terman, MD, PhD**, anesthesiologist, director of Acute Pain Services, University of Washington
**Mackenzie McCauley, PharmD**, clinical pharmacist, University of Washington
**Roseanne Andersen**, Washington Osteopathic Medical Association
**Rose Bigham**, Washington Patients in Intractable Pain
**Cyndi Hoenhous**, Washington Patients in Intractable Pain

## Staff

The WSMA Opioid Prescribing Work Group is supported by WSMA Policy Director Jeb Shepard.

Comment #12

**From:** toni wyman
**To:** Boyd, Amelia (WMC)
**Subject:** Pain Management
**Date:** Friday, July 26, 2024 7:11:13 AM

External Email

Sent from Gmail Mobile
Hello and good morning, my name is Toni Wyman and I live in Gillette Wyoming. I was diagnosed with an incurable disease in 1985, RSD/CRPS Reflex Sympathetic Dystrophy or Complex Regional Pain Syndrome, I have been treated by the same doctor since 2004. I'm not really sure when the problems started as I have neurological issues caused by this disease. It is rated as the highest pain syndrome using the mcGill's pain scale, and tops out at 45 out of 50. Since around Covid sometime, I started having a hard time getting my valid opioid prescription filled. My doctor put me on buponorphine which made me very sick and rotted my teeth in a very short time. They cut my benzodiazepine in half and took away one of my muscle relaxers. I've been on these medications for almost twenty years so now I'm not only in more pain, I can not function properly. The pain has taken over my life and now I have other symptoms. When my pain is not controlled properly, I have tremors so bad it interrupts my life. These changes to medications have not only changed my life for the worst, it has also affected my relationships with my family as I no longer am able to attend family affairs and such.

I'm writing this in hopes of change and soon! I don't know how much more my body can take. I know there are so many like me all over the world!! We feel we have been forgotten and tossed aside like a bag of trash!

Please hear my plea and take action before it's too late! So many have died because the doctor patient relationship has been destroyed. The Pharmacys have the power to reject valid prescriptions and that's not right. My doctor has told me several times now that he would increase my pain medication dose but I would have to taper my benzodiazepine even more! That medication is the only thing that helps with my tremors, tremors I don't have when I'm adequately medicated.

My muscles are in constant spasm since taking away the muscle relaxer that works. I get very little sleep, if any and it's all because I was forced off or force tapered, off the medications that worked! Again, please hear my plea!!??

Sincerely

Toni Wyman

Comment #13

**From:** toni wyman
**To:** Boyd, Amelia (WMC)
**Subject:** Proposal for no MME
**Date:** Friday, July 26, 2024 7:16:32 AM
**Attachments:** Bill Protection of Medicine Act Draft 052324.docx

External Email

Please see attachment, sent to each state representative

# American Pain and Disability Foundation

Odessa, TX • Indianapolis, IN
A Nonprofit Foundation • IRS Chapter 501(c)(3) • EIN: 84-2647447

# Epidemic of Misinformation Sweeping America

- According to NIDA.NIH.gov, the national drug overdose deaths—number among all ages, rose to 107,941 with deaths involving synthetic opioids—primarily illicitly manufactured fentanyl accounting for 73,838. TRUE
- A single dose of an opiate such as hydrocodone, morphine or oxycodone places the opioid naïve patient at a great risk of becoming addicted. False
- The use of Long-Term Opioid Therapy is the first-line treatment of chronic pain conditions above such non-pharmacological modalities as Cognitive Behavioral Therapy, Yoga, Tai Chi and other mindful movements. False
- The restriction and reduction of prescribing daily opioids for the treatment of chronic pain has had a significant impact on the recreational use of opioids. False
- Cannabinoids and topical application of CBD effectively restores quality of life and function for those suffering from rare chronic pain diseases. False
- The Centers for Disease Control and Prevention Guideline, "*Opioids and Chronic Pain: A Guide for Primary Care Providers*" has improved patient outcomes. False
- Morphine Milligram Equivalents (MME) limitations have reduced overdose risk associated with higher dose prescriptions of Long-Term Opioid Therapy. False
- The Drug Enforcement Administration interdiction activities have not harmed chronic pain patients despite the indictment and conviction of their medical practitioners for the crime of prescribing an FDA approved and clinically appropriate medication. False

# There is a novel way to drastically reduce illegal fentanyl deaths

When patients are force-tapered or otherwise blocked from treating pain with last-line treatment plans involving proven effective pain medications, they resort to self-medicating with street drugs containing illicit fentanyl and they overdose. RESTORE LEGAL PAIN MANAGEMENT MANAGED BY LICENSED MEDICAL PRACTITIONERS AND DITCH THE MME PSEUDOSCIENCE by simply changing state law. A Sample bill is attached.

# S.B./H.B.

IN THE SENATE/HOUSE OF THE STATE OF _____

MAY 23, 2024

# QUALITY OF LIFE RESTORED

Provides that decisions regarding the treatment of patients experiencing chronic pain shall be made by the prescriber with dispensing by the pharmacist in accordance with the corresponding responsibility as described in federal regulations and State administrative rules. Provides that ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by specific morphine milligram equivalent guidelines. Defines "chronic pain" and "opioids."

**Section 1. Short title; table of contents**

(a) Short title — This Act may be cited as the "**Protection of Medicine**" or the "**POM**" **Act**.
(b) Table of contents — The table of contents of this Act is as follows:



**Section 2. Definitions**

In this Act, except as otherwise provided:

(1). The term "medical practitioner" means any individual physician, physician assistant, nurse, nurse practitioner, pharmacist, dentist, podiatrist, veterinarian, or any other licensed medical practitioner.

(2). "Chronic pain" means a state in which pain persists beyond the usual course of 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 12 weeks and is adversely affecting the function or well-being of the individual.

(3). "Opioid" means a narcotic drug or substance that is a Schedule II controlled substance under paragraph 17 in 21 USC 802, also referenced as the Controlled Substances Act.

**Section 3.1 Findings**

Congress finds the following:

(1). Whereas the Supreme Court of the United States unanimously ruled in Ruan vs. United States, at 142 S.C. St. 2370, 213 L.Ed.2d 706 (2022) that:

(a). "a doctor who acts in subjective good faith in prescribing drugs is entitled to invoke the CSA's authorization defense.", and/or that

(b). a prescription is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of […] professional practice."

(2). Whereas if the US Food and Drug Administration (FDA) has approved a medication as safe for human use, practitioners should be able to prescribe it, and pharmacies and patients should be able to acquire it.

(3). Whereas patients are being forced to resort to illicit substances, travel lengthy distances, and/or take their lives if and when they cannot access medications that are legally prescribed by a practitioner and deemed medically necessary.

(4). Whereas, the Controlled Substance Act, [21 USC Ch. 13 §801(1)] states that "Many of the drugs included within this subchapter have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people." Misapplication and misinterpretation of this law have created negative consequences on American citizens.

(5). Whereas the term "addiction" means a compulsive need for and use of a substance or activity, regardless of negative consequences known to the user. On the other hand, the terms "tolerance," and/or "dependence" are distinct from, and do not imply addiction. Rather, it is a separate molecular structure that means a treatment modality has reached a therapeutic level and that an individual cannot be physically without that modality without consequences, such as withdrawal. This was affirmed by the National Institute of Drug Abuse, which stated, "recent studies have shown that the molecular mechanisms underlying addiction are distinct from those responsible for tolerance and physical dependence, in that they evolve much more slowly, last much longer, and disrupt multiple brain processes." Nora D. Volkow, MD, & A. Thomas McLellan, PhD, "Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies," *New England Journal of Medicine.*, Vol. 374, No. 13, Mar. 31, 2016.

**3.2 Purpose:**

**The purpose of this bill is to:**

(1). restore and protect the practitioner patient-relationship, by ensuring that medical practitioners are not subject to frivolous, malicious, political, financial, and/or otherwise arbitrary civil or criminal disciplinary actions, and by protecting chronic patients' rights to access clinically indicated, medically necessary healthcare, regardless of the choice of treatment modality.

(2). prevent the Morphine Milligram Equivalent guideline system from being applied to a practitioner's decisions regarding the appropriate treatment of chronic pain, while also protecting

practitioners who, in good faith and/or for a legitimate medical purpose, order, dispense, prescribe, or administer pain medications, including opioids.

**Section 4 Actions:**

**Be it enacted that -----**

(1). Decisions regarding the treatment of patients experiencing chronic pain shall be made by the prescriber with dispensing by the pharmacist in accordance with the corresponding responsibility as described in 21 CFR 1306.04(a).

(2). Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by specific morphine milligram equivalent guidelines (MME).

IN CARE OF:

THE AMERICAN PAIN AND DISABILITY FOUNDATION

# Opioid Prescribing General Provisions for MDs and PAs

**Rule Description:**
Opioid Prescribing General Provisions for MDs and PAs

**Code Reviser (CR) Document:**

- CR-101 (https://wmc.wa.gov/sites/default/files/rules/WSR_25_10_039.pdf)
- WAC 246-919-850 through 985 (https://wmc.wa.gov/sites/default/files/rules/WAC%20246-919-850%20through%20985.pdf)

**RCW-WAC:**

- WAC 246-918-800 through WAC 246-918-935 (https://app.leg.wa.gov/wac/default.aspx?cite=246-918-800)
- WAC 246-919-850 through WAC 246-919-985 (https://app.leg.wa.gov/wac/default.aspx?cite=246-919-850)

## Public Comments

Comment #14

**Julia Obermeyer (not verified)** - *May 06, 2025 06:35 PM* Reply (/comment/reply/870/2718)

As a chronic pain patient and someone with a rare disorder under the NORD criteria, I would like this rule to take effect as I am constantly denied opioid pain management in the ER and told to go to a pain clinic by my primary care physician. I believe that all chronic pain patients deserve adequate relief so they aren't constantly living in pain where it impacts their lives.

## Comment #15

**Patricia Dunn (not verified)** - *Jun 26, 2025 06:22 PM* Reply (/comment/reply/870/2810)

As a chronic pain patient with a rare disease, I have e been negatively effected by current prescribing practices. I have complained repeatedly about not tolerating the long acting buprenorphine, my provider has continuously disregarded my complaints of pain not controlled and adverse side effects. Today, I finally saw a different provider and recieved a change in treatment for previous dose that was effective. Additionally, while they continuously tried to raise my dose of the medication I did not tolerate, they also tried to reduce the short acting opioid that I was tolerating. Forcing patients to take buprenorphine instead of full agonist opioids harms patients like me who have adverse effects such as severe headaches. The newer electronic questionnaires also make it difficult to document problems as many do not allow patient to add additional information. Please allow for the updated wording that would protect pain patients access to life saving medications & prevent forced tapering. Too many of us are not even receiving basic standard of care. Our pain is under treated and are told that the only medication available is buprenorphine, even when we do not tolerate it, they continue to prescribe it.

## Comment #16

**Vickie Bannister (not verified)** - *Jul 02, 2025 06:26 PM* Reply (/comment/reply/870/2845)

As I live each day it is painful for me to be independent as I once was with severe joint pain. Doctor visits are useless because of restrictions on my Drs to deny pain meds. This is government controlled and I know these Drs. Are getting incentives by not giving them. This is absolutely unacceptable and also PATIENT ABUSE from my Drs. This needs to change immediately because the ones that are overdosing are the drug seekers on the streets. I'm no drug seeeker I'm just trying to live out my days with relief from pain. My parents and grandparents took opioids and they were never addicted to the drugs and passed away from old age. What a critical one lane position to be in. Change the law for these hurting people.

## Comment #17

**R Brown (not verified)** - *Jul 04, 2025 12:58 PM* Reply (/comment/reply/870/2852)

Pain is not a crime. And prescribing pain medicine to treat people with pain should not be criminalized. I have a 20 year battle with chronic neuropathic pain due to lesions in my brain and brain stem. It took the medical community years to even find the cause of my pain. I suffered so long without pain intervention because the doctors couldn't find anything wrong. Finally they imaged my brain. And yet, I still struggle with knowing every month if my medication will be approved. Once I was completely cut off by a doctor and another time, another doctor cut my dosage in half because he thought I was thin and blamed the pain meds. I have been the same size since high school. Both times the cut/down size was done without my knowledge or consent. The medical establishment is thrilled to be able to offer a cocktail of other off label medicines that say will help and they all come with a boat load of side effects and adverse reactions; or procedures that often make you worse. Here, take this anxiety med for pain, or this seizure med for pain, or this antidepressant for pain. How about pain medication for pain?? I have suffered with both in ways that are irreversible. When I hear I should relax, I want to scream. Could you relax when you are in pain all the time? Seriously? And then, "don't get stressed" or "take a walk" or "get a massage". The simplistic thinking is mind boggling. 20 years I have been in pain every single day. I have a pain med that works. It's an opiod. It doesn't make me pain free but it makes my life imaginably better and I am able to be productive. Without it, I

cannot contribute to society in a meaningful way. I live in fear wondering if someone will decide I no longer need it. I wouldn't want to live like that. I truly don't get the thinking that somehow using simple pain medication to treat pain is wrong. Live in one of our bodies for a day. The pain a lot of us deal day in day out with would cripple you. We just want quality of life. Every human deserves that.

## Comment #18

**Jeanne Peterson (not verified)** - *May 26, 2025 06:11 PM* Reply (/comment/reply/870/2719)

Since when did my life become less important than an addicts life? Your removing opiates from pain patients so try and prevent addicts on the street from getting their hands on them and overdosing, it's already been proven the overdoses are NOT coming from prescription medications, we have an fentanyl crisis not an opiate crisis and pain patients are committing suicide by the thousands due to being cut off or tapered down so low they can't handle the pain. I've been on the same dose same opiate for 22 years and I'm being cut off. So I will have zero quality of life. And you don't care as long as you can save that addict on the corner that isn't asking to be saved. We're paying the price and sadly you have lied to physicians and told them Washington state doesn't have an MME limit yet your sanctioning them for prescribing over the 90MME limit and now physicians don't trust you so they refuse to go back to treating pain regardless of how you word it. It's a matter of time before the suicide deaths out number the overdoses because it's happening already. Prescriptions have been cut down 96% yet the overdoses continue to rise so that tells you right there it's not coming from prescription medications. I will no longer be able to play with my grandchildren, I will no longer be able to maintain my home living alone, my life will be nothing more than sitting in a chair, suffering, waiting to die. Pretty sad when we have to beg God to take us just to get some relief from the pain and nobody cares. You should be so proud.

## Comment #19

**Unanimous (not verified)** - *May 26, 2025 10:52 PM* Reply (/comment/reply/870/2720)

I've been on pain meds for well over a decade, close to two now, and when my pain doctor just disappeared on me and all her patients, I and many were left panicking. It became horrifically clear how hard it's become to get help EVEN for people on pain meds for almost 2 decades who have 0 abuse history and issues, who have never taken a single pill out of line- to get ANY help. My PCP "wasn't comfortable" multiple pain docs that took weeks or more to get into "weren't comfortable" or said "because the laws and crackdown on opiates... sorry." I got so stressed over the fear of going into physical withdrawals from being suddenly cut off because my doctor just disappeared after this whole time managing my pain, because of her I got out of a walker and wheelchair I had been doomed to in my early 20s, I got so stressed because I was watching my meds disappear and kept being told no no no that I got SHINGLES from the stress. The living hell I was forced to go through for no damn reason. Do we not matter to anyone?? Of course help protect addicts but what about responsible pain patients suffering from horrific conditions?? I shouldn't have my life at only 36 dangled over my head like this, I have enough torment just being alive as is. I have contemplated suicide so many times because of pain and what my disability has taken from me, and believe me, taking the only thing away from me that's helping give me ANY quality of life back isn't what's going to stop me from ever doing that, it'll cause it. Funny what being given stable housing when poor from disability and given STABLY prescribed medication can do for someone's mental and physical wellbeing. An addict will go anywhere they can and risk anything to get those meds to use, why are we making it harder for people prescribed these meds for serious reasons to get them?? How is that helping anyone?? My sister died at 21 thanks to her taking unperscribed ativan that was laced with fentanyl, she was murdered by whoever did that to

that ativan. Maybe if it hadn't been so hard for her to get ativan for her serious anxiety symptoms, maybe she'd still be here. And maybe even if she was taking that more recreationally- I knew she had bad anxiety and was struggling to get it prescribed but she might also have been taking more than she should have knowing how she was unfortunately- but maybe at worst if she was taking it for the wrong reason, maybe if whoever she got that from had had an easier time at LEAST getting it from a doctor easier, maybe at least it would have been normal ativan and not laced to kill her. I don't understand how making it harder to get life saving medication helps anyone, even addicts. All that does is kill and destroy the lives of responsible patients like me, and it also makes it harder for people like my sister to at least have found a way to get that from someone selling it from a real prescription at least. That just means less real and safe meds like that on the street and more $$$ in criminals making drugs that kills pockets. It was the same argument when it came to deciding legalizing marijuana here. They ultimately decided doing that meant less money in criminals pockets, more regulation with legalization and tracking that better, and more people who used that for pain being able to get it without risking jail or being laced and murdered. Unfortunately for me marijuana doesn't help, it conflicts with a psych disorder I have and I just don't like feeling the effects of being high like that at all. It's beyond ridiculous that I'm someone who hates drugs for how many people I've lost, how many exes I've cried and begged to stop using and hurting themselves I've dealt with, being forced on adderol as a minor when wrongly diagnosed with adhd when it was a schizophrenia disorder that they forced an amphetamine on top of, I was forced to live in a literal nightmare world for 7 years as a minor and no one listened or cared, I'm lucky to be alive still and don't know what even kept me here through literal hell.. just to end up like this. Apparently begging doctors when cut off from a drug that would cause severe physical withdrawal pain and sickness to help me. A drug that I've begged an ex to stop abusing and hated every second of watching people I loved misuse what I now NEED to function. It's incredibly angering. They had no problems getting this illegally, while I ended up with shingles from the severe stress and panic of being cut off and it taking over a month to find a doc who finally emergency helped me and still he ended up tapering off my oxycode which was my ONLY breakthrough pain med because his clinic has a policy like most saying they can't prescribe a benzo and opiate at the same time... which I was on for decades!! Do people not even understand how many people with pain disorders also have severe anxiety disorders?! So now we have to chose between dysfunctional pain or dysfunctional anxiety? I was forced to loss my oxycodone thanks to that, my sleep meds I need nightly are also a benzo. That also would mean being driven insane not sleeping again, I already can hardly sleep with the max amount of sleep meds allowed, that runs in my family, none of us can sleep even on the max amount of that and no one knows why. What's funny is, I haven't refilled my MONTH supply of oxycodone in almost a year now but I still have about 12 pills left. If that says enough about being a responsible pain patient. That WAS my breakthrough pain meds. That's what I would take to be able to do my artistic shoots that I use to vent my really bad mental breakdowns, now I can't without pain, or taking some of the last pills I might ever have. That was for a big day like the rare moments I can do something like go to a theme park or a fun event that I know I'll have to try my hardest to function like a normal person for the day. That was to help me ideally NOT be in a wheelchair. That was so I can keep up with my bf and his family when camping one week the whole year. I have nothing for that once those couple pills I've clung to for almost a year now are completely gone. And for what??? An addict WILL find ways to get that same medication, will I? Clearly not. I know the risks and don't want to end up like my sister, though that shouldn't be something I've even have to risk or think about just to have more quality of life like anyone else. I envy everyone who doesn't live like this and doesn't personally understand the living hell that this has caused untold amounts of people in my shoes. PLEASE stop hurting us and help us. It's already SO hard and feels like a fulltime job I can't keep up with fighting advocating managing my body that's trying to kill me. PLEASE help us make this life any less miserable. What about when WE end our lives because we couldn't take the pain we are left in anymore??

## Comment #20

**Anonymous (not verified)** - *May 27, 2025 09:45 AM* Reply (/comment/reply/870/2721)

Please stop the war on pain patients. Everyone deserves ADEQUATE pain relief.

## Comment #21

**Shannon Russell (not verified)** - *May 27, 2025 12:00 PM* Reply (/comment/reply/870/2722)

I've been through it all. Having two doctor's retire one because of the fear of the opioid crisis and 2016 guidelines. His partner although agreed I should be on the amount of pain meds didn't want to prescribe them and refused to take over cause. I've had to search for doctors willing to keep me on my current amount which are very far and few because of the 1016 guidelines I'm over the mme amount. I'm one of the lucky ones that has some of my pain controlled for the most part. But that's not without a fight. I don't go to appt alone anymore cause being a female in pain I'm not always listened to. I e had my pharmacy that I've gone to for decades deny me my pain meds cause they didn't agree I should be on them. The mme limit shouldn't exist but instead a limit of how well pain can be controlled . Doctors are more then willing to do surgeries that most of the time just cause more problems then they fix. Please he chronic pain patients become people again.

## Comment #22

**Viola Von Lindern (not verified)** - *May 28, 2025 04:09 PM* Reply (/comment/reply/870/2723)

I am commenting on the petition Maria Higginbotham submitted on behalf of all of us who have intractable incurable painful disabilities and all others who are suffering with needless pain after surgeries, from car accidents, end of life etc. Doctors in Washington state no longer treat pain. We all are being tortured instead of treated and I don't believe anything will reverse this now. I do hope the Washington medical commission can do something to force doctors to care about the disabled again. My story is the same as every other disabled person. i started having this daily gnawing pain 15 years ago. Before any opioids ever were prescribed we tried over the counter medicine, biofeedback, counseling, PT and many off use prescriptions until it was proven that only opioids would help me. Until 2021 I was stable at 120 me on a pain contract with zero problems with my primary care provider at Valley medical. After over 15 years at Valley and 7 years with this provider, she retired. No one at Valley would continue my care and honor my pain contract. I've been told that the doctors at Valley are required to sign a contract of employment that prohibits them from prescribing opioids. Since then I've been to 2 pain clinics with caregivers who don't care. I've been put on Suboxone, listed with OUD now in my records and red flagged at first pain clinic. The Clinic I'm at now refuses to go above 50mme (the latest CDC "guidelines"). I was stable at 120mme for 7 straight years with no red flags. I loved being with my huge family at holidays and our other gatherings, going to be with friends and I loved volunteering. I loved walking my little dog out in the sunshine, planting some vegetables and flowers, etc. Since 2021 I have done NONE of that. I can no longer grocery shop, clean house and it's too painful to shower as often as I should. This is not a life worth living. I no longer hold hope for a change because all the doctors have been schooled how to justify NOT prescribing and all they have to do is makeup whatever they want to say about you in the chart. I appreciate the effort WMC is working on these rules changes and completely agree with the need. I do feel the doctors and PAs in Washington need to somehow fear the DEA less, ignore the addiction doctors who

know nothing about treating pain and you need to mandate stronger that they get back to the ethics and paths they took which includes to "cause no harm".

## Comment #23

**Maria Higginbotham (not verified)** - *May 31, 2025 06:05 PM* Reply (/comment/reply/870/2724)

Re: WAC 246-919 Opioid Prescribing Rules Submitted in Honor of Gretchen I. Introduction — Gretchen's Story and Petition Background Last July, I filed a petition requesting specific changes to the WAC rules that govern opioid prescribing in our state. I filed this petition after watching a dear friend suffer from a forced taper that was initiated in 2022. I wanted to make changes that might save her. Unfortunately, in December 2024, she became ill with pneumonia and was taken to the University of Washington, weighing less than 100 pounds, unable to walk or swallow. She was diagnosed with ALS and passed away just 10 days later. I didn't save her—but I hope my efforts might save the next patient suffering from a forced taper, bedridden in agonizing pain. This public comment is submitted in her honor. II. Purpose of the Petition This petition and rule revision project seek to protect chronic pain patients—especially those with rare, progressive, or palliative conditions—from the devastating consequences of rigid opioid policies. It proposes evidence-based revisions to WAC 246-919-850 through 985 that reflect clinical realities, uphold ethical treatment standards, and align Washington's rules with national best practices. III. Core Concerns and Justifications The current opioid prescribing rules have resulted in patient abandonment, medication delays, and forced tapering—often without regard for individual medical needs. Substantial clinical and regulatory evidence supports reform: - FDA PMR 3033 (2025) found that patients using long-acting opioids under physician supervision showed

## Comment #24

**Ana (not verified)** - *May 31, 2025 07:00 PM* Reply (/comment/reply/870/2725)

I have endometriosis. I've had 6 surgeries. My doctor finally send me to pain management. You know what pain management told me?! "We don't treat that" it's really painful, my life has changed so much. I can't be a mother anymore. Other doctors have told me the same thing. "NO" when questioned, they all say they can't because they're being watched. Then when finally I was given some from my doctor after two years. Then the pharmacist decided I don't need them?! Because they have laws they told me. Not ok. I need my life back. I need to care for my kids. Never before have I ever needed pain medication until now. And I am being denied and punished. Please help me. Please do something.

## Comment #25

**Isaac T Arnett Jr (not verified)** - *Jun 01, 2025 10:02 AM* Reply (/comment/reply/870/2726)

I have been suffering with pain from a number of chronic health issues. I have tried so many off label meds that didn't work and caused more complications from side affects. I finally started being treated with opioids and successfully so, however, I have been forced to taper to where I am undertreated. I am becoming less able to get out of the home and have asked my primary care Dr. to help me consolidate my treatment and even though it is within the current rules he has refused and has been pushing suboxone. Because I don't want suboxone, he will not help me. The pain clinic I go to tells me I am maxed out which is not true, according to what I read from Wa State med. Commissioners rules. I am looking at losing the bit of pain relief I do get because my PCP is unwilling to due his duty. I have also had troubles getting my prescriptions filled and have to go every 2 weeks instead of 28 days as it used to be. i have had no problems in my records. Now I am also being forced to see the

pain clinic every 28 days because I am over 50 mme a day. I've been being treated since 2011 and have never had a dirty UA of any behavioral issues. It should not be so difficult for me or anybody, to be treated with an effective medication.

## Comment #26

**Sarah Tompkins (not verified)** - *Jun 01, 2025 12:24 PM* Reply (/comment/reply/870/2727)

As a chronic pain, patient who has been on opioids and fentanyl patches for over a decade I can speak to the unfair, stigmas and judgment, the chronic pain patient's face from providers who are afraid to prescribe near 90 MME. It's thanks to my pain management that I have been able to volunteer for patient organizations related to my chronic illnesses, lobby in my state and Washington DC for legislation and policies affecting chronic pain, Rare, disease, Ehlers-Danlos Syndrome, and disability patients like myself and millions others. We know that patients who are doing well on their pain management should not be tapered to appease a specific MME number, if the patient is doing well and their pain is managed their pain management and medication should not change due to any bureaucratic rule. Providers are the ones who should determine patients pain management. For chronic pain patients who have been on opioids for years, it's essential that providers understand that our postoperative or acute pain management will look different from a non-pain patient. Too often, my pain management provider has had to write pain medication for a postop surgery for which she did not do, has little understanding of, and is not her responsibility to manage the postoperative pain of; however, due to other providers, feeling the fear of being punished for providing over 90 MME, too often the responsibility falls, unnecessarily and inappropriately on my pain management doctor to manage my postoperative pain as well as my chronic pain. Please support our chronic pain community and our providers by ensuring language that empowers providers to prescribe as they see it for chronic pain, and postoperative pain for chronic pain providers, ensuring chronic pain patients aren't unnecessarily punished, put through undo pain, or put at risk for suicide Due to unnecessary or inappropriate tapering of their pain medication. Thank you for your time and consideration, and please support this amended language.

## Comment #26

**Daph (not verified)** - *Jun 01, 2025 12:45 PM* Reply (/comment/reply/870/2728)

I have multiple long term chronic illness. Im on palliative care for Breast Cancer and the effects of surgeries and chemotherapy left me debilitating pain! I didn't ask for cancer and the pain BUT I AM ASKING FOR PAIN RELIEF!!! PLEASE DONT'T TAKE PAIN RELIEF FROM ME! CANCER ALREADY STOLE SO MUCH OF MY LIFE!! PLEASE! I take opioids just to get through daily life. I'm NOT an addict- I just want to live a semi-normal life without excruciating pain. I receive care from a pain clinic and without my regimen I truly wouldn't have a quality of life. I can barely walk, bathe myself, dress myself or do daily tasks as it is. I BEG you to PLEASE allow me to live a decent quality of life. My medication allows me to get out of bed! I have spinal stenosis, hEDS, osteoporosis,osteoarthritis,degenerative disc disease,a fractured back, and that's only a few that I deal with DAILY! I don't get " high" or any type of "euphoria" from my daily pain management routine. I GET PAIN RELIEF just to move around without excruciating pain! PLEASE LISTEN TO US CHRONIC PAIN PATIENTS!! We deserve to live with dignity and respect. With all due respect, WE AREN'T ADDICTS!!! We just want to live WITHOUT EXCRUCIATING DAILY PAIN just like you and your family. OPIOIDS CAN SAVE LIVES!!!! Sincerely, A CHRONIC PAIN PATIENT THAT JUST WANTS TO LIVE

## Comment #27

**Anonymous (not verified)** - *Jun 01, 2025 12:47 PM* Reply (/comment/reply/870/2729)

Since the “opioid epidemic” began chronic pain patients have been collateral damage in the effort to find an answer to the opioid issue. They have had their medication cut or discontinued suddenly and for no reason. Most stable chronic pain patients have been taking opioids for years without issue and yet they were the ones who were punished for the opioid problem. Many chronic pain patients have either been forced to take street drugs or have ended their lives because of the situation created by the various regulatory agencies. This Commission and this rule are an opportunity to begin to rectify this by allowing doctors the freedom to treat pain patients without fear of prosecution and will allow chronic pain patients to have their pain treated with the proper doses of medication rather than some arbitrary MME number that is entirely too low for most chronic pain patients who have been taking opioids for many years. Please do the right thing and correct the mistakes that were made by the regulatory agencies and give chronic pain patients their lives back. This medication allows pain patients to live, to play with their kids, to interact with their family, to go to work, or even just to get out of bed. Give them their lives back. Thanks

## Comment #28

**Anon (not verified)** - *Jun 01, 2025 04:47 PM* Reply (/comment/reply/870/2730)

Hello - I have a rare disease and several comorbidities. One of the difficulties of managing this condition is that many medications cause extreme side effects or do not function in the same manner they would for a “typical” patient. Over the last many years, I have tried 40+ medications to control pain and associated symptoms. I’m unable to safely tolerate many classes of mediations. I use opioids - safely and within my prescription limits because they offer the best pain relief I am able to tolerate. It often feels stigmatizing when discussing care, finding a new doctor (I’ve only had to switch once due to retirement, but finding clinics who are comfortable prescribing opioids was challenging). Chronic pain patients aren’t taking these meds for fun - I finally agreed to try them when I was unable to play with my children many years ago after trying everything else I and my care team could think of. We take them to lower pain (never to zero) and maintain whatever quality of life we can, often in the face of difficult, rare, life changing, and permanent injuries or diagnoses. Fighting the stigma on top of managing difficult conditions is exhausting and disheartening, and I”d appreciate any rule changes that made that struggle slightly easier. Thank you.

## Comment #29

**Deborah Rohan (not verified)** - *Jun 02, 2025 12:30 AM* Reply (/comment/reply/870/2731)

Opioids are a necessary tool in the toolbox of chronic pain patients especially patients like myself with hypermobility spectrum disorders. This is a genetic collagen defect which is turning out to be much more common than previously thought. I was not diagnosed until almost 40 even though I have been having excruciating lower back spasms since I was 11. But guess what. Opioids have been part of my life for decades, but I have never become dependent. They exist as a key tool among many other tools that I use to manage myself. I am the success story I am because of opioids. Imagine dislocating your vertebrae and how excruciating it would be to feel like you are being torn apart without anesthetic. Imagine knowing for certain this will happen to you three to four times a year. Tell me how you would have the confidence to go out and exercise and do physical therapy and do all the things you need to do in life, If you didn't have pain management for those excruciating times. What happens to me is basically a spinal subluxation. The vertebrae move too far because the ligaments aren't doing their job to hold them together, So the muscles clamp down in pain pill spasm damaging the muscles, in a desperate attempt to hold the body together. The

nerves in that area are extremely sensitive so the pain is excruciating, 10/10 pain. When I am down with one I cannot get out of bed to access food and water and the toilet. I am completely helpless with our opioids and would die. Once, my husband urged me to try harder and push through the pain in order to get out of bed... I did and was left screaming on the floor in agony, unable to lower myself to the floor or climb up to the bed for 15 excruciating minutes. It was mentally traumatic. With opioids it is still extremely painful but I managed to lift myself out of bed a couple times the first day a few more times the second day and on and on to make the two week long process to return to normal function. I have suffered extreme mental trauma when one time a doctor decided that I should not be prescribed opioids. It would be like going into surgery and suddenly being told you don't deserve anesthetic. Inhumane, barbaric, It is a war crime to deny pain meds to victims even in times of war. Why are responsible American citizens with legitimate disability and pain being treated less than enemies in war?

## Comment #30

**Shannon Schildt (not verified)** - *Jun 04, 2025 04:32 PM* Reply (/comment/reply/870/2732)

I have been suffering in silence because doctors will not prescribe hydrocodone for my chronic pain which I took as needed for many years and only at night with absolutely no issues from patient or doctor. I was always prescribed a count of thirty and used as needed which fluctuated in duration longer than thirty days. I would go back to my doctor when I needed it refilled. Over the past eight years it has been a struggling battle as doctors were becoming more and more fearful to prescribe. About four years ago, I was forced to chose either sign a form that said I would not abuse this opioid drug or be refused being prescribed the requested thirty day supply I had always been given before policies were regulated on doctors. I respectfully signed the document, but at the cost of my integrity as it then labelled me a seeker. I went to physical therapy as requested that did not help with my chronic pain. I was forced to try other medications that did not work because doctors refused to refill the opioid prescription. One drug I was prescribed caused more harm to me leaving me in more pain. I am now labeled a seeker because I keep asking to have my opioid prescription refilled that has not been refilled in over two years. I suffer in agony from the chronic pain, isolate, struggle at work because it is hard to put a full day in which I fear being let go. We have treated a controlled drug as if it is a street drug labelling everyone who seeks it an addict or a criminal. I respectfully ask that the rules, policies and regulations affecting the controlled opioids be rewritten with the understanding that patients and doctors do not abuse them.

## Comment #31

**Jody Lovelace (not verified)** - *Jun 06, 2025 05:16 PM* Reply (/comment/reply/870/2733)

To Whom It May Concern, I am writing to address the upcoming decisions regarding pain management guidelines. I am a lifelong friend of a chronic pain patient, a friendship spanning over 30 years. Over the past 11 years, I have witnessed my best friend’s physical health deteriorate. She suffers from SLE Lupus, Ankylosing Spondylitis, and is a carrier of the PalB2 gene. She was once an active individual, deeply involved with her family and friends, enjoying camping trips and weekend excursions. Today, there are days when she cannot even get out of bed. After beginning pain management, it took nearly 18 months to find a treatment plan that provided some relief. Although the regimen isn’t perfect, it has restored some quality of life, enabling her to participate in select activities if planned properly. I accompanied her to appointments and saw her endure a grueling trial-and-error process with various medications, infusions, and procedures. Eventually, a regimen of opioids, taken every six hours, allowed her to manage her pain. This treatment gives her the ability to complete everyday tasks such as showering, attending appointments, and other activities

most of us take for granted. However, every two months, she faces immense anxiety over her upcoming pain management appointments, uncertain of what changes might occur. Despite her compliance—accurate biological samples, correct pill counts, timely refills, and consistent attendance, she constantly has to fight to maintain her medication. It feels unjust. She is prescribed only 80 MME, yet finding compassionate providers who treat patients with the care they deserve has become nearly impossible. When drafting the new guidelines, please ensure they explicitly state that withholding treatment or enforcing tapering without justification contradicts the rules and is unacceptable. Please remember that the choices you make will profoundly affect real individuals—mothers, fathers, sons, daughters, and friends. This could even impact your own loved ones. I implore you to consider what I have shared and trust that you will make the right decisions for people like my friend. Thank you for your time and thoughtful consideration.

## Comment #32

**Bree (not verified)** - *Jun 10, 2025 10:24 AM* Reply (/comment/reply/870/2734)

Please hear the chronic pain patient cries. So many have lost crucial prescription pain medication from their doctors after the flawed CDC guidelines that they've admitted conflated prescription overdoses with illicit fentanyl overdoses to push thousands on addiction Medications. People within the CDC who helped to write those prescribing guidelines have been found to have been paid by the makers of the addiction medications and have high conflicts of interests! The DEA has been going after small time innocent doctors who are Treating their patients with prescription opioids who have severely painful disabilities, and illnesses where all other medications have failed. These people are not addicts and want their form of quality of life back. So many of these patients are US Veterans who've now sadly, committed suicide. And not just Veterans, you can read plenty of stories of Moms, Dads, Brothers, Sisters, friends, who've also sadly taken their own life as to not have to be punished to live in debilitating pain because the DEA has targeted and ruined so many kind & compassionate doctors and destroyed their careers and reputations for trying to help these people. And no everyone's afraid to treat them. It has created a devastating environment for both Doctor & Patients alike. Please hear their cries! They're trying to stand up to Bring awareness. But, Big Parma has bottomless pockets and are always able to control the narrative. Chronic pain patients are NOT drug seekers! They wants to be productive members of society. Please help us all! Thank you for your time!

## Comment #33

**Debra Nolan (not verified)** - *Jun 12, 2025 04:36 PM* Reply (/comment/reply/870/2735)

As a 62 year old woman I have gone through a lot in my life. I raised 3 girls to adults and through college. During my 20-30's I had a total of 16 surgeries all major surgeries. I was given opioid medications for approximately 4-6 weeks so I could rest and heal and return to work and caring for my children. I didn't fear having to have the surgeries back then because I knew my doctors would take care of me and keep me comfortable. I still had pain but it was bearable. I had extra pain meds to take at night so I could sleep. After 9 surgeries on my intestines and bowel, advancement in medicine had a genetic testing that showed a problem that they could finally treat with medication. I never had to continue pain medication past the post op period. Fast forward 20 years, I get hit from behind by a semi truck fully loaded. My vehicle was knocked over 300 feet to another street. My back was broke, torn rotator cuff and knee. Thankful to be alive. For months I used Tylenol and Motrin for the horrific pain. I couldn't take the pain any longer. My primary care doctor prescribed me Norco 10 4 x a day and a small dose of long acting Hyslinga. After a few months, I was sent to a pain management doctor only because my primary care doctor told me he couldn't continue to

prescribe for fear of arrest. My mouth drops as I had no idea of the new found opioid prescription hysteria. So I got to pain management. I figured pain management would continue my current treatment since I was comfortable and still able to work. Nope. Pain management insisted I get epidural injections because my insurance would cover it and it's supposed to help with back pain. I knew nothing about them and figured no Physicians could do anything that wasn't FDA approved. After several of these injections my pain was worse. Plus pain doctor stopped the long acting medication because of DEA fear. So then ablation was the next best thing. So I'm doing ablation. Oh my GOD. I thought I was going to die from the headache that lasted 3 months. I was miserable. Not only was my pain care destroyed, and since now I can not work, Medicare is being milked of thousands. THOUSANDS. Before Interventional Pain clinics, I paid an office visit and had a running prescription every 3 months. Medicare was charged for urine screens at pain clinic. I had to do pill counts like a toddler. So when I question why they were counting my pills, I was told ' to make sure you are not selling or diverting them". I was shocked. I laughed and said " well if I didn't need the medications I wouldn't have had all those 6" long needles jammed in my back all these years and I sure couldn't sell all the prescriptions for the amount I pay to come here". So pain doctor was then mad at me for speaking truth and common sense. I then learned of the DEA and Narxcare and how HIPAA doesn't protect your medical information if you are a pain patient. So another layer of discrimination. Isn't pain a symptom of something wrong in the body? Isn't pain a health care condition? I since learned that you are treated as addicts, pay a price as if you are an addict even if you are like me and never did an illegal drug in your life. Now, the " addicts" get synthetic Opioids to keep them comfortable. WTH??? So, I worked, raised a family, always obey the laws of the land , but I am a criminal because my body is broken? Doctors are being arrested because they meet face to face with people and try to control their pain? What country am I in now? So since my experience with pain and how pain patients are treated, I have poured myself into research. I have learned of the corruption of how the CDC guidelines came about and the damage they have caused. I have learned how PROP went from having to treat patients to making millions on opioid lawsuits. The most UN AMERICAN thing I have learned is that pain is not the number 1 cause of veteran suicide. UNACCEPTABLE. Totally. Treatable pain, and people are dying so that profiteers can try and have chronic pain patients labeled as addicts or the new profitable OUD diagnosis. All of this is disgusting for the medical community to sit back and allow. Then my mother had pancreatic cancer. I had to argue and fight and get ugly to get her pain controlled?? So she could pass away peacefully and not in screaming pain? Good Lord, please stop the madness and give our educated, licensed doctors the freedom to treat patients. Make it an actionable offense if they refuse to treat , not an offense if they treat pain. It is draconian and barbaric to allow anyone to suffer in pain when we have safe, effective and inexpensive Opioid medications that were invented for just this purpose. Yes there will be people that will abuse. Yes there will be overdoses. Just like with alcohol. Yet alcohol isn't a necessity yet still available even though deaths happen because of it. We all can live without having a beer. We can live if our bodies are injured or diseased and the pain is unbearable. Please bring mercy, compassion, and common sense back to chronic pain care. It IS a matter of LIFE or DEATH.

**Debra Nolan (not verified)** - *Jun 12, 2025 04:51 PM* Reply (/comment/reply/870/2737)

Replicate comment to fix a few errors in my previous comment. a 62 year old woman I have gone through a lot in my life. I raised 3 girls to adults and through college. During my 20-30's I had a total of 16 surgeries all major surgeries. I was given opioid medications for approximately 4-6 weeks so I could rest and heal and return to work and caring for my children. I didn't fear having to have the surgeries back then because I knew my doctors would take care of me and keep me comfortable. I still had pain but it was bearable. I had extra pain meds to take at night so I could sleep. After 9 surgeries on my intestines and bowel, advancement in medicine had a genetic testing that showed a problem that they

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## Comment #34

**Cheryl Thurmond (not verified)** - *Jun 12, 2025 04:47 PM* Reply (/comment/reply/870/2736)

I appreciate that the voices of people suffering are finally being heard. My husband is a chronic pain patient and suffers so much with his pain. The doctor is force tapering him to the level that is comfortable to the doctor's own fear. My husband has rapid metabolism of medication and requires a higher level of pain medicine. We have chart notes, surgery notes, blood tests, and 3 doctors who agree to his rapid metabolism but we can't find a pain doctor to help my husband. Referrals to pain doctors are rejected when they see his pain needs. Our government is responsible for starting this "war on pain patients" and now the doctors are fully complicit. I implore to you to do what is right, and help the people who live in pain on a daily basis!

## Comment #35

**Linda McDonald (not verified)** - *Jun 13, 2025 06:26 AM* Reply (/comment/reply/870/2738)

Hopefully they will do something soon for everyone suffering! I was used as a pin cushion having Medicare milked. The last procedure ended with me in the ER 4 months ago and I still have numbness in places I shouldn't have. The Dr who did the procedure didn't even answer calls from the ER Dr while he was caring for me. I have had numerous of these procedures and never This problem. Before I moved my pain control was managed with just medication and all of the rules and then some doctors thinking you are automatically an addict if you are on opioid they want to just do procedures when because of other comomorbidities I'm not even supposed to have these procedures but they are willing to risk my actual life. I've been in pain management 15 years and never not one failed drug test or write up or anything and with same Dr but I had to move out of the area and problem started with new Dr. They treated me not according to my pain but as Dr actually said their OFFICE POLICY. These doctors now have the taste of making the big bucks for procedures instead of just a refill appointment. I feel that's going to be the problem if anybody tries to straighten this out. We need primary care doctors to be able to prescribe again. Interventional pain clinic have the taste of making 10k off of Medicare in 15 minutes as opposed to the PCP making 100 for 10 minutes. So interventional pain clinics will never give up that big money. How did they get Medicare to pay for non fda approved epidural injection that can cause paralysis? Some more back scratching? Medicare pays millions in urine screens. Worthless urine screening. If anyone wanted to divert medicine they know when their doctors appointment is to have their medicine in their system. It is beyond ignorant to be paying for such workers urine screens. Plus 7k non fda approved epidural injection? Profiteers have hijacked Medicare and will milk the funds dry so the next generation will lose out on Medicare benefits. Why? Because there are millions of CPP. What use to cost 500 a year for treatment, has costed my insurance 58k so far this year and the results are not as good as just the medication alone. Opioid medicine works. It controls pain. Nothing else has worked as well. It is inexpensive. I've been put on Bupe and Suboxone medicine and neither of those worked for pain. Thankfully my doctor listened and put me back on my Opioid medicine after my blood pressure wouldn't come down due to pain. After only a few months on the bupe films my teeth melted out of my mouth. So add 9 k for my teeth to be pulled and now disgusting dentures. It is draconian how pain patients ate treated and members of PROP need prison time.

## Comment #36

**Thomas Michael ... (not verified)** - *Jun 13, 2025 12:06 PM* Reply (/comment/reply/870/2739)

I am a long term Chronic Pain Patient who has suffered in pain and agony ever since the so called "opioid Crises" began. I was cut off ALL of my meds by my Doctor, despite my begging

him to slowly taper me. I have been in search of any Physician to help me. I appealed to the Medical Commission many toms. All without success. Doctors who do not relieve pain is the new norm. I wholly endorse these new changes to the rules and can only hope that someday soon, I will be able to find adequate pain relief. My last attempt to find a doctor was yesterday. She told me they no longer prescribe opioids for pain. Suboxon is the new norm. She said she was "So Very Sorry " that I was prescribed opioids for over twenty years. I asked her, Why would you be sorry that 90% of my pain was relieved for over twenty years? These new young doctors are being Brainwashed in Medical School at a very young age. She kept saying we have found them to be ineffective (opioids) we have found them to not relieve pain, we have come to the conclusion that opioids are bad. I asked her, who is this "We" you are talking about, she said the instructors in medical school and her fellow doctors. I asked her Have you ever been prescribe opioids for pain, she replied no she had not. I asked her why would you take advice from someone who was never prescribed opioids for pain, over a patient who had taken them for over 20 years and found great relief. I thanked her for her time, she said, wait a minute, don't you want me to prescribe something for you High Blood Pressure, it is extremely high, I told her that if my High Blood Pressure killed me, it would be a Godsend that would finally relieve my Chronic Pain. I am contesting Medicare to refuse to pay for her services as she did nothing to relieve my pain

## Comment #37

**Patricia Dunn (not verified)** - *Jun 15, 2025 04:54 AM* Reply (/comment/reply/870/2740)

I am a chronic pain patient that has suffered under the newer opioid restrictions. I have CRPS, fibromyalgia, migraines, SPONDYLOLITHIASIS, plantar fasciitis- pain is my everyday existence. Before the 2016 guidelines that were interpreted as a mandate, I recieved good pain control. Since then, I have endured a failed spinal cord stimulator that began shocking me for 20 min at a time. I had to kill the battery to get it removed because medical professionals would not believe me- I had to show a video of me convulsing uncontrollably to prove it was happening. I have been prescribed every off lable drug for pain, instead of relief I got headaches, chronic kidney disease, weight gain and was told to use a keto diet to loose weight despite having a gfr of 60 or less. I have a slight advantage over most pain patient in that I have a nursing degree. I knew that following the keto diet advice would further damage my kidneys and make me require dialysis. I fired that prescriber. Currently, I have been seen by a pain clinic since 2022. The entire time, I have had minimal access to full agonist opioids (3) 5mg hydrocodone per day with belbuca. The hydrocodone is not enough, and the belbuca causes debilitating headaches. I take ubrelvy for the headaches (originally prescribed by the pain clinic PA, now by neurologist because the new PA refused to file insurance prior authorization paperwork) I have tried reducing buprenorphine dose at my request, stopping buprenorphine product - helped headaches but left me in pain from my chronic pain conditions, so still stuck not having quality of life. I have tried changing from 15 mme hydrocodone to 16 mme hydromorphone, but only recieved dosing 2 x per day. Which left 16 hrs per day in agony. I have switched to buprenorphine patch with 1/2 hydromorphone pill 4x day, and headaches return. The long acting MS backorder was sighted as the reason she would not order a trial of morphine when insurance denied restarting buprenorphine products. I get good relief with dilaudid 2mg 4x a day, yet they think that's too high of a dose. The same provider prescribed belbuca 300 twice a day, despite my complaints of headache with buprenorphine. Again, I had to ask each time for a dose reduction, they wanted to increase my dose despite me not tolerating it. They have continued prescribing buprenorphine for 3 yrs with reports of intolerance every check up. I do not experience intolerance with the full agonist opioids. I take my medication as prescribed, submit and pay for "random" drug screens at EVERY appointment. But am not really offered informed consent. I know the respiratory depression risk and have had dilaudid at much higher doses (180/month) without any problem, but I'm restricted to 2 per day and told that if I want long acting relief my ONLY option is a medication that I don't tolerate. The assault against opioids

harms me EVERYDAY. ADDICTS have better access to opioids than I do. I'm being continually punished for the actions of addicts, who sought self medication from the streets. We need overdose deaths to record how the drugs were sourced (legal vs illicit), legitimate prescriptions are tracked and when they don't have a prescription it's obviously been acquired by illicit means. These death are the result of criminally acquired drugs, yet legal prescription are being restricted. Restricting legal access will never stop illicit acquisitions and OD's. But prohibiting legal access will push desperate pain patients to seek relief either through streets or suicide. Tolerance is developed in numerous medications- diabetics often require dose adjustments, blood pressure, blood thinners need frequent adjustments, yet when a pain patient needs adjusted dose they get labeled as an addict. I do not seek euphoria, but I do want to have more than 1hr of consistent pain relief where it doesn't take effort to distract me from pain. When your baseline is 6 or higher, quality of life declines sharply. ADL's become exhaustive and unmet. Bodies need to be moving, pain medication allows us to get OOB and be mobile. Restricting access is forcing us to be sedentary, which is a know risk factor for so many co-morbidities. Disability pay is poverty wages, traditional opioids are cheap, yet we are forced onto expensive buprenorphine products that rot our teeth, which Medicare will not treat, which leads to malnutrition. We need access to opioids, please allow changes to the language that will protect my access to these lifesaving medications.

## Comment #38

**Pamela Beall (not verified)** - *Jun 15, 2025 09:15 AM* Reply (/comment/reply/870/2741)

My elderly mother was force tapered from only 40mg of hydrocodone to 20 several years ago and strong armed into infusions, more physical therapy, gross amounts of gabapentin (then pregablin) and high amounts of ibuprofen and additional Tylenol to "treat" her debilitating Rheumatoid Arthritis, Severe lower back damage with scoliosis, osteoarthritis and Fibromyalgia pain. I've watched her mobility worsen because of UNDER treated pain. Her primary Practitioner literally told us " I cannot prescribe more, it's against the law" and when I pressed her on that fallacy, she dropped my Mom by "referring" her to pain management which also is Not Treating her pain. They insist on epidural spinal injections that have NOT WORKED. This mindset is all over multicare network and it's slowly stealing my mom's mobility and giving her almost no quality of life. She's not the only one. I've talked to so many others experiencing the same neglect! People just don't know they can push back or question! They don't feel good enough to fight, don't know they even can. Without an advocate these patients just DIE suffering. I can go on and on with dates, times, experience so feel free to contact me! This has to stop now. Every single one of us is ONE injury or serious illness away from needing appropriate pain relief. None of us are getting younger. Please help us.

## Comment #39

**Tina Schmidt (not verified)** - *Jun 15, 2025 11:08 AM* Reply (/comment/reply/870/2742)

Over the past decade I have dealt with nonstop issues getting my chronic pain addressed, since relocating home to Washington. I had a wonderful pain management clinic in Georgia that offered PT, counseling, opioid prescription pain relief and random drug testing. My quality of life is night and day different since relocating back for family. I had my surgery at Virginia Mason in Seattle in the fall of 08, due to nerve damage and chronic pain at the surgical site I was kept on opioid pain medication and muscle relaxers. This care transferred well when I went to Georgia. Upon return to Washington in 2014, I went back to Virginia Mason and they would no longer prescribe. I had to try psychological medicine with enormous side affects with no pain relief. I did injections in my back as well as the testing for

nerve ablation, neither worked. Trying to find a provider to treat me took 7 years. 7 years of spending most days on a heating pad, nearly all of my daughters elementary year and into middle school.. The doctor I found at CHI Franciscan was wonderful, he had suffered a similar injury to my own. Under his care, I was referred to have steroid injections again, that again did not work. He prescribed oxycodone and skelaxin, but a lower dose than I had been on previously as he said he had to stay within certain limits. It was better than nothing. I could do more than the previous 7 years. Then chi Franciscan and Virginia Mason merged. Initially nothing changed, but abruptly, November of 24 my doctor was gone, no notice or explanation. The new doctor I was assigned to gave one script and said it was “policy” that I would receive no further medication and referred me again to their pain management clinic that only does injections/procedures. I left that day in tears, didn’t reschedule and fell into a deep depression for several months, stuck on a heating pad again majority of my days. I finally went on my chart and asked that new doctor to refer me to an outside pain clinic that would keep my treatment plan I had. I was elated when I saw the referral in my chart. Tried calling the new clinic several times to make an appointment, no response. Then I decided to go back in MyChart so I could print out the referral he sent; IT WAS GONE. So now I’m stuck. I have missed a good portion of my daughter’s life and now I’m going to loose the rest as she enters high school. All because of political agendas over a fake “opioid crisis”. Less than 1% of pain patients are addicts, less than 1%! People, like myself, are punished, our lives made miserable over nothing but propaganda. If it weren’t for my child, I don’t think I’d bother even trying anymore. Life isn’t enjoyable when you have no mobility, everything becomes sheer will to do, so only the basics, if that, get done. My back, bottom and back of thighs are discolored from living on a heating pad. I have severe muscle atrophy and weakness and no help. I sincerely hope that changes are made, to give us suffering a quality of life. No one should have to suffer endless pain.

## Comment #40

**Wendee Hewitt (not verified)** - *Jun 15, 2025 11:49 AM* Reply (/comment/reply/870/2743)

Please stop demonizing people with chronic pain, while catering to IV drug users. After breaking my back, I was told to use advil and tylenol and offered injections and a nerve ablation. Not only did any of that not treat my pain, I now have life threatening issues because of it. Doctors should be treating pain, not bureaucrats.

## Comment #41

**Anonymous (not verified)** - *Jun 15, 2025 02:57 PM* Reply (/comment/reply/870/2744)

I am writing in support of Maria Highenbotham's petition. It's beyond time pain patients are no longer treated like criminals for seeking care and pain relief. As a patient diagnosed with 3 rare chronic pain conditions, I need help to receive appropriate care. I am in pain on a daily basis. I have difficulty using the stairs in my home. I have difficulty sleeping because the pain increases at night. I am currently allowed 30 Percocet to last me two months. The majority of the time I just beat the pain but I also work full time and need to be able to function. I'm not allowed adequate pain relief and not given any alternatives while addicts are given free medication sometimes multiple times a day to save them from overdoses. Chronic pain patients with legitimate prescriptions are not the cause of the crisis. Research has proven this. The CDC admitted their statistics did not deliniate between deaths from illegally obtained drugs and deaths from prescription drugs. I have chest pain on a regular basis because of my conditions. When my pain flares up, I'm told by my doctors to go to the ER. I refuse to go because I am treated either like it's just anxiety and told to go home and think good thoughts. Or I'm treated like a criminal and a drug seeker and told to go home with no

help. It is a right of every person to receive adequate medical care which includes appropriate and adequate care for pain.

## Comment #42

**anonymous (not verified)** - *Jun 16, 2025 06:33 AM* Reply (/comment/reply/870/2745)

Please keep the prescribing of opiates in the hands of providers, professionals who have been trained to assess the needs and conditions of their patients. An arbitrary underlying diagnosis (such as "cancer") is not the only reason for chronic pain: there are numerous common under-reported/ diagnosed conditions (such as Ehlers Danlos Syndrome), as well as many rare diseases, that leave patients suffering with chronic pain. Please allow ALL patients that suffer from pain the opportunity of relief, under the same compassionate and careful prescribing guidelines.

## Comment #43

**Anonymous (not verified)** - *Jun 16, 2025 10:29 AM* Reply (/comment/reply/870/2746)

I support the recommended revision to opioid prescribing rules for MDs and PAs. The proposed changes promote individualized, evidence-based care by clarifying that stable, compliant chronic pain patients should not be forced to taper or discontinue opioid therapy, as doing so may cause harm and fall below the standard of care. Removing predetermined MME thresholds aligns with federal guidance and reflects current medical understanding, while proposed exemptions for patients with rare diseases ensure these individuals receive appropriate, compassionate care. These updates support both patient safety and provider accountability through clear, current, and effective regulation.

## Comment #44

**Anonymous Drs (not verified)** - *Jun 16, 2025 01:26 PM* Reply (/comment/reply/870/2747)

I hope this message finds you well and in great spirits. I am writing to express my deep concern regarding the ongoing unjust prosecution of physicians who have dedicated their lives to treating millions of suffering Americans. These actions not only undermine the essential trust between doctors and their patients but also threaten the very foundation of medical freedom in our nation. Many of these cases appear to be politically or financially motivated, with parallels to the false and unjust persecution you have personally endured. These hardworking doctors deserve our protection, not persecution, for their commitment to improving lives and upholding the Hippocratic Oath. I also urge you to direct Attorney General Pam Bondi to immediately disband the Health Fraud Prevention Partnership (HFPP), a public-private collaboration heavily influenced by the insurance industry. This organization wields unchecked power that compromises the autonomy of medical professionals and restricts patients' access to necessary care. It poses a significant threat to the health and well-being of countless Americans. As someone who has tirelessly championed the rights of everyday citizens and battled against injustice, I believe you have the ability and the resolve to bring an end to these injustices. Your leadership in protecting medical freedom would resonate deeply with millions of Americans who value both their health and their liberty. Thank you for considering this important issue. I trust in your commitment to justice and the American people's well-being, and I am confident that your decisive action will help restore fairness and integrity to our healthcare system.

## Comment #45

**Kellie Gasser (not verified)** - *Jun 16, 2025 06:42 PM* Reply (/comment/reply/870/2754)

Chronic Pain Patients have been suffering for over 9 yrs, since CDC 2016 Guidelines, the 2022 revision never changed a thing in any state that I'm aware of. I've contacted CDC & received in writing the following info: the guidelines were never intended for Chronic Pain Pts or Pain Management Dr's. It was for Acute Pain, Primary Care Dr's, ER Dr's, etc. Some of the examples listed were for pts who " may be" diverting....or possibly having an issue with OUD or Addiction. NOT Chronic Pain Pts w legitimate pain, following rules & protocols/regimens of treatment set for them. Those receiving benefits of pain relief especially when benefits were outweighing any consequences. Those who may be not receiving benefit, Diverting, suspected OUD, etc. COULD submit drug screen test, COULD be asked for pill counts, COULD Be asked to be seen every month or more often than those not having issues. NOT as a form of PUNISHMENT JUST BECAUSE THEY ARE A CHRONIC PAIN PATIENT! When did becoming a pain pt become a CRIME? or why are most, if not ALL CPPs looked at as Addicts drug seeking, not to be trusted, treated like Parolees, gaslit by Healthcare, whispered about in the halls of clinics, side eyed at the pharmacy, yelled at by Emergency rm techs, literally laughed at & ridiculed on social media, and I could go on!! Fact is ANYONE could become a CPP in any second of any day! Vehicle accident, work injury, bad diagnosis, etc. You or your loved one?? Your children?? Some you know will be affected! When did finding a dr to treat your pain at a level that's livable to you , therapeutic doses, not this 25 mme per day which is for a sprained ankle! Turn into something worse than a JOB INTERVIEW?? What gives Healthcare workers the right to belittle us? There are millions of pain pts, I think we pay quite a bit of everyone involveds salaries! Insurance premiums! Pharmaceuticals! Not to mention ice pks, heating pads, spinal stimulators, tens Units, etc. $$$ No one deserves to be belittled and while we are feeling our worse! Not everyone is on disability, many of us work full time plus jobs! Professional jobs. Entry level jobs. Doesn't matter. We are doing the best we can. Did some PATIENTS make the rest look bad? Sure! Did some Dr's deserve a sentence? Sure! But it's not all.pts or all Dr's! Some Dr's genuinely care for their pts. Should they have to worry about their reputations & homes? Not to the extent that they want nothing to do with CPPs! What happens when CPPs can't get the treatment they need? Some never leave their homes, never see Dr again, some completely deteriorate, some actually have unalived themselves. Some go to street for pain relief in other drugs & end up w ILLICITLY MANUFACTURED FENTANYL- which has been the downfall of PAIN MANAGEMENT!! It doesn't need to be this way! Without some guidance by the States & Federal Gov, CDC , and even the DEA, things will continue to go downhill. How many have to go from happy, productive Citizens to broken, degraded pain pts - to no fault of their own!! I don't believe any state truly knows how cpps are treated, living, dieing, and just wanting to end this life of pain . No other medical group or condition gets treated like this! There are medical conditions that are far worse than some of the pain patients but they at least get some respect, dignity, sympathy & empathy! It's time to let those who know best in this field to treat those who need them most!! I could repeat facts & statistics but feel yoy have that info & irs time to hear some truths from those living this daily and some fir decades! If we're all addicted, qe wouldn't be working, if we're all.diverting we wouldn't be in pain, if we're using street drugs, most wouldn't be around anymore. Mamy cpps have been dealing w their pain for 10,.20,.30 plus yrs. Still here, still healthy minus our pain issues, still raising our families, taking care of our homes- find me addicts that have all this going on & managing it while in some really bad pain 24/7. Thank you!

## Comment #46

**LaRae Nova Puls... (not verified)** - *Jun 17, 2025 02:38 PM* Reply (/comment/reply/870/2760)

As someone living with Ehlers-Danlos Syndrome and running a support group for others with chronic illness across Washington and the Pacific Northwest, I urge you to support this bill. Many of us suffer from persistent, often debilitating pain. I've watched friends lose their lives

—some by suicide—after being forcibly weaned off the medications that allowed them to function. Others have died misusing medications out of desperation. These are preventable tragedies. We're not asking for unlimited prescriptions. We're asking that providers be allowed to treat chronic pain based on the individual needs of their patients—without arbitrary restrictions tied to a cancer diagnosis. Personally, I recently broke a bone in my foot. I have a sensory processing disorder and don't always register pain the way others do, but even I have had moments of tears and immobility from the intensity of what I can feel. Yet I was offered no pain relief. Over-the-counter options are limited for me due to liver issues, and I'm already on daily aspirin and Celebrex. Many in my community have even fewer safe options. Pain management must be humane, individualized, and accessible. Please allow providers the freedom to prescribe appropriate medications to all patients with chronic pain, not just those with certain diagnoses. Thank you for considering the needs of people like me —and the many who can no longer speak for themselves.

## Comment #47

**Susan Aasen (not verified)** - *Jun 17, 2025 03:44 PM* Reply (/comment/reply/870/2761)

Please support this bill returning to physicians the right to prescribe opioid medications as they believe is in the best interest of their patients. I have multiple chronic health conditions. Although I do not require constant pain medication, the current rules have so affected doctors that many of my doctors are afraid to prescribe opioids even for the occasional needs I have. Don't eliminate pain relief for virtually all legitimate users on the grounds that there are some who are abusing those meds.

## Comment #48

**Ronda Bruse (not verified)** - *Jun 18, 2025 03:13 PM* Reply (/comment/reply/870/2762)

Thousand of patients with severe intractable pain (chronic pain) are being harmed, stigmatized , tapered, taken off (without consent) the only medications , that properly treat these severe conditions, leaving patients like myself in torturous PAIN 24/7 I have numerous conditions , that cause me horrific pain. Diagnosed with severe spinal stenosis arthrosis, scoliosis, osteoarthritis DDD , fibromyalgia just to name a few. Since the guidelines, so many ppl have lost access to their life saving medication, that for many are now bedbound, no longer can work, unable to sustain life , cook , clean, shower , family time etc etc etc This is wrong on So many levels, many are being tortured. This has got to stop , we need the guidelines 86 . When is eough is enough? Isn't it time pain stigma ends ?! We need our Drs, the DEA, is only hendering the chain of medicine causing unnecessary stress, on both patients and Drs. Drs should not be living in fear of their livelihoods, this entire scheme puts shame , unnecessary pressures on Drs and patients alike, not to mention PTSD , Dr patient relations is being destroyed. Since the CDC guidelines in 2016 patients have been gaslighted, shamed, neglected, ignored, etc etc. Intractable pain, chronic pain is a serious medical condition that requires treatments, just like any other serious medical condition It's time it's taken seriously, our lives Matter ! We need our Drs who stand with us , believe in the sacred Oath to DO NO Harm . This is absolutely pertinent to the care of ppl in pain, cancer patients, rare diseases , vets etc Thank you Sincerely your's, RB

## Comment #49

**Anonymous (not verified)** - *Jun 18, 2025 04:44 PM* Reply (/comment/reply/870/2763)

WMC needs to advise doctors that if they refuse to prescribe the proper amount of pain medicine based off the patients history with previous doctors and at the same level proven to

work with stable proof in the medical records they will lose their license. With MRI, X-ray and CT scans in records and the previous doctor's pain contract never broken, no early refills and no bad urine tests on file doctors who lower doses anyways or refuse pain medicine completely need to specially be told they will lose their license. Falsifying medical records in the Drs mind to make the government happy is against the laws of their license. Refusing to honor and abide by the terms of a pain contract when taking over care for a chronic pain patient should be illegal. Making patients unstable by reducing the medication that has worked for years under another doctor should never be allowed and should be illegal and enforced by the law. It's been 4 years since I had 7 years stable on 120 me. When my doctor retired I was forced tapered to 50 me and my life has been ruined since then. Now my records falsly show I am stable at 50mme because that's the max I can get. If you consider not being able to shower without inflicting extreme pain on myself stable. Stable in not being able to grocery shop, do laundry, clean house and cook for myself. Stable in being stuck at home. Doctors and their clinics need to be forced to put us legacy patients all back on the higher doses that gave us quality of life.

## Comment #50

**Anonymous patient (not verified)** - *Jun 18, 2025 08:04 PM* Reply (/comment/reply/870/2764)

I am suffering from several painful chronic conditions. Also major ptsd. My doctors have forced me to taper off my 5 \325 Norco x 6 per day. My pain was bearable. Not gone, but I could live. Now no pain meds, and they are tapering me off my lorazepam against my will. I am suffering so much physically and emotionally. The doctors don't want to hear it. I am 67 years old and wish I could pass away. This is not a life.

## Comment #51

**Anonymous (not verified)** - *Jun 18, 2025 08:05 PM* Reply (/comment/reply/870/2765)

Please allow providers the freedom to prescribe pain medications to ALL patients with chronic pain as needed" . This could change so many lives!

## Comment #52

**Ellyn (not verified)** - *Jun 19, 2025 05:09 PM* Reply (/comment/reply/870/2768)

Thank you for considering chronic pain patients who have been left out of decision making for over a decade as PROP pushed their agenda into all of our chronic pain doctor's prescribing practices. I was diagnosed with an incurable, unpredictable and very painful condition over two decades ago. When my treatment began, it was individualized and I was able to commute 2 hours each day, work 10-12 hour days, raise two teenage children as a single parent-as well as attend to daily cooking/household responsibilities. Since the "opioid crisis", manufacturers lawsuits and PROP mandating the more expensive buprenorphine as the gold standard of care for BOTH substance use disorder and chronic pain (despite no reliable data buprenorphine is truly effective for chronic pain) my medical 'care' has drastically changed. Also in spite of the fact that I tried in complete good faith to find an alternative effective medication/treatment (believe me- if there was an effective medication/treatment for my condition other than prescription pain medication, I would absolutely LOVE that. Dealing with not only the lowered dosages, but the abhorrent discrimination and hostile treatment by doctors makes this treatment the absolute LAST one I would select if I had any kind of a choice). As a brief illustration-this list is much longer, but I am giving the top highlights to save time: •Despite my body adapting to the medication (tolerance ~that EVERY doctor is aware of), my dosage has been lowered and lowered and

lowered for zero medical reason. •I have been subjected to open door urine tests (in a HALLWAY, no less, with perfect strangers walking by the open door). •The medications I tried in good faith and with much initial hope caused intolerable side effects-one causing me to lose my driving skills to the point I couldn't determine what side of the road I needed to drive on. One caused me to arrive at a classroom that I had been attending classes at every day for the last three months (for work) and being unable to find my way home (having to call my partner to give me turn by turn driving directions to find my way home). • Some of these side effects took WEEKS to leave my system. Conversely , prescription pain medications give me no disruptive side effects whatsoever- they relieve my pain so I can focus on details and my task at hand. •I am subjected to the PDMP; which (other than benzodiazepines & medications for things like ADHD) NO OTHER patients requiring critical life saving medications are subject to. •I am only allowed ONE pharmacy for my medication and if they don't have it in stock, I am forced to go without. • In addition, when the prescription is finally filled, the 'clock' that my medication fill date is allowed gets reset to the new date. For example, if my fill date (exactly 28 days from the last fill date- which leaves you with zero medication at the beginning of the day until you can drive to the pharmacy and obtain the filled prescription) is Tuesday and the pharmacy is out until Friday, that means I am without medication Tuesday, Wednesday, Thursday and at least half of Friday as the pharmacist usually can not complete the prescription until the afternoon. This resets my new fill day to Friday instead of Tuesday. • Despite using the same pharmacy for over two decades, I am occasionally subjected to nasty comments, tones of voices and even made to go back to the end of the line if the pharmacy hires new people with anti-opioid bias (and there are more people that blame chronic pain patients whose only effective treatment is Rx pain medications for the deaths of their friends/family than not.) • So not only am I under-medicated for no medical basis, but I am treated like a criminal by the entire medical establishment from appointment setters to pharmacy staff. One particular pharmacy staffer would yell out the name of my medication when alerting me it was ready to pay for- making me vulnerable to any criminals within earshot that were inclined to assault me and steal my medication. Some would tell me they 'were out of bags' for me to conceal my medication in. These are hardly the only issues with this medication. Please believe me when I reiterate that I sincerely wish ANY. OTHER. MEDICATION. OR. TREATMENT. WOULD WORK FOR ME. LITERALLY ANY OTHER. To date, I have not found one in the least effective. So from two decades ago with the lowering of my medication dosage, the constant stress of when and IF I would have my medication this month, my ability to work has decreased from 50-70 hours per week to about 10. My income has decreased from about $130,000 per year to about $25,000. I had to declare bankruptcy and I lost every asset of value I owned. I have gained 30 pounds that I'm unable to lose (and can't afford GLP medications as I don't have commercial insurance. My average blood pressure has gone from 110/65 to 130/85. I believe this is my body's indicator of chronic untreated pain and for any other condition, it might not be considered proper medical treatment. My sleep apnea has worsened causing greater pain levels and brain fog. I feel there is a significant lack of "care" in my medical care. Because I take a medication that other people abuse, I am held to a my higher standard of behavior & proof than any other patient taking a medication required for ANY quality of life. Depending on who is making decisions for me- with zero consultation with my doctor or I- people like the DEA or PROP can decide to lower the manufacturing quota to zero, the manufacturer of the medication can use any adulterant in the generic recipe which can render it less effective in my one-of-a-kind body chemistry and I literally have zero power to change any of this. If a patient with diabetes requires more insulin for her body chemistry, she gets it. If my body chemistry requires more pain medication, I am shamed, blamed and typically told I'm an addict and my only option is methadone or buprenorphine (despite having NO behaviors used to truly define substance use disorder). Sadly for me, after I gave in and tried both it was found that I am allergic to them. Also, the mandatory daily SUD meetings were both baffling, expensive and not helpful. I could not relate to any of the stories or suggested changes to my life. For example, I coukd not imagine taking a full bottle of medication without stopping to the point of overdose-as I heard more than once. (I wasn't taking medication to avoid life; I was literally trying very hard

to get physically to the point where I could live it to the fullest with less pain.) The use of morphine milligram equivalent (MME), when it is truly researched and the science behind it evaluated without bias, has no real validity. The concept is further eroded by the fact that everyone's body chemistry and genetic ability to metabolize Rx pain medication is absolutely unique. Similar to snowflakes or fingerprints, no two humans metabolize pain medication exactly the same way. To equate a dosage exactly the same for a 280 pound male and a 130 pound female is ludicrous on its face. When you add in differing genetic makeups, it stretches the credibility beyond belief. There is literally no medical science to justify using MME in any guideline, yet that is what current chronuc pain treatment guidelines say: individualized care UP TO 50 MME- despite the fact that FDA has no individualized limit for these medications. In a further example of absolute discrimination between people with SUD and chronic pain, when SUD patients are treated with buprenorphine for THEIR medical condition-the MME allowed for them (despite the fact that buprenorphine IS LITERALLY an opioid) HAS NO MME CEILING LIMIT. Chronic pain care is rampant with discrimination as to who "deserves" effective treatment vs SUD treatment where it seems as if the system 'bends over backward' to benefit the person with SUD~despite the fact that overdose deaths from buprenorphine are now higher than those from oxycodone/hydrocodone. Again, NO other patients and NO other medications are singled out like chronic pain patients where Rx pain medications are the LAST RESORT. Imagine if a patient needing insulin or blood pressure medication was loudly & publicly harassed and her prescription not filled for days. I suspect this would be treated as malpractice. For patients with chronic pain we have absolutely no recourse. No attorney will even CONSIDER taking a case for a patient with chronic pain who has been under-treated with prescription pain medication. Not one. It is the polar opposite from our society's approved lawsuits against pain medication manufacturers and doctors who prescribe these medications-lawsuits that have been filed by states attorney generals in virtually EVERY STATE. So, to come upon this petition for relief and to be able to make public my testimony of trying to not give up hope to have quality of life despite being undertreated by my medication of last resort, I am beyond thrilled. My hope is that the stories from me and other CP patients will finally provide a true understanding of what CP actually go through. It is my further hope that this will result in advocacy that actually overturns the discrimination and mistreatment we CPP have been living with for decades now. Lastly: All humans are vulnerable to this situation of untreated & under treated chronic pain. All of you are just one accident or incurable medical diagnosis away from being exactly where I am. It is my hope that you can work to make changes before this affects you or your loved one. I would not wish this situation upon anyone. Thank you for your kind consideration.

## Comment #53

**Anonymous (not verified)** - *Jun 20, 2025 01:55 AM* Reply (/comment/reply/870/2772)

This is an outcry yes please help pain refugees get what is needed to help them have a small portion of their lives back . Many have died , many are being tortured to ☠️ Pain stigma need to End ! . Painful conditions require treatments just like any other serious medical condition.. Pain Matters! Period ... Do no harm is a oath Drs need to live by the health and well-being is crucial n critical for giving proper care . .This is dire , we also need the guidelines for prescribing to be 86

## Comment #54

**Susan Hope (not verified)** - *Jun 20, 2025 08:04 AM* Reply (/comment/reply/870/2777)

From: Susan Hope In Support of the Petition Submitted by Maria Higginbotham I am writing to share my personal experience and to support the petition filed by Maria Higginbotham. I speak not just for myself, but for the many patients across Washington who have been

abandoned or harmed under current opioid prescribing policies. My pain journey started when I was a child. I lived back east and was frequently bit by ticks. My grandparents were frequently taking me to the doctor but it wasn't until late adulthood I found out I have Lyme disease along with other medical problems. For more than 24 years, I was safely and responsibly prescribed two opioid medications, along with a muscle relaxer (Soma) and a benzodiazepine (Klonopin). These medications allowed me to function and maintain some quality of life despite serious medical conditions and long-standing PTSD. I never misused my medications, and I lived with stability for decades — until my doctor retired. The first doctor who took over my care — the one I now refer to as the "Superman cape doctor" because he said he was leaving to go fight the opioid crisis — reduced all of my medications drastically in a single visit. He cut both opioid medications, my Soma, and my Klonopin by more than half in both dose and quantity. I had done nothing wrong. There was no medical reason given. It was simply because I was taking those medications. That same pattern continued with the next doctor at the same clinic. She is younger and told me directly that "opioids don't help pain." She also wants me off my medication — not because of any issue with me, but because of her belief system. Like the first doctor, she keeps pushing Suboxone, even though I do not have an addiction and have repeatedly told her I will never go on that drug. Every appointment with her gives me panic attacks. I avoid going to the doctor now because I do not feel safe or respected. Since being destabilized, my PTSD has worsened dramatically. I experience severe overstimulation — everything is too loud, too bright, too overwhelming. I've become housebound and bedbound. I rarely see my children or grandchildren anymore. I don't go out. I don't enjoy life. My insurance doesn't approve surgeries anymore, and I feel like I've been discarded. I'm 65 years old. I did everything right. I took my medications safely for decades. And yet I've been treated like a criminal — not a patient. This is what happens when policies override clinical care and humanity. Please pass the petition that Maria submitted. It reflects the truth for so many of us who have no voice left. We deserve compassion, not punishment. Respectfully, Susan Hope Washington State

## Comment #55

**E Palmer (not verified)** - *Jun 20, 2025 01:26 PM* Reply (/comment/reply/870/2780)

I am disabled by severe, chronic pain and am writing in support of the petition for requested changes of opioid prescribing rules to MD WACs 246-919-850 through 246-919-985 and PA WACs 246-918-800 through 246-918-935. The war against the opioid epidemic has resulted in chronic pain patients becoming unintended victims of unnecessarily strict prescribing regulations. I have a rare, genetic disorder that's getting progressively worse. It's incurable & treatment is limited. It mostly affects my joints, spine, muscles, and nerves. I grew up in a spine brace & now (at 50 yrs old) use a cane, walker, and/or wheelchair when necessary. Although I've long had some level of disability, in recent years I've become so immobilized by pain that I rarely leave home. A short trip to run errands puts me in agony for days. It hurts too much to go out with friends- I've lost them. I'm afraid to do simple activities & cause myself more pain. It wouldn't be this bad if I still had access to opiates. I have NO history of substance use disorder. I dislike the side effects of opiates, so took them as sparingly as possible when they were prescribed. I was a responsible patient for years, and fortunately wasn't physically dependent on them, because I was cut-off without a taper in 2016 through no fault of my own; the clinic closed. Then the new federal guidelines came out and most doctors became too afraid to prescribe opioids at all for chronic pain & even for acute pain. Despite worsening pain & degeneration, I've been unable to get a prescription for opioids since 2016 (except once for 5 days post-surgical). It's dangerous and cruel to cut stable patients off of pain medications, especially without tapering. Since 2016, I've gone to a few pain management clinics & tried various non-opioid methods that insurance would cover: injections, gabapentinoids, antidepressants, corticosteroids, physical therapy, chiropractic, OTC meds, etc. But none would eventually prescribe opioids when alternative treatments were insufficient, even during flares or injuries. I'm exhausted from relentless pain & being

treated like a drug-seeking addict. Frankly, I'm not sure how much longer I can endure this constant agony with no relief in sight. The drastic overkill is unnecessary and harmful. Please consider these changes to the opioid prescribing rules so they aren't an obstacle to adequate healthcare.

## Comment #56

**Troy Tompkins (not verified)** - *Jun 20, 2025 03:02 PM* Reply (/comment/reply/870/2781)

As a husband caregiver to a chronic pain patient living with rare diseases, including a connective tissue disease, impacting every aspect of her health, causing disability, and severe daily chronic and acute pain, I have seen how difficult it is for chronic pain patients to receive adequate and effective pain management and care. Please adopt Maria Higgenbottom's amendments so that opioid prescribing serves best the Patient's healthcare, and ensures patients are not unnecessarily tapered, or taken off of their pain medication and pain management program, which we know so often leads to unnecessary suicides with an understandable lack of hope from the patient's perspective. Being a caregiver husband means that I am the one to pick up my wife's pain medication's, and so often I hear that they do not have enough of her pain medication in stock, and it leaves a scrambling to call our doctor to get another prescription to another pharmacy to ensure the continuation of my wife's pain, medication and management, and it can leave me feeling hopeless for helping her. Please protect chronic pain patients and their providers ensuring both can provide the proper level of pain management for each patient, as we know every patient is unique and different and needs a different uniquely tailored to Care, especially in pain management.

## Comment #54 Duplicated

**Susan Hope (not verified)** - *Jun 20, 2025 04:36 PM* Reply (/comment/reply/870/2782)

I apologize for duplicate comment, I tried to edit my original but couldn't. Please accept this as my official comment. From: Susan Hope In Support of the Petition Submitted by Maria Higginbotham I am writing to share my personal experience and to support the petition filed by Maria Higginbotham. I speak not just for myself, but for the many patients across Washington who have been abandoned or harmed under current opioid prescribing policies. For more than 24 years, I was safely and responsibly prescribed two opioid medications, along with a muscle relaxer (Soma) and a benzodiazepine (Klonopin). These medications allowed me to function and maintain some quality of life despite serious medical conditions and long-standing PTSD. I never misused my medications. I have no history of addiction — only a past history of cigarette use. I lived with stability for decades — until my doctor retired. The first doctor who took over my care — the one I now refer to as the "Superman cape doctor" because he said he was leaving to fight the opioid crisis — reduced all of my medications drastically in a single visit. He cut both opioids, my Soma, and my Klonopin by more than half, in both dose and quantity. I had done nothing wrong. There was no medical reason given. It was simply because I was taking those medications. That same pattern continued with the next doctor at the same clinic. She is younger and told me directly that "opioids don't help pain." She also wants me off my medications — not because of any concern about my behavior or my health, but because of her belief system. She keeps pushing Suboxone, even though I've told her repeatedly that I do not have an addiction and will never go on that drug. Every appointment with her gives me panic attacks. I avoid going to the doctor now because I do not feel safe or respected. Eventually, I tried calling the original clinic in Anacortes, where my longtime doctor used to work. There are many doctors in that office, so I hoped one might be willing to take over my care. But when I called and told the receptionist I was looking for a new primary care provider, she didn't ask for my name. The very first thing she asked was, "Do you take any opioids or benzos?" I paused and said,

“Yes...” And immediately, she said, “None of our doctors are prescribing those anymore.” That moment hit me hard. It was clear that patients like me are being screened out — not based on our behavior, but based on the medications we need to survive. It was frightening and deeply dehumanizing. I also want to explain that I didn’t start out needing daily pain medication. For years, even before the last 24 years of consistent use, I would try to tough it out. I avoided meds as much as I could and would only take opioids in short bursts when absolutely necessary. I’ve always believed in natural health, exercise, and using as little medication as possible. But now that I can’t get adequate pain relief, I’m no longer able to exercise at all. My health has declined. I’ve gone from being active to being mostly bedbound. The truth is, I’ve had pain since childhood. My grandparents took me to doctors over and over again because they could see something was wrong. But no one could figure it out. Years later, I learned I had chronic Lyme disease — likely from repeated tick bites growing up back East. I now know that was the source of my lifelong pain. But for most of my life, it went undiagnosed. Since being destabilized, my PTSD has worsened dramatically. I experience extreme overstimulation. Everything is too loud, too bright, too overwhelming. I rarely see my children or grandchildren anymore. I don’t go out. I don’t enjoy life. My insurance no longer approves surgeries, and without adequate care, I’ve been discarded by the very system I trusted. I am 65 years old. I followed every rule. I was a compliant, careful patient. And I’ve been treated like a criminal — not a human being. This is what happens when rigid policy replaces clinical care, compassion, and common sense. Please pass the petition Maria submitted. It reflects the truth about what’s happening to real people like me. We deserve compassion, not punishment. Respectfully, Susan Hope Washington State

## Comment #57

**Sarah J (not verified)** - *Jun 20, 2025 08:18 PM* Reply (/comment/reply/870/2793)

I have been in significant, life altering pain for more than half of my life. I tried quite literally everything under the sun prior to seeing a doctor about the pain I am experiencing. Any OTC patch, cream, spray, rub, and medication I could find. I tried Chiropractic adjustments, Physical Therapy, meditation, stretching, heat, cold, aquatic therapy, you name it, I tried it. Then, I tried multiple prescription meds before I ever relented to try opioid pain meds. Several of those, as well as some of the other things I tried before, actually made things worse for me due to experiencing adverse effects (some rare) and a couple of life threatening events. I can't take a variety of medications because I have reactions to them. Either adverse effects or outright allergies, including anaphylaxis. When my doctor started me on opioid pain medication, it was the first time that I can truthfully say that I got real pain relief. After a couple of years of adjustments, we found the combination and dosages that worked for me. Well enough that I was preparing to get my first ever job. Then, my doctor got wind of the CDC's guidelines coming out and I was cut in half overnight. I experienced further reductions after that due to the demands of my insurance. I am now at a level where I am getting by. Not living. Not thriving. But I am getting by. Now, I hear that pain patients are being cut down even further to 50MME and I am frightened because I know what that will mean for me. I already spend my days feeling like a piece of furniture more than a human being. I live in fear that I, like countless others, will find myself without adequate pain relief or perhaps without any pain relief at all. That would be indescribably devastating for me and others who are still fortunate enough to receive this valid medical treatment that provides us with enough relief to maintain some semblance of a life. I urge you to institute protections for pain patients before the proverbial other shoe drops. You have the power to help us and we implore you to use it. As pain patients, we come from all walks of life. Every type of person there is can and does experience life changing chronic pain. We don't deserve to be treated as second class citizens simply because we have one or a combination of health conditions that cause pain that we did not ask for, do not want to have, and have few options that can provide real and actual pain relief for the vast majority. I implore you to please preserve that capability for us. The bottom line is it isn't about the type of medication, it's about the quality and breadth

of the relief that the medication provides to us. If there were comparable alternatives, it wouldn't be such an issue, but at current, there are none that provide proper relief to as many chronic pain sufferers as pain medications do. Please understand, we just want to reclaim some of our former ability, and these medications help us do just that. Thank you for your time and careful consideration.

## Comment #58

**Cora Harris (not verified)** - *Jun 21, 2025 09:24 PM* Reply (/comment/reply/870/2797)

This WHOLE ENTIRE ISSUE & what it ALL BOILS DOWN TO is genetics!! 1% of the population are ultra rapids & another 3 % of the population are rapid metabolizers of medications. This is our genetics & we have no control over this. (Btw- this has nothing to do with how fast pple metabolize food- the 2 are not related). The other 96% of the population are regular or slow metabolizers of meds & everyone is making rules & regulations & leaving 4% of the population out completely. We are being discriminated against & every civil right is being broken for us! The doctors that are treating us are the ones going to prison because AI is being used while breaking HIPPA to do so, to snuff them out! So many people are being tortured to dealth. Having heart attacks, strokes & worse- dying!! Not to mention suicides! Yall doing this are pure evil & dont forget we are fighting for you too. Disease & injury comes without warning or notice & in a blink of an eye you could be us!! Before more die, and just FYI tens of thousands have already died.... FIX THIS!!!!! You have blood on yr hands & God is watching y'all!

## Comment #59

**Thomas Michael ... (not verified)** - *Jun 22, 2025 03:02 PM* Reply (/comment/reply/870/2798)

I wish to add the following to my previous comment. These changes do not go far enough. In relation to Drug Testing, We are all disgusted with being treated like Criminals. Do we Drug Test each Physician, before they come to work? How about the Police Officers, or Senators, ect. These people are in a position of power and authority. How about we Drug Test EVERYONE who seeks medical care of ANYKIND. WE could DRUG TEST all of the patients who arrive at an EMERGENCY entrance. And we could DENY ALL of them medical treatment. Perhaps we could go door to door each and every day, and DRUG TEST EVERYONE on the planet! Federal Laws forbid the denial of medical care to anyone currently using an illicit drug. 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. Federal Law supersedes State Law. I brought this to the attention of the Medical Commission, many years ago. And nothing was done to correct this injustice.

## Comment #60

**Yvonne Helmick (not verified)** - *Jun 23, 2025 04:45 PM* Reply (/comment/reply/870/2802)

I support Maria Higginbotham petition and plead with the commission to stop the unethical treatment of patients, give them the rights they deserve. I am 81 years old and the past couple years I've been dealing with severe back pain, it breaks my heart to see what my daughters have suffered through. I have 2 daughters in their 60's who have struggled for over 20 years with severe intractable pain due to an aggressive and destructive disease that destroys collagen. They have both had numerous surgeries and I have watched as their lives have become about doctors appointments and stress going to the doctor. They have had their medication tapered even though they were stable and had not done anything wrong. The doctors said it's because the state won't let them prescribe as much as they need to have some quality of life. I don't understand how they can do this and leave patients suffering wishing their lives would end. This is not what doctors are supposed to do

**1** 2 (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas?page=1)
next › (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas?page=1)
last » (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas?page=1)

# Opioid Prescribing General Provisions for MDs and PAs

**Rule Description:**
Opioid Prescribing General Provisions for MDs and PAs

**Code Reviser (CR) Document:**

- CR-101 (https://wmc.wa.gov/sites/default/files/rules/WSR_25_10_039.pdf)
- WAC 246-919-850 through 985 (https://wmc.wa.gov/sites/default/files/rules/WAC%20246-919-850%20through%20985.pdf)

**RCW-WAC:**

- WAC 246-918-800 through WAC 246-918-935 (https://app.leg.wa.gov/wac/default.aspx?cite=246-918-800)
- WAC 246-919-850 through WAC 246-919-985 (https://app.leg.wa.gov/wac/default.aspx?cite=246-919-850)

# Public Comments

## Comment #61

**John Bruse (not verified)** - *Jun 23, 2025 04:47 PM* Reply (/comment/reply/870/2804)

John Bruse I'm writing this comment in support of a petition filed by Maria higginbotham requesting changes to Washington state opioid policies and rules. If something doesn't change soon, there will be more suicides to pain, more overdoses from desperate patients in pain seeking relief on the streets. The current pain treatment system is killing pain patients This has put so much unnecessary stress on my family. Watching my poor wife weathering away from severe under-managed pain . She has severe intractable pain caused by spinal stenosis, arthrosis, osteoarthritis, DDD , scoliosis spodolosis fibromyalgia just to name a few

. When her pain was adequately managed she could actually participate in life , now she's bedbound and utterly crying her life away Stigmatizing pain has Never been the right answer, as it is for her, just giving her adequate pain control, only gives her a small portion of life back , but I'd much rather see her smile , do some of the things she enjoys, maybe even make new family memories..  she needs to be able to care for herself first cuz this has been absolutely horrible for her mental state , let alone her health n well being . Nobody should have to live in such misery, my wife is my best friend going in 38 yrs and she has always had a positive outlook on life , please we need the MME lifted , I need my wife back . My wife suffers dearly with severe intractable pain throughout her back, spine and neck I'm at my wit's end here, what more I can do to comfort her ?  she is literally being tortured to death. Something needs to be done now this is dire .

## Comment #62

**Advocate care taker (not verified)** - *Jun 23, 2025 06:07 PM* Reply (/comment/reply/870/2805)

Unbelievable, and this is happening more n more When is this barberic mindset of torturing the general public ( pain refugees) our most vulnerable going to end?  It gets worse,  now we are going through shortages, unheard of delays on prescription medicine, the DEA has again ruled for manufacturing cut backs on life sustaining meds ( Rx pain meds ):this is causing unnecessary pain and withdrawal on the most vulnerable amongst us . . Disabled, vets , cancer patients, severe painful conditions are being left high n dry This war on Pain patients , our Drs have gone on Long Enough! If we don't do anything, are pain management Dr will be gone , and more patients will die . Everyone, come on now , haven't you seen enough of these horrors ? please when you're denied pain meds for your sons broken arm , your grandma major surgery etc Speak up , stand your ground, and advocate Tell them that the CDC guidelines Need to be 86 ! Yes as a care giver,  I would say,  it's extremely important you up the MME to the Drs own discrepancy, to satisfy the patients need for individualized care .

## Comment #63

**J French (not verified)** - *Jun 25, 2025 08:33 AM* Reply (/comment/reply/870/2806)

I am constantly trying to keep pain patient from committing suicide and this is not an exaggeration. It is almost a daily activity.. from patients unable to access the medication because pharmacist refused to fill it or because of the nationwide shortage or because over 4000 pain doctors have been arrested and imprisoned and there’s very few pain doctors left, and the fact that doctors are terrified to prescribe pain medicine today because they’re afraid they’re going to be arrested in prison their license taken, and their assets seized. This is not an exaggeration either.. it is a dire situation today for pain patients. The fact that thousands of pain patients have taken their own life as the only way to relieve their pain is very very bad.. every year the DEA reduces the amount of pain medication being made even though patients cannot access it because of the shortage these things are disconnected. When a state of emergency is put in place for the war on drugs, it should not be doctors being arrested, and patient being left in tormenting Pain because they cannot access their medication... pain. Patients are now treated as if they are criminals and a worthless population to society, but many of them with the proper treatment can still work and function like some normal adult adults patients dying from cancer or other disease diseases should not be denied a comfortable death because someone’s afraid that a dying person might become addicted to a medication.. when patients are forced off of their medication’s against their will it’s violating their patient rights. WHO in May published their new guide guidelines for pain treatment and it’s the opposite of what the United States is using.. It’s very clear that it directed at the United States because internationally. Everyone knows that we’re

treating pain patients horribly in the United States.... With prescriptions reduced by approximately 75% and it having zero effect on the overdoses, it's obvious that that's not working and it's harming and killing patients... when a government takes advantage of a vulnerable population and their own society it's wrong. What's even more traveling? Is that the actions that were taken how to predictable outcome by experts and that has been proven to be so there's plenty of studies that prove that patients do not abuse their medications it's less than one percent of patients that ever have any problems with their medication's and To Me that seems pretty obvious when someone's taking it to treat pain they need to treat their pain.... Obviously the diversion and other actions that were happening didn't have any effect over the rate of overdoses and it's also made them go up even more.... If anyone had listened to the experts like they should've done when the 2016 guidelines were put into a fact, none of this would've happened because the 2016 guidelines were made without anyone present who knew anything about pain management... patient in pain should be allowed to be treated ethically you mainly and compassionately and that is not happening today it's the total opposite.. please change that please... thank you!

## Comment #64

**Kana Neibert (not verified)** - *Jun 25, 2025 08:57 AM* Reply (/comment/reply/870/2807)

I have served as a patient advocate in women's health for more than 20 years and spent 20 years in direct patient care. Now, after being struck down with septic shock I have undergone extensively painful treatments including a partial foot amputation and live every day suffering with pain that is safely treatable using a variety of therapies including opioids. I have worked with patients in addiction recovery, but that is not where the majority of patients with chronic illness and chronic pain fall. We deserve access to medicine that allows us to find a quality of life instead of suffering inhumanely because we pay the price for a failed system that allowed illegal fentanyl and other drugs into communities that have destroyed the lives of many people and families. I have lost my own friends and patients to drug addiction, but as people living with chronic pain, we should not suffer because of others. There is ZERO medical evidence showing the majority of drug addiction comes from originally being prescribed opioid medication-the majority of addiction comes from people and teens who gain access to opioid medicine they were never prescribed in the first place. I URGE you to start supporting the patients who need access to safe opioid use and stop criminalizing us along with the prescribing doctors. Also, pharmacies should be held accountable for stepping out of their lane and denying patients their medications-leave the decision to use opioid therapy up to the doctor and their patient. Please give us an opportunity to live our lives with dignity when it is already so difficult living with these chronic illnesses.

## Comment #65

**Theresa Gonzalez (not verified)** - *Jun 25, 2025 10:17 AM* Reply (/comment/reply/870/2808)

I have been a chronic pain patient since 2009 after a L5S1 dissection and fusion which left me in more pain then before surgery . I have many more issues now with lower back and neck . I've had evry shot and ablation done to no relief . I was put on 5mg Oxycodone 4 times a day and remain at that dosage for 5 years and was doing well . I could function with everyday taskes . Then everything changed with all the rules and regulation that got changed . It is ridiculous how the pain community is being treated . We are not drug addicts or pill seeking we are just trying to live life and be as productive as we can as citizens. If I could remain on the dosage and frequency that I was taking for 5 years that proves I am not an addict looking for the high . Something really has to give and consideration has to be given to this

community we are entitled to be treated with respect and not live in torment every day for the rest of our lives .

## Comment #66

**Anonymous (not verified)** - *Jun 25, 2025 11:06 AM* Reply (/comment/reply/870/2809)

I understand the problem with people getting addicted to opioids. However, it is unfair for people who live in chronic pain to have to suffer and have no quality of life because they can no longer access opioids. My aunt lived in terrible pain all the time and she ended up taking her own life because she couldn't take living in pain anymore. Lots of people couldn't understand why she did what she did but I do because I know what it's like to live in pain every minute and have your future know that that's all that's ahead of you. Please reconsider the stance on opioid medication's so the people who live in constant pain can have some quality of life

## Comment #67

**CHERI Harkness (not verified)** - *Jun 27, 2025 02:36 PM* Reply (/comment/reply/870/2811)

I have been a chronic pain patient for 30 years. Worked as a RN for 25 years. I have been in pain management for 7 years. Was on one pain med until one month ago. Told by two pharmacist they could not get it anymore. So was switched to another. No this month told that they reached there quota for the month. So I could only get 20 pills from the one pharmacy. I have to call Monday and get the rest sent to another. I just want quality of life. I will never be pain free but some less pain in my goal.

## Comment #68

**Julie Heinze (not verified)** - *Jun 28, 2025 01:49 PM* Reply (/comment/reply/870/2812)

As a Chronic Pain Patient for 8 years with a rare disease it is difficult to receive adequate relief here when you have multiple conditions that all require medication that sometimes seem to compete with other medicines I had been prescribed previously. I became a Chronic pain patient 8 years ago and saw a pain management doctor in CA who was very well versed in my rare condition and knew that I may need different medication dosages that the typical patient. I also took a genetic test which showed I have intolerance to some medication. I have to take beyond the normal dosage of antidepressants and other similar medications. About 2.5 years ago, we moved to Washington state and I had to find a new pain management doctor near me. I live in a rural county and unfortunately I found 0 pain management doctors near me. I finally found a few in Olympia which are 70+ miles away from me. I first started at one facility that only had a PA, no physician on site to oversee him. He stopped all the medication I was on because "it was in violation of WA drug standards." I was not given a refill or tapered down to change over to WA state standards. I was on a regimen that was working in CA but since I was now in WA, I could not stay on something that worked. Off I went on a several month journey of increased pain and suffering until he finally decided I was non-compliant with his pain management plan. I told him that while at the dentist, I took 1 Valium prior to dental work. I told him prior to the procedure but he forgot to document it. When my urine test came back positive for Valium, he fired me even though I had told him it was for the procedure. I am with a better pain management doctor now. But still can't get back on the routine I had in CA because it violated WA state guidelines. So I began a several month journey to try and get relief again. I am finally getting closer to adequate pain relief. But WA

state needs to have some flexibility when people move from out of state to in state. It sure caused a lot of problems and significant pain for almost over 2 years.

## Comment #69

**Leslie (not verified)** - *Jun 28, 2025 02:18 PM* Reply (/comment/reply/870/2813)

As a chronic pain patient with a rare disorder, I support the proposed changes. I have struggled to find care that is compassionate and that listens to what I have to say. I have found medications that work and allow me to maintain employment as well as have a life. The possibility of losing those makes it where I may lose my ability to fully live my life. I also do not seek out care at the ER because of fear of being seen as not following a pain contract. Additional care and compassion is needed.

## Comment #70

**Jennifer Klebaum (not verified)** - *Jun 28, 2025 02:55 PM* Reply (/comment/reply/870/2814)

As a person with ehlers danlos syndrome I believe that adequate pain management should be more accessible to people like me. I have suffered many years of being prescribed meds that don't work and even further my suffering because doctors are too scared to prescribe what actually works. One such med that I was prescribed was duloxetine, the side effects of that med were worse than any opioid pain control I have ever been prescribed. I have been forced to jump through many hoops and been treated like an adict even when I follow doctors guidelines and rules for opioids. Please make this an easier to access care.

## Comment #71

**Cynthia Dixson (not verified)** - *Jun 28, 2025 02:55 PM* Reply (/comment/reply/870/2815)

As a chronic pain patient with several pain conditions I jabe NEVER had access to pain medicatipm die to regulations that make doctors too afraid to prescribe any kind of pain medicine. My quality of life has gone down hill so much so that I merely exist rather than having any ability to do anything but suffer. It has affected my health - making me unable to move very much because movement exacerabtes the pain. It jas affected my sleep making me get at most 4 hours of sleep a day even with 10 mg of Ambien. Instead when I express how much suffering I contend with all I habe EVER been offered is PT (which I go to and ot only exacerbates my pain) and OTC paon medocome with RICE (rest, ice, OTC, elevation) as the solution. And the ER treats me as a drig seeker even when I'm jist asking that they check my kidney necause ot feels like its dying (it was a kidney infection) and that was pnly checked AFTER the nurse stuck a needle in my arm and then dug it around to see if I woild react (that pain was NOTHING compared to the pain in my kidney) and even then it took them well over an hoir to ask the doctor if I could have pain meds and most of the staff was just puttering around and talking about their weekemd plans). So not only are medications that would improve QoL in patients being denied regularly, but providers (both nurses and doctors treat every chronic pain patient I've ever known like we're addicts and to be clear they dehumanize them too I'm sure. The regulations are only harming people like myself and put us at further risk pf death by suicide - not because we wish to die but because we see no end to our pain, no one who is supposed to help us (doctors/nurses "do no harm" includes insuring we don't needlesslt suffer) will do anything for us besides list "drug-seeking" on our charts right next to our CRPS, hEDS, fibromyalgia, 'suicide headaches' (Cluster headaches), hemipeligic migraines, chronic migraines with aura, and herniated discs diagnosis, etc. while knowing that these conditions are very painful. These laws need to change to give more leeway to doctors so they can be unafraid to provide pain medication to chronic pain patients and end

our suffering. Others in a situation similar to myself have gone looking for these medicatioms through illegal means (and I can't fault them for it) because they could no longer suffer, sometimes leadong to OD and/or death which could have been avoided altogether if they had had proper medical care and pain treatment without absurdly strict laws

## Comment #72

**Carissa Fay Wikstrom (not verified)** - *Jun 28, 2025 04:06 PM* Reply (/comment/reply/870/2816)

Public Comment: Urging Protection of Pain Care for Patients with Rare, Complex, and Overlapping Conditions I am submitting this comment in strong support of the proposed revisions to Washington's opioid prescribing rules. As someone living with multiple rare, progressive, and idiopathic illnesses, I am deeply affected by how these policies shape access to necessary, compassionate care. My diagnoses include: Hypermobile Ehlers-Danlos Syndrome (hEDS), which causes chronic joint dislocations, soft tissue injuries, and severe widespread pain Suspected Vascular Ehlers-Danlos Syndrome (vEDS), associated with unexplained arterial fragility and likely contributing to my episodes of idiopathic intestinal bleeding Small Fiber Neuropathy, confirmed by biopsy, producing unrelenting burning pain and sensory disturbances Mast Cell Activation Syndrome (MCAS), which affects multiple organs and triggers debilitating inflammatory reactions Ankylosing Spondylitis, causing axial spinal inflammation and structural damage Postural Orthostatic Tachycardia Syndrome (POTS), impairing autonomic regulation and causing dizziness, fatigue, and tachycardia Inflammatory Bowel Disease (IBD), with ongoing gastrointestinal pain and unpredictable flares Chronic Fatigue Syndrome / ME, leading to physical collapse and post-exertional crashes after minimal activity Idiopathic intestinal bleeding, suspected to be ischemic in nature and likely tied to vascular fragility from suspected vEDS Other inflammatory and neuropathic pain syndromes that remain undiagnosed despite extensive medical evaluation Despite the complexity and systemic nature of my illness, I have been able to maintain function, dignity, and some quality of life thanks to a carefully monitored opioid pain management regimen. I have remained stable, compliant, and committed to non-pharmacologic strategies as well. But for pain this severe and multifactorial, opioids are essential. Without these medications, I would be incapacitated. Past experiences with forced tapering and restricted access have caused physical harm, increased emergency visits, and worsened my condition. These setbacks were not the result of misuse but of policies that prioritize metrics over medical judgment. The proposed rule changes are critical. They recognize that effective care must be individualized and that rare and complex patients cannot be safely treated under rigid, standardized dose limits. These updates will help restore the trust and clinical freedom that patients and their providers need to make informed decisions together. I urge the Commission to adopt these changes. Pain relief is not a luxury. It is a basic part of humane, ethical, and evidence-based medical care. Please protect our right to stability, dignity, and hope. Thank you.

## Comment #73

**Erin Hoffman-John (not verified)** - *Jun 28, 2025 04:22 PM* Reply (/comment/reply/870/2817)

The laws restricting opiates were well intended but have had many unintended consequences. When I was recovering from a c-section I got conflicting advice from medical professionals about the use of opiates. Careful and moderate short term use of opiates enabled me to heal faster because they allowed me to move and rebuild strength. Pain medicine is complex and not well understood. We need to support further research and enable doctors to treat patients effectively. Many studies show women and elderly people are disproportionately impacted by the need for this kind of legislation. I have watched elderly loved ones suffer through enormous pain due to opiate restriction when their

conditions were chronic but ultimately terminal. The pain took them away from their families. Our families deserve better than the suffering caused by the current laws.

## Comment #74

**Anonymous (not verified)** - *Jun 28, 2025 04:36 PM* Reply (/comment/reply/870/2818)

As a person with chiari 1 malformation, and Cranio cervical instability I've had ongoing headaches and neck pain since I was teenager(currently 58). I was misdiagnosed for decades and finally was diagnosed at age 54. In the last 4 years I've needed 2 chiari decompression brain surgeries and a fusion of the base of my skull to my top 2 vertebrae. I have also been diagnosed with hyper mobile ehlers-danlos which causes widespread, progressive pain due to inappropriate collagen production. It has caused my spine, hips, pelvis, knees, and ankles to be unstable. It is also associated with chiari and Cranio cervical instability. This year I've been diagnosed with intracranial hypertension and again the diagnosis causes chronic pain.There is no cure for what I have. The progression often leads to increasing joint and organ dysfunction and mobility problems. I would not be able to get up and move each day without opioid pain medication. After serving as a nurse for 28 years, I am now permanently disabled and, frankly, without pain relief, suicidal thoughts become more difficult to battle. I would not have chose any of these diseases but I cannot escape them. Please try to see through our eyes when you consider how to manage chronic pain.

## Comment #75

**randy johnson (not verified)** - *Jun 28, 2025 05:19 PM* Reply (/comment/reply/870/2819)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #76

**Jamie (not verified)** - *Jun 28, 2025 06:03 PM* Reply (/comment/reply/870/2820)

I am a 37 year old female who was told I was crazy for being in pain until about age 28. My doctors said "you are too young to be in pain like this." At 28 years old, I found a doctor who specializes in rare disease and was finally formally diagnosed with a rare condition called Ehlers Danlos Syndrome or EDS for short. I lack the collagen in my joints and muscles to hold me together like a normal person causing extreme pain in almost every aspect of my life, including sleeping. I have used advil so much growing up that I now have holes in my stomach. The only relief I get I from narcotic pain medicines which help me live and ALMOST normal life with the exception of having to be extremely careful with how I move every day. My doctor has struggled with the laws in place to help me because it is the only medicine on the planet I am not allergic to. Even after my 11 surgeries I have been denied helpful pain medicine because of these laws. I will never be a "normal" person by any means, but the pain medicine helps me atleast get out of bed most mornings when I can actually have it.

## Comment #77

**Danica Golden (not verified)** - *Jun 28, 2025 06:48 PM* Reply (/comment/reply/870/2821)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #78

**Cecelia Linsley (not verified)** - *Jun 28, 2025 08:20 PM* Reply (/comment/reply/870/2822)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #79

**Allen S (not verified)** - *Jun 28, 2025 08:49 PM* Reply (/comment/reply/870/2823)

As a 2 time Kidney transplant patient who has been sick since I was 9 with various chronic painful conditions my only source of quality of life is opiate pain medication. Suboxone and SUD medication used to treat addicts is not a first line use for chronic pain it's a off label use. It damages teeth and is extremely addictive in its own. I cannot take this medication for pain due to having a transplant and it being hard on my transplanted kidney and liver. Nor will I accept taking something used to treat fentanyl and heroin addictions and I shouldn't have to.However since Dr are scared to write prescriptions for real pain medication this is what they are pushing out of fear. It shouldn't be so hard to let a Dr treat my pain with pain medication. They shouldn't have to be scared to do there job. Please help me by helping them know it is ok to treat pain, please continue to let me have a semi productive normal life.I also want to add we have a illicit Fentynal epidemic NOT a legal pain medication epidemic. Thank you

## Comment #80

**Kayleigh Merlino (not verified)** - *Jun 28, 2025 09:35 PM* Reply (/comment/reply/870/2824)

I'm writing in support for the petition to change opioid prescribing in Washington State. As a chronic pain patient I have found it extremely hard to find a doctor who is willing to continue my dosage of pain medication.Mainly because of the fear of being repremanded. My dosage isn't high but gives me quality of life, being able to do simple tasks such as shopping and cleaning house. I shouldn't have to fight so hard to have my pain treated. Doctors are resorting to prescribing Substance use disorder medication as a first line treatment in fear because of set guidelines. These medications are not intended to treat pain and have horrible side effects. Doctor's should not be scared to treat patients and patients should be

able to live semi normal lives. I have a friend who committed suicide due to untreated pain, I also had to watch a family member who was on hospice and who's pain was being under treated. Please help us in the pain community we are begging for help. Doctor's should know it's ok to treat there patients and should also know it's not ok to not treat there patients.

## Comment #81

**Kenetha (not verified)** - *Jun 28, 2025 10:31 PM* Reply (/comment/reply/870/2825)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #82

**Lenni Shea (not verified)** - *Jun 29, 2025 09:16 AM* Reply (/comment/reply/870/2830)

Hello, I am not a chronic pain patient but I am a substance use disorder professional for the past almost 11 years in WA and I have 15.5 years in recovery from addiction. I have seen many people who have had to turn to illicit substance use over the years because doctors will not adequately treat their pain, forcing them to use suboxone as pain medication (it really isn't, there is some limited use), or reducing (or ending) patients access to pain medication that works for them, due to fear of addiction, causing undo harm to patients. Patients who end up turning to illicit substances are at much higher risk for addiction, overdose and death due to the unregulated nature of illicit drugs. Pain patients deserve adequate access to medication, and arbitrary limits that don't allow for mutual decision making between physician and patient need to end, now. Thank you.

## Comment #83

**Tasha Santos (not verified)** - *Jun 29, 2025 09:18 AM* Reply (/comment/reply/870/2831)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #84

**Jo Pierson (not verified)** - *Jun 29, 2025 11:05 AM* Reply (/comment/reply/870/2832)

My daughter is deemed fully disabled by both federal and state guidelines because of hEDS, POTS, MCAS, and Sighted Non24 Wake/Sleep disorder. At 27 years old, she relies on narcotics to allow her some semblance of normalcy. Without her physician's ability to personalize her

medication regime for the dynamic nature of her pain, she would almost certainly have suicided by now. She was deeply suicidal until we were able to find a physician that took her pain seriously in spite of her age, and treat her appropriately. I have the same 3 disorders (excluding the Non24) and rely on pain management medication to allow me to stay on the tax paying side of employment. Without my doc's ability to manage my pain medication, I would not be able to function at the level necessary to maintain my employment, provide for my daughter's care, or manage my household.

## Comment #85

**Anthony Hutchinson (not verified)** - *Jun 29, 2025 11:33 AM* Reply (/comment/reply/870/2833)

Thank you for your consideration of modifying rules regarding opiate prescriptions as related to people living with chronic pain. I have Ehlers-Danlos Syndrome. It causes chronic pain due to joint hypermobility. One aspect of this condition is frequent and unexpected joint dislocations causing severe pain. Access to opioid pain medication to alleviate this pain is challenging in part due to requirements that I see doctors in person, doctors are reluctant to prescribe opioids for fear of being investigated and possibly having their license revoked, and emergency and urgent care having policies against prescribing opioid medications. When I dislocate my hip, shoulder, ankle, etc a trip to the doctor is unnecessary. I have experienced these many times, and after the first couple trips to see a doctor regarding these was educated on how to reduce the dislocation myself, including walking others through it if need be. It is important to reduce dislocations quickly since the longer they persist the more soft tissue damage is incurred and the more forceful the reduction is since muscles and swelling have locked the dislocation in place. I know which dislocations I need to seek care to reduce. Frequently the *only* reason to make a trip to urgent care would be to get the pain medications to reduce suffering while recovering; except urgent care facilities do not prescribe opioids because of the legal morass caused by fear that I could be medication seeking. It is often excruciatingly painful to make a trip to a doctor after a dislocation, particularly when it affects my ability to walk or stand. The best care is rest and pain relief. Sitting in a car for twenty minutes each way, the waiting room for up to hours, and mobility through large medical facilities is so unpleasant and increases the pain and extends recovery time I simply don't. I go without the safe and effective medications intended for this exact situation. I detest opioid pain medications. They exacerbate comorbid gastrointestinal issues such as gastroparesis and constipation, usually to the point that continued use for more than a few days causes nausea and vomiting. They are addictive, and I also start experiencing tolerance after a few days making them less effective. However, having the option to relieve extreme pain immediately after a dislocation so I can actually sleep would be helpful. For these various reasons, particularly concern with addiction, my doctor recommended I look into Kratom. I have gone without prescription opioid medications for many years using it. However, it is not terribly effective at managing acute pain. It has well known safety concerns associated with it since it is unregulated and dosage is hit or miss. It has worked well, particularly at avoiding the addiction that commonly accompanies chronic pain. My symptoms are getting worse as I age. I'm nearly fifty and have had this condition my whole life. I have dislocated joints countless times, each time increasing the likelihood of future dislocations. My muscles aren't as able to stabilize joints to compensate for the laxity in my tendons. I experience more severe chronic pain as time goes on. Access to more effective medications than I can buy over the counter at the local smoke shop would greatly improve my life. It would reduce the risks of adverse side effects than relying on unregulated kratom. It would reduce expenses since insurance does not cover kratom. The long term effects of kratom use has not been studied. Providers assume anyone presenting with pain is faking it and is a drug seeking junkie. Years ago I had a dislocated vertebrae in my neck. I stretched my shoulders behind my back, and my neck popped and I had shooting pain. It was the first time this had occurred, so I sought care and would have even if I had pain medication. The physical exam at the ER in the middle of the night showed a vertebrae was mildly dislocated

and the surrounding muscles were spamming. In order to prescribe opioid pain relief I was required to have pointless x-rays simply so the doctors and facility had hard evidence of a physical injury to justify their prescription. The x-ray tech could tell I was in extreme pain and apologized for being required to subject me to the procedures. This extended my time in the hospital by hours, during which I had no pain relief. Once the doctors had the proof confirming what they already knew from a thorough hands on examination, they gave me muscle relaxers and morphine and sent me home with a prescription for enough for a few days. The Washington state rules required them to extend and exacerbate my suffering. I don't know if this was explicit or implicit, but from my perspective it doesn't matter. They knew I was in pain and they knew what medication I needed, but they and I had to jump through hoops to receive the care I needed. Please consider updating the rules to enable access for chronic pain sufferers. As they currently stand they are effectively a form of disability discrimination that deprives people of the medications they need. I'm not asking for enough opioids to numb my pain round the clock for years on end. I'm asking to be able to get a few days of opioids with a phone call to my doctor and have a couple days on hand for when my next inevitable dislocation occurs. I'm asking that providers stop being encouraged to assume all chronic pain sufferers are drug seeking addicts because failure to do so could cost them their license. Thank you

## Comment #86

**Cyndi Kershner (not verified)** - *Jun 29, 2025 11:53 AM* Reply (/comment/reply/870/2834)

I am writing in support of the proposed updates to Washington's opioid prescribing rules. These changes are critical to protect patients with rare, progressive, or complex conditions from losing access to the medications that allow them to function and live with dignity. I personally know someone who lives with a combination of rare diseases, including Ehlers-Danlos Syndrome, Ankylosing Spondylitis, Small Fiber Neuropathy, and idiopathic intestinal bleeding. Stable pain management has allowed her to remain engaged in life. Without it, her condition deteriorates rapidly. Please adopt these rule changes and protect the right of patients and doctors to work together without unnecessary restrictions.

## Comment #87

**Ashley Gangl (not verified)** - *Jun 29, 2025 01:41 PM* Reply (/comment/reply/870/2835)

I've suffered with loose joints, chronic subluxations and dislocations, endometriosis, multiple abdominal surgeries and other complications. I'm allergic to morphine, but opioids, tho they work, are damn near impossible to come by... for me. My parents don't seem to have a problem. Every time they go to the doctor, they get prescribed opioids. I've pursued specialist care and diagnoses for over 15 years. I get bounced from doctor to doctor. Told I'm too young to be in this much pain. After a C-section I was given IBUPROFEN! That's it! And only a 3 days supply. I begged for more. Told them I couldn't handle the pain. They said it was policy and they were "saving me from addiction". A couple years ago I went to the ER with classic appendicitis symptoms and the ER doc confirmed I needed surgery but the surgeon called me an addict. Said I only wanted surgery so I could get the post op drugs and he wouldn't be part of this "ridiculous addiction culture" he tried to force me to go home. The ER doc and surgeon fought. They agreed to do the surgery and my appendix burst on the OR table. When I woke from surgery, I was told "yeah, ok, you had appendicitis, but we're still not convinced you aren't an addict so we will not be giving you pain meds post surgery" Think about that! This "opioid epidemic" is killing real people. And NOT the addicts! I could have died because they assumed I was drug seeking EVEN after the CT showed I was telling the truth! People are committing suicide because they have no hope! Doctors dismiss our pain. Refuse us pain meds and decent care. We get bounced from provider to provider and then told it's our fault

and we're trying to manipulate the system for drugs! No. We're. Not! We just want a decent quality of life! I wanna take my kids to the park. I want to be able to go to the zoo. I want to be able to fold laundry or clean out my car without breaking into a sweat and vomiting from pain!!! I recognize that addiction is a tragic and complicated illness. I have so much empathy for those struggling with addiction. But why are the people WHO ARE ASKING FOR HELP being passed over and basically told "go away we don't care about you" meanwhile you're creating laws and regulations to try to FORCIBLY save the addicts THAT ARENT EVEN ASKING TO BE SAVED! Why is their life more important than mine? You realize you aren't just screwing me over right? The cost of denying me pain meds has a ripple effect. I need help bathing, cleaning, dressing, cooking. I can't properly parent my kids so I have to get help with that too. I can't grocery shop or work. So we're a single income home and my husband has to take time off to take me to appointments. Your "war on drugs" means I have to spend money on supports- because insurance sure as hell isn't going to help. Means I contribute less to society. Means more hospital visits. Means detrimental affects on my mental health. And allllllllll of that costs money. But I could save money, show up for my kids, work and contribute to the home and society, maintain more independence and require less support.... if I only had access to decent pain management. But, yeah, no... let's spend millions on this "war on drugs" attempting (and failing) to save addicts who AGAIN didn't asked to be saved!

## Comment #88

**Anonymous (not verified)** - *Jun 29, 2025 02:30 PM* Reply (/comment/reply/870/2836)

7 years ago if you told me my body would completely betray me and I'd be in my current condition I would have never believed you. The reality is we never think it can happen to us, until it does, or at least to someone we love. After decades of searching I was finally diagnosed with a rare condition that requires pain management. I went from summiting mountain tops to relying on a walker and wheelchair. I have so much pain every day that I spend a lot of time contemplating ending my life to stop the pain. It's so hard to get appropriate pain management care. Opioids literally have saved my life this year and I'm treated like a criminal constantly even though I want to be on these less than anyone else could possibly want me to be on them. I'm 35 and fighting to stay functional, which is a very generous word, for my young family. This is so important and would help individuals access care. ER doctor's treat people with legitimate complaints as pill seeking so much so that before I had to stay on opioids this year, my PCP made sure I always had leftovers so I could bring it with me to the ER to prove I need the doctors to take me seriously and I'm not pill seeking, so please help me. Help alleviate that burden for those of us who didn't ask to be here. Please update your opioid prescribing rules. It one day could be you.

## Comment #89

**Erika (not verified)** - *Jun 30, 2025 09:44 AM* Reply (/comment/reply/870/2837)

I'm writing in support of patient-centered changes to Washington's opioid prescribing rules. Patients should be able to work with their doctors to find or continue the right treatment for them without one-sided rules. I am a person who has the misfortune of having a bunch of conditions such as fibromyalgia and hyper mobility that cause chronic pain. I have been on a stable opioid dose for many years, and that allows me to be an active person who can manage some of the pain via diet, movement and lifestyle and contributes a lot to society instead of a debilitated person stuck in a pain cycle. I have been subject to the opioid prescribing rules swinging back and forth over the years, as well as the stigma of being a well-looking opioid taking patient. After the latest 'crackdown' a few years ago, my insurance started requiring a ridiculous multi-hour prior authorization process that I can't reasonably ask my doctor to complete. Therefore, I have to pay out of pocket for my pain medication

even though I have great insurance. It's long past time we go back to allowing prescribers to use their best judgement and common sense based on each patient's situation without fear of ruining their career. Chronic pain patients aren't the problem in the opioid epidemic, and we never have been.

## Comment #90

**Elsie Shipman (not verified)** - *Jul 01, 2025 10:09 AM* Reply (/comment/reply/870/2841)

Please let this rule go through. One size fits all for dosages and treatment doesn't work well for anyone, but especially not chronic pain patients. Reasonable and thoughtful general measures with an eye toward comprehensive and well-tailored medical care will be good for everyone!

## Comment #91

**Wendy (not verified)** - *Jul 02, 2025 11:01 AM* Reply (/comment/reply/870/2842)

Patients should be treated based on their specific, individual needs. If a doctor is being irresponsible with how they prescribe opioids, the doctor should suffer the consequences, not the patients! My complex medical history has included times in my life where I was accused of seeking excess opiates and ignored, simply based on what my chart said, even though I was actually asking for non opioid treatment. When doctors are distracted by limitations they're not looking at the patient in front of them!

## Comment #92

**James Hannah (not verified)** - *Jul 02, 2025 05:21 PM* Reply (/comment/reply/870/2843)

As a chronic pain patient I am tired of the way the pharmacy treats me when I fill my scripts or we ha e to fill early because I had flair ups or like the last 2 years I had emergency surgery to remove a stone from the bile duct that was 11 mm dilated and then my gallbladder was dying. But when I went to the ER on May 9th 2024 I didn't know just how sick I was but my liver was so Inflammed that it was eating my gallbladder a d when they got it removed they found a marble size stone that was trying to pass. So that sent my body into freak out mode. We had to go up on the MME because of the pain and which at that point finally was what I needed to function more as a human. Then this year I started having g Pancreatits so we had to go up and change medications as I was throwing up pills so we went to liquid morphine and this and that and the pharmacy just freaked out every step of the way thinking my doctor who is a DO is stupid and didn’t know what was going on. I am tired of being treated like I am drug seeking wverytime I go to the ER or the pharmacy. My doctor hands are tired as she is trying to treat my pain but the 120 MME is to low for me as someone that is 6 foot 3 inches tall and weight 315 lbs. I was put on Oxycodone in 2014 in Idaho because I had a lumbar Pars Defect that needed surgery to fix which I ended up having a fusion of my L5-S1. Now I am in constant pain in my back and down my left leg. I have Mixed Connective Tissue Disease so I am always in pain. I don't want to be on so much pain meds I can't do anything g I just want t my doctor to be able to get me the right dosage and keep me stable. But the rules have the organization she works for wanting to cut me off or keep me at the 120 MME. No pain clinic wants to help which the state says they are supposed to make recommendations to PCPs treating chronic pain. I am so tired of fighting just to have some what of a normal low pain day. I know we will never take the pain 100% away but if I can ha e enough that I am able to walk and do things like take my dogs on a hike or go swimming g at the YMCA that I have e a membership to but because of the pain not controlled very well I don't do those things. He'll I don't hang out with friends and go do things because of the pain. I just want to lay in bed and

do nothing. I am on SSDI because of how bad my chronic stuff is. So let my doctor who is a DO treat my pain. Let doctors treat people's pain. If you don't people are going to keep killing g themselves or turning to street drugs for relief and ODing because fentanyl is in everything now. Please change the rules and take the MME away it does no good for anyone as everyone is different when it comes to metabolizing medications.

## Comment #93

**Anonymous (not verified)** - *Jul 02, 2025 05:26 PM* Reply (/comment/reply/870/2844)

I am a chronic pain patient! I am still trying to work a full time job at 65 years old! I want to work until I am 70 years old! I don't want to go on disability and have to depend on the government! Without my pain being managed that is what will happen to me! Pain is making me not able to do normal everyday things, like cooking, cleaning, going to family gatherings! I just want to be able to be a productive member of society and be able to have a somewhat normal life! Please help the patients that are suffering and struggling to survive! Sincerely, Gloria Nicklas Gloria.nicklas@aol.com

## Comment #94

**Sammy Galasso (not verified)** - *Jul 02, 2025 09:24 PM* Reply (/comment/reply/870/2846)

I am a cancer survivor who has been left with permanent side effects loss of smell nerve pain chronic pain and numerological issues from treatment I was in excruciating pain for 2 months straight during my year of cancer treatments and surgeries and would never had been able to care for my 4 and 9 year old without opioid pain management. I had no support system and had to go thru it basically al9ne.i live in constant anxiety and fear that my cancer will return and my pain won't be treated with anything other than tylenol. Not giving opioids for major surgery cancer chronic illness and permanent injury shows no mercy and are crimes against humanity while abusing and leaving to suffer US citizens who are at the most vulnerable. People are overdosing from going to the streets to manage their pain and getting fentenyl laced counterfeit pills or some have committed suicide? Why should the legitimately sick be punished because others CHOSE to become addicted.? We are not restraint or banning alcohol with has mamed killed and destroyed more lives over the decades than any opioid ever did.

## Comment #95

**Sara Barr (not verified)** - *Jul 02, 2025 09:25 PM* Reply (/comment/reply/870/2847)

Pain patients are being under treated and mistreated. When I was pregnant my doctor dumped me, causing potential harm to my child. Withdrawal can be fatal for a fetus and no other doctors would take a pregnant patient on pain meds. Years later when I was able to get back into pain management we are now treated like criminals. Forced to sign contracts that limit our autonomy. We are no longer allowed to make choices for ourselves. We are forced to undergo risky procedures or we lose access to our meds. This is medical blackmail. Our doctors are terrified to give us a reasonable amount of medication or combine medications we have been on for years because they are afraid of going to jail. My pain management doctor won't prescribe more than 30mme for any patient because of this. It is literally his job and what he got into medicine for, but he's afraid of jail and afraid his patients will no longer have anyone to treat him. Level 1 trauma centers are giving patients Tylenol after accidents and major surgery. The metric for successful pain treatment now is withholding pain

medicine. It’s barbaric. No one is willing to take a stand. It will be you or your family touched by this one day. The people who have the ability need to fix this.

## Comment #96

**Anonymous (not verified)** - *Jul 03, 2025 08:19 PM* Reply (/comment/reply/870/2848)

I have trigeminal neuralgia and autoimmune joint degeneration. My physicians have refused to provide and pain relief. At my last visit i was refused topiramate, a non narcotic drug used to help with nerve pain. The provider was concerned that this medication was too strong. I feel like they are so afraid to treat pain that they no longer feel comfortable prescribing even non-opioid pain medications. There is an opioid crisis but fear mongering about all opioid use is cruel for patients who need pain control to have any quality of life.

## Comment #97

**Mindy Powers (not verified)** - *Jul 04, 2025 12:20 AM* Reply (/comment/reply/870/2849)

Hello, I’m a chronic pain patient and have been for years. I have watched my previous Doctor get arrested for treating pain in an under serviced area. I’m afraid every month that something will happen and I won’t get my pain medication. Pharmacies are now only filling my medication for less than written because they don’t have enough. I then have to pay all over again 2 weeks later. My Doctor is fantastic and understanding, however I get scared because I’m a full time mother, wife, daughter and people leader. If I were to have to go without, my quality of life would be impacted. I need my medication. The government is able to open our borders and allow the fentanyl to pour in, however pain patients get treated like criminals. We need help! We need our medication in order to live a productive life.

## Comment #98

**Debra Nolan (not verified)** - *Jul 04, 2025 11:26 AM* Reply (/comment/reply/870/2851)

Healthcare should be based on the doctor patient relationship. No two people are the same so making " rules" on how or what to prescribe is not keeping the standard of care for the patients. You can't claim medicine isn't a direct science and then make rules ad if it is a direct science. All the harm that has happened to chronic pain patients started by allowing former addicts and addiction medical doctors ( PROP) to determine medicine and limits based on addiction protocols. It has cost lives. Veterans have committed suicide because no human being can take unrelenting pain for long before something will give. You would think that professional people would see the outcome of the crackdown by the 900% increase in overdose deaths after PROP infiltration of the CDC and rules on chronic pain care. Come on, look at the evidence. Prescription opioids were never the cause of the opioid crisis. Every decade there is a new drug on the streets and it kills people. All the government did by cracking down on physicians is remove safe supply from addicts that got pain medication under false pretense. Which is worse? Addicts getting safe pharmacy grade opioids or going to the street and getting one pill that kills? No one will ever be able to stop addiction. War on drugs has been going on for decades and it's only gotten worse. Yet in the crossfire chronic pain patients have been forced to suffer for crimes they didn't commit. Their health care decimated and what little care they get has way more added expense. This is not right and you have the power to step in the direction to correct this horrific scam pulled off by PROP. Funny, after PROP made their millions they don't seem to be in the public spotlight much anymore. They made their money and left a stream of death in their path to the bank. It's time to stop this madness. Doctors are educated and licensed to make decisions based on

the patients before them. It's time the " overlording" stop and let doctors treat pain so that lives can be saved and suffering reduced in the people that need these medications.

## Comment #99

**Joyce (not verified)** - *Jul 04, 2025 02:09 PM* Reply (/comment/reply/870/2853)

As a mother to a disabled adult daughter I can say that living in fear of medications being taken away is real. She needs all of her medications which include opioids. Without them the fear is that she will decide that it's just not worth living anymore which is understandable. Nobody wants to live in constant pain. Even with her meds she lives with pain, it's just that her meds make it possible to get out of bed. Please do whatever needs to be done to allow pain patients to continue the care that they have been receiving for years (with absolutely no issues).

## Comment #100

**Misti (not verified)** - *Jul 05, 2025 06:02 PM* Reply (/comment/reply/870/2854)

I have been a chronic pain patient for 30 years due to a rollover auto accident. My spine has been fused, my disks are degenerating, and my spine and neck are full of arthritis. I am facing a life of pain that will only becomes worse as I age. There is no surgical cure or interventional therapy that is going to make me pain free. I am a compliant patient with zero diversion issues that has consented to demeaning oversight for a medical issue I do not have (OUD) and a crime I did not commit. I have been belittled, stigmatized and demeaned by both physicians and pharmacists. I have been unable to get the treatment that worked for me for years - two of the lowest dose hydro is one pills per day. Instead, I've been forced to do spinal injections that I knew wouldn't work but I submitted to bc it was basically a requirement of the pain management office at my hospital. I was forced to take Belbuca and pregabalin 3x/day in spite of the fact that it provided only minimal relief and zero effectiveness at treating breakthrough pain. Two years ago I spent $22k out of pocket to repair my teeth. I thought it was bad genetics - turns out it was bad medicine. No one warned me that submitting to my pain management docs prescribing demands would not only label me an addict in physicians' eyes but also bless me with catastrophic dental failure. All of this because physicians aren't willing to prescribe two low dose hydrocodone pills per day? It's not only mind boggling, it's barbaric. Do you realize there are surgeons operating on people now that will only prescribe Tylenol for pain? Absolutely ridiculous.

## Comment #101

**Tera (not verified)** - *Jul 06, 2025 12:23 PM* Reply (/comment/reply/870/2855)

I am a 47 yo woman with spinal issues after having lumbar osteomyelitis in 2014 following a hysterectomy, then recently having a thoracic spinal mass; both infections permanently damaged my spine. I went from being a very active person, to only leaving my home for current drs appointments. I was unable to get a dr to accept me as a patient following the 2016 CDC guideline update and suffered for years. Presently I'm being seen for my thoracic mass, however it's been diagnosed as resolved and I'm being tapered off my medications despite the pain remaining in my back. I perform stretches and band exercises to try to rebuild strength and follow dr recommendations, however the pain persists and I'm soon going to be abandoned again. I also suffer from other conditions due to the damage from these infections. My life is difficult as it is, and I am doing the best that I can, but most days

are miserable. I pray things change for all chronic pain patients soon because what we are all living is a miserable experience. Thank you for reading and consideration.

## Comment #102

**Michelle Kiker (not verified)** - *Jul 07, 2025 01:31 PM* Reply (/comment/reply/870/2857)

I have been a chronic pain patient for 30 plus years, in the last 10 years I've had my medications taken from me little by little. My doctor is afraid to prescribe due to the DEA running rampant in this country. The DEA should not be able to control how prescribing is done in this country. They should not be able to buy testimony in court. They should not be able to influence how doctors determine the best course of treatment for patients. Doctor's went to school for 10 plus years to learn what is best for their patients. The DEA has not. The DEA should not be able to freeze physicians assets , leaving them no way to defend themselves. Doctors are leaving the practice of medicine in droves because they are afraid of the DEA. Every person in this world is one accident or illness away from needing proper pain control. Let that sink in.

## Comment #103

**Anonymous patient (not verified)** - *Jul 07, 2025 03:48 PM* Reply (/comment/reply/870/2858)

EVeryone knows pain is a fact of life. An unchecked pain causes damage to the patient. Let me tell u my story... i am 69yrs old, no history of drug use, i have neuro Lyme disease and a broken back at L5. Its actually Grade 2, Unstable Spondylothesis. Well i was denied pain medication from day 1 when i broke my back, just injections an nerve blocks, both of which i Loudly refused. Consequently, i used aspirin an Rx NSAIDS. First i got bleedine ulcers. Now i have blockage at duodenum going into my intestines!! Its almost fully blocked theres so much scar tissue. Oh an i DO NOT HAVE GERD. ALL these Drs faults as had i been put in pain mgt from beginning, i would not be looking at upcoming surgery to put a stent in an deal with this the rest of my life!!! Please, im begging u, change this. Im tired of suffering!

## Comment #104

**Natasha Collier (not verified)** - *Jul 07, 2025 05:03 PM* Reply (/comment/reply/870/2859)

Every chronically ill person should have the care that provides them with the best quality of life.. if that includes opioids, then the government and medical community should NOT move to them to another medication that is less effective simply because of the fear mongering over opioids. Please allow doctors and patients to make the best decisions together. Not a beurocrat. It only causes more suffering for a community that already has few resources. Thank you.

## Comment #105

**Carol (not verified)** - *Jul 08, 2025 03:28 PM* Reply (/comment/reply/870/2860)

I suffered horrifically for fifteen years with the Johnson & Johnson Ethicon Mesh, undergoing twelve surgeries in three years. I endured sepsis, kidney and bladder infections sometimes twice a month, but the chronic pain from head to toe was the most unbearable. When disability denied me in 2012 and I went back to work, I thought I would die from the pain signals exploding in my brain. FYI: The FDA notifications of 2008 & 2011 -which I was not privy to until the State of Washington sued Johnson & Johnson- stated that adverse reactions such

as chronic pain and numerous infections/surgeries were NOT rare. My doctor had prescribed opioids in and around 2008 or 2009. I needed four a day to just be at home, and took over 8 to get through a four hour shift. In the end, before having the mesh removed, I was using a cane and to get up from the seated position was increasingly difficult and painful, and I knew I would need a wheelchair soon. Thankfully, I switched to another doctor in the same office who offers integrative medicine a few years before learning my prior doctor was to retire. My friend who was still with that PCP was told her pain medication for her chronic pain would still be taken care of in house by the PA who would replace the retiring MD but that did not happen. The PA said he/she was uncomfortable prescribing opioids and my friend had to travel quite a distance (over 60 miles) to get the care necessary for her ongoing pain (pain medication) from a pain specialist. She recently shared that the specialist put her on new medication that is much better for her, energy-wise and pain-wise. So, this is an interesting result, but doubt if many could travel this far, or because pain keeps people from working, they may not have a car, or be able to afford the cost of gas. Maybe a better solution is to have pain specialists travel and meet with patients to review their medications and make suggestions to doctors and PA's. Maybe this can be a win-win for everyone involved. We cannot however, make the patient who is already exhausted travel and do the leg work simply because a medical professional is afraid of pain medications or being brought before the commission. I was thankful that my new primary care doctor was not shipping me off to a pain specialist, as I had enough medical issues that I only wanted to be under her care. I trusted her. She made a big difference in my life, helping me to get healthier, using supplements, along with prescription medications. She understood me as a whole person. She helped me get stronger not only physically but mentally as well. Chronic pain takes a toll on a person physically, emotionally, and spiritually, so when a patient is told they are the problem, or they are made to feel as though chronic pain is not a normal part of the human existence, the PA or MD is causing harm to the patient. According to the Centers for Disease Control and Prevention (CDC), in 2021, more than fifty million adults in the United States suffered with chronic pain, and more than seventeen million adults faced high-impact chronic pain which is pain that causes limits to their daily activities. And the risk of suicidal ideation, suicide attempts, and completed suicides, are twice as high in people who suffer with chronic pain. These are staggering statistics, yet patients are under prescribed or not prescribed at all. It is unacceptable. I finally found a doctor who would remove the mesh, and almost all of my pain issues went away! I do have chronic inflammation and neuropathy from the mesh, and fibromyalgia which could also be a byproduct of the mesh, so I may never be truly off the opioids, but I no longer need them every day as I did. My body is in healing mode. If I had stayed with my doctor and he retired, I would have been in a very unhealthy place if I was not prescribed my pain medication or worse, I was made to travel any distance to another doctor. People who suffer with chronic pain are already dealing with enough, please educate PA's and MD's of their responsibilities to care for patients who suffer with chronic pain. Then educate the public of their rights to be treated accordingly. As I am healthier, my doctor was recently forced by her practicer to have her patients meet with a pain specialist. I met with him. He did offer a new medication called Journavax which I took with my opioid recently after back surgery. It may have been helpful, as I am a month out and doing great from fusion surgery. We are now discussing whether I need to continue to meet with him. I don't take much of my pain medication anymore, since the mesh is gone, but I know I need to have it on hand for when I do need it. He does travel to my doctor's office, but I would prefer my doctor, and find the extra cost involved not worth it for me. So, maybe meeting with a pain specialist before a surgery to see what is new on the market, or once a year to review how things are going might be okay, but it might not be helpful ongoing. It might be stressful. If a medical doctor and a patient have an on-going healthy relationship that is working it should be up to them, and not forced.

## Comment #106

**Carol (not verified)** - *Jul 08, 2025 03:34 PM* Reply (/comment/reply/870/2861)

I suffered horrifically for fifteen years with the Johnson & Johnson Ethicon Mesh, undergoing twelve surgeries in three years. I endured sepsis, kidney and bladder infections sometimes twice a month, but the chronic pain from head to toe was the most unbearable. When disability denied me in 2012 and I went back to work, I thought I would die from the pain signals exploding in my brain. FYI: The FDA notifications of 2008 & 2011 -which I was not privy to until the State of Washington sued Johnson & Johnson- stated that adverse reactions such as chronic pain and numerous infections/surgeries were NOT rare. My doctor had prescribed opioids in and around 2008 or 2009. I needed four a day to just be at home, and took over 8 to get through a four hour shift. In the end, before having the mesh removed, I was using a cane and to get up from the seated position was increasingly difficult and painful, and I knew I would need a wheelchair soon. Thankfully, I switched to another doctor in the same office who offers integrative medicine a few years before learning my prior doctor was to retire. My friend who was still with that PCP was told her pain medication for her chronic pain would still be taken care of in house by the PA who would replace the retiring MD but that did not happen. The PA said he/she was uncomfortable prescribing opioids and my friend had to travel quite a distance (over 60 miles) to get the care necessary for her ongoing pain (pain medication) from a pain specialist. She recently shared that the specialist put her on new medication that is much better for her, energy-wise and pain-wise. So, this is an interesting result, but doubt if many could travel this far, or because pain keeps people from working, they may not have a car, or be able to afford the cost of gas. Maybe a better solution is to have pain specialists travel and meet with patients to review their medications and make suggestions to doctors and PA's. Maybe this can be a win-win for everyone involved. We cannot however, make the patient who is already exhausted travel and do the leg work simply because a medical professional is afraid of pain medications or being brought before the commission. I was thankful that my new primary care doctor was not shipping me off to a pain specialist, as I had enough medical issues that I only wanted to be under her care. I trusted her. She made a big difference in my life, helping me to get healthier, using supplements, along with prescription medications. She understood me as a whole person. She helped me get stronger not only physically but mentally as well. Chronic pain takes a toll on a person physically, emotionally, and spiritually, so when a patient is told they are the problem, or they are made to feel as though chronic pain is not a normal part of the human existence, the PA or MD is causing harm to the patient. According to the Centers for Disease Control and Prevention (CDC), in 2021, more than fifty million adults in the United States suffered with chronic pain, and more than seventeen million adults faced high-impact chronic pain which is pain that causes limits to their daily activities. And the risk of suicidal ideation, suicide attempts, and completed suicides, are twice as high in people who suffer with chronic pain. These are staggering statistics, yet patients are under prescribed or not prescribed at all. It is unacceptable. I finally found a doctor who would remove the mesh, and almost all of my pain issues went away! I do have chronic inflammation and neuropathy from the mesh, and fibromyalgia which could also be a byproduct of the mesh, so I may never be truly off the opioids, but I no longer need them every day as I did. My body is in healing mode. If I had stayed with my doctor and he retired, I would have been in a very unhealthy place if I was not prescribed my pain medication or worse, I was made to travel any distance to another doctor. People who suffer with chronic pain are already dealing with enough, please educate PA's and MD's of their responsibilities to care for patients who suffer with chronic pain. Then educate the public of their rights to be treated accordingly. As I am healthier, my doctor was recently forced by her practice to have her patients which includes me, meet with a pain specialist. I met with him. He did offer a new medication called Journavax which I took with my opioid recently after back surgery. It may have been helpful, as I am a month out and doing great from fusion surgery. We are now discussing whether I need to continue to meet with him. I don't take much of my pain medication anymore, since the mesh is gone, but I know I need to have it on hand for when I do need it. He does travel to my doctor's office, but I would prefer my doctor, and find the extra cost involved not worth

it for me. So, maybe meeting with a pain specialist before a surgery to see what is new on the market, or once a year to review how things are going might be okay, but it might not be helpful ongoing. It might be stressful. If a medical doctor and a patient have an on-going healthy relationship that is working it should be up to them, and not forced.

## Comment #107

**Rose Bigham (Wa... (not verified)** - *Jul 20, 2025 12:35 PM* Reply (/comment/reply/870/2862)

Washington Patients in Intractable Pain is pleased to offer proposed changes to WAC-246-919-850 through 985 under separate cover. Our comments reflect what we understand to be the continuing challenges facing Washington state pain patients and their providers, especially those managing chronic and/or intractable pain conditions. We sincerely appreciate the WMC's ongoing efforts to prioritize appropriate patient care. WMC's continued commitment to educate providers that Washington state's opioid prescribing rules supersede any other agency or federal guidelines regarding pain management is commendable. We look forward to continued collaboration to help ensure that the voice of pain patients in Washington state are heard and acknowledged, and that improvements in pain management and patient outcomes are the result. Respectfully - - Rose Bigham

« first (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas)
‹ previous (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas)
1 (/rule_making_2025/opioid-prescribing-general-provisions-mds-and-pas) **2**

| | |
|---|---|
| **From:** | Rose Bigham |
| **To:** | Karinen, Kyle S (WMC); Matthews, Micah T (WMC); Boyd, Amelia (WMC) |
| **Cc:** | cynhoenhous@gmail.com |
| **Subject:** | WashPIP Proposed language: Rules Workshop Draft Language Available: Opioid Prescribing General Provisions for MDs & PAs |
| **Date:** | Sunday, July 20, 2025 12:23:09 PM |
| **Attachments:** | image001.png<br>WMC Opioid Prescribing General Provisions Draft Language - WashPIP proposed language changes.pdf |

External Email

Greetings! Attached is a document containing Washington Patients in Intractable Pain's proposed language changes to WAC 246-919-850 through 246-919-985, under WSR #25-10-039.

Once we saw the draft language which was circulated last week, we felt there were some changes strongly needed which were not yet reflected in the draft. The language in the attached document is based on the original WAC language, not the draft. We hope that this format makes it simpler to incorporate into the existing draft for discussion.

We are looking forward to the workshop discussion on the 30th.

Thanks very much!

Respectfully,

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




**From:** Washington Medical Commission <WAMedicalCommission@public.govdelivery.com>
**Sent:** Wednesday, July 16, 2025 2:45 PM
**To:** rosebigham@hotmail.com
**Subject:** Rules Workshop Draft Language Available: Opioid Prescribing General Provisions for MDs & PAs

rulemaking - washington medical commission

# Opioid Prescribing General Provisions for Allopathic Physicians (MD) & Physician Assistants (PA)

The WMC 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 WACs 246-919-850 through 246-919-985 and PA WACs 246-918-800 through 246-918-935.

The Preproposal Statement of Inquiry, or CR-101, was filed on April 30, 2025, as WSR #25-10-039. For more details about this rulemaking, please refer to the CR-101 document linked below.

**CR-101**

The first workshop for this rulemaking will be held on Wednesday, July 30 beginning at 1 pm. This workshop will be held virtually. Please register to attend by clicking below:

**7/30/2025 Workshop Registration**

## Draft Language Available

The draft language which will be discussed at this workshop is now available by clicking below:

**7/30/2025 Draft Language**

Notices for this and future workshops will be distributed through this list and posted to our Rules in Progress page.

Written comments to be discussed at this workshop are due by 5:00 pm on July 21, 2025, and should be submitted on this site: Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission

*Commissioners and staff will attend this meeting virtually.*

Physical meeting location:
Department of Health
111 Israel Rd SE
TC2 Room 167
Tumwater, WA 98501


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| **Date:** | July 20, 2025 |
| **To:** | Washington Medical Commission: Upcoming Prescribing Rules Workshop |
| **From:** | Rose Bigham, Washington Patients in Intractable Pain |
| | Cyndi Hoenhous, Washington Patients in Intractable Pain |
| **Subject:** | Proposed changes to MD WACs 246-919-850 through 246-919-985 |

Below are WashPIP's proposed rule changes for **WSR 25-10-039.** We look forward to the workgroup discussion.

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

(1) "Aberrant behavior" means behavior that indicates current misuse, diversion, unauthorized use of alcohol or other controlled substances, or multiple early refills (renewals).

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. Acute pain is six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of urine, hair, or other biological samples for various drugs and metabolites.

(4) "Cancer-related pain" means pain that is an unpleasant, persistent, subjective sensory and emotional experience associated with actual or potential tissue injury or damage or described in such terms and is related to cancer or cancer treatment that interferes with usual functioning. Cancer-related pain may persist past the treatment phase and into the remission phase.

(5) "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. ~~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.~~

**Commented [WP1]:** Source: IASP definition, https://www.iasp-pain.org/advocacy/definitions-of-chronic-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*)'

(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~~one hundred-twenty milligram morphine equivalent dose (MED), or more, per day.

(10) "High-risk" is a category of patient at ~~high~~increased risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or abuse, aberrant behavior, ~~dose of opioids~~, or the use of any concurrent central nervous system depressant.

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

(12) "Hospital" means any health care institution licensed pursuant to chapters 70.41 and 71.12 RCW, and RCW 72.23.020.

(13) "Low-risk" is a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, and 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, and 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~~ a conversion table approved by the commission. MED is considered the same as morphine milligram equivalent or MME. Its use is limited in scope and does not set a numerical precedent for prescribing. No single MED indicates a safe dose for individual patients. Likewise, no single MED indicates adequate pain control for individual patients. Bioavailability of various opioids, metabolism, individual risk factors, and patient response dictate that the type and dose of opioids must be individually titrated.

(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.

**Commented [WP2]:** There is no valid "high dose" definition, as each patient's metabolism, individual risk factors, and patient response dictate that the type and dose of opioids must be individually titrated. But at a minimum, it seems logical to use our own state's referral threshold as the definition for "high dose"; not outdated CDC language which has proven to be a hardship for patients and providers.

**Commented [WP3]:** Level of patient risk should be derived solely on patient history, behavior and co-morbidities, NOT on dose. Disproportionate focus on MED has dictated prescribing practices and shifted focus away from individualized care and prescriber expertise and discretion. Patients with no documented risk factors have been losing sufficient pain care since the release of the CDC Guideline.

**Commented [WP4]:** Level of risk should be derived solely on patient history, behavior and co-morbidities, NOT on dose (high OR low).

**Commented [WP5]:** Level of risk should be derived solely on patient history, behavior, and co-morbidities, NOT on dose (High, low, OR moderate)

**Commented [WP6]:** No single MED indicates a safe dose for individual patients. Likewise, no single MED indicates adequate pain control for individual patients. Bioavailability of various opiods, metabolism, individual risk factors, and patient response dictate that the type and dose of opioids must be individually titrated

Source of sentence re: individual titration: https://www.ncbi.nlm.nih.gov/books/NBK555200/

(19) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness.

(20) "Perioperative pain" means acute pain that occurs surrounding the performance of surgery.

(21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW. Other jurisdictions may refer to this as the prescription drug monitoring program or "PDMP."

(22) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(23) "Refill" or "renewal" means a second or subsequent filling of a previously issued prescription.

(24) "Subacute pain" is considered to be a continuation of pain that is six- to twelve-weeks in duration.

(25) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that is a normal physiological consequence of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

[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.]

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**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 ~~re~~consider whether the continued use of opioids ~~or whether tapering or discontinuing opioids~~ is clinically indicate~~d~~; 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~~ may not be indicated for acute perioperative pain in some cases.

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

(9) If the physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-919-895 and 246-919-900 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

[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.]

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**246-919-900**
**Treatment plan—Subacute pain.**
The physician, having recognized the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase shall develop an opioid treatment plan.

(1~~) If tapering has not begun prior to the six- to twelve-week subacute phase~~, ~~the~~ The physician shall reevaluate the patient during the six-to-twelve week subacute phase. Based on effect on function or pain control, the physician shall consider whether opioids will be continued, tapered, or discontinued.

**Commented [WP7]:** 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 Non-Cancer Pain In Japanese Patients: Results From An Open-Label Study – 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/algorithms/clinical-management/clin-management-post-op-pain-web-algorithm.pdf

(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.]

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**246-919-905**
**Patient evaluation and patient record—Chronic pain.**
When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician shall include in the patient's record:

(1) An appropriate history including:

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and

(d) Review of comorbidities with particular attention to psychiatric and substance use.

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

(a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;

(b) Any pertinent diagnostic, therapeutic, and laboratory results;

(c) Pertinent consultations; and

(d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category. Risk assessment tools shall not include scores or

information generated by automated decision making systems or automated decision support systems.

(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.]

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

(1) The physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-919-985, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;
(b) For a moderate-risk patient, at least semiannually;
(c) For a low-risk patient, at least annually;
(d) Immediately upon indication of concerning aberrant behavior; and
(e) When the physician considers tapering or referral for a potential substance use disorder
~~(e)~~(f) More frequently at the physician's discretion.

(2) During the periodic review, the physician shall determine:

(a) ~~The patient's compliance with any medication treatment plan;~~The patient's history of compliance with treatment plans and written agreements documented by medical records and PMP queries.

(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~~ the observed or reported effect on function and/or pain control and on compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

**Commented [WP8]:** 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 [WP9]:** 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.

**Commented [WP10]:** 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.

(a) History and physical examination related to the pain; 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

~~(b)~~ (c) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

~~(c)~~ (d) 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) Observed or reported effects on function or pain control will be documented, as well as the rationale for changes in the treatment plan.

~~(4)~~ (5) 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)~~ (6)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.

**Commented [WP11]:** Further clarification that frequency of UATs should roughly match the descriptions listed above in 1.a-c, to avoid financial impact and burden on patients.

[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.]

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**246-919-950**

**Tapering considerations—Chronic pain.**

Not all chronic pain patients will need their opioid prescriptions tapered. The decision to taper should be based on compliance with the treatment plan and written agreements, patient outcomes regarding pain and function, and consideration of risk verses benefits. A Periodic Review – Chronic Pain (WAC 246-919-920) must be conducted when the physician considers tapering or a referral for substance use disorder evaluation Relying on medical decision making and patient-centered treatment, the physician shall complete all parts of the Periodic Review ~~. The physician shall only~~ prior to consider ing tapering or referral for a substance use disorder evaluation, unless the exemption scenarios described below are met. ~~when :~~

1) This review shall include:
   a) ~~-~~History of compliance with treatment plans and written agreements documented by medical records and PMP queries; and

b) Documented functional stability, pain control, or improvements/deterioration in function or pain control at the present opioid dose.
c) Any history or indication of misuse, abuse, substance use disorder, or diversion, or adverse event.
d) Documenting medical decision making for continuation or change to the treatment plan.

2) Exemptions to the required Periodic Review:
~~2)~~3) 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.~~

**Commented [WP12]:** Thoroughly documenting the decision to taper helps both the provider and the patient by providing a sound basis for tapering, referral for substance use disorder, or for continuation of medication as is.

[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.]

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**246-919-955**
**Patients with chronic pain, including those on higher 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 higher dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-919-930 if:

(a) Physician meets the criteria of a pain management specialist as defined in section 246-919-945.
(b)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)~~c The patient's dose is stable and nonescalating;
(~~c~~)d The patient has a history of compliance with treatment plans and written agreements documented by medical records and PMP queries; and

~~(d)~~e 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.

(4) Denying medical care based solely on a patient's use of prescribed opioids will be considered to be a departure from standards of practice.

NEW SECTION:

**Patients with chronic pain, including those on higher doses of opioids, in an established relationship with a physician.**

**Commented [WP13]:** This new section is to specifically address patients who are stable, in an established relationship with a provider, and who are being forcibly tapered despite no medical indicators. This is mainly due to the pressures which providers may feel. This is one of the steps we can take to help providers use their medical discretion without fear of repercussions.

(1) A physician treating an established higher dose chronic pain patient should not fear disciplinary action from the Commission for prescribing, dispensing, or administering opioids when treating pain so long as:

(a) The mandatory consultation requirement with a pain management specialist as described in WAC 246-919-945 has already been met or initiated, or the consultation requirement exempted under WAC **246-919-930**

(b) the care provided is consistent with sound clinical judgment

(c) The patient's dose meets the goals of the treatment plan

(d) The patient has a history of compliance with treatment plans and written agreements documented by medical records and PMP queries;

(e) The patient has documented functional stability, pain control, or improvements in function or pain control at the presenting opioid dose.

(f) The patient has no adverse reactions:

(g)Queries of PMP and Periodic Review are conducted at appropriate intervals for risk category. WAC 246-919-920

(2) No disciplinary action will be taken against a practitioner based solely on the quantity, MME, frequency, or duration of opioids prescribed.

[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.]

# Comments from the WMC Rules page as of August 19, 2025 at 4:19 pm

**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?<br>☐ I have not had pain<br>☐ I have had pain, but on less than half the days<br>☐ I have had pain on more than half the days, but not every day<br>☐ I have had pain every day, but not all the time<br>☐ 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?<br>0=No pain 10= Worst imaginable pain<br><br>In the past 7 days, how much did pain interfere with <u>your day-to-day activities</u>?<br>0=No interference 10=Completely interferes<br><br>In the past 7 days, how much did pain interfere with <u>your enjoyment of life</u>?<br>0=No interference 10=Completely interferes | Mean or sum of the three 0-10 pain ratings.<br><br>**<u>Mean</u>** **<u>Sum</u>**<br>Mild < 4 < 12<br>Moderate 4 to < 7 12 to 20<br>Severe 7 to 10 21 to 30<br><br>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

<table>
<tr><td colspan="3">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:</td></tr>
<tr><td>Participation restrictions because of pain</td><td>• Over the past 6 months because of pain…<br><br>I have had trouble doing my usual work (including work for pay, work around the home, volunteer work).<br><br>Never Rarely Sometimes Usually Always<br><br>• I have had trouble doing my regular social and recreational activities (such as visiting friends, going to the movies, attending clubs or religious activities).<br><br>Never Rarely Sometimes Usually Always<br><br>• I have had trouble taking care of myself (for example dressing, bathing, or feeding myself).<br><br>Never Rarely Sometimes Usually Always</td><td>At least one item rated “usually” or “always”</td></tr>
</table>

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.

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## 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.

| 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.]

**Citation Index**

[FSMB 2024 Guidelines] https://www.fsmb.org/siteassets/advocacy/policies/opioid_prescribing_guidelines.pdf
[AMA Code of Medical Ethics] https://code-medical-ethics.ama-assn.org/
[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**

[FDA Naloxone Co-prescribing Guidance] https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone

[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

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.

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### 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

Veterans Administration. STORM Study Summary. https://www.pbm.va.gov/

AMA Policy D-120.932. https://policysearch.ama-assn.org/policyfinder/detail/D-120.932?uri=%2FAMADoc%2Fdirectives.xml-D-120.932.xml

AAFP Statement. https://www.aafp.org/news/health-of-the-public/cdc-2022-opioid-guideline.html

FSMB 2024 Guidelines. https://www.fsmb.org/siteassets/advocacy/policies/strategies-for-prescribing-opioids-for-the-management-of-pain.pdf

ASIPP 2023 Guidelines. https://pubmed.ncbi.nlm.nih.gov/38117465/

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HHS Pain Management Task Force Final Report (2019) https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

[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

[FDA Drug Disposal Guide] https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know

[DEA Take-Back Programs] https://www.dea.gov/everyday-takeback-day

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

[California 2023 Guidelines] https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf

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

[FDA Naloxone Co-prescribing Guidance] https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain