
# Opioid Prescribing
# General Provisions for MDs & PAs

Rules Workshop

October 29, 2025

# Rules Workshop Agenda

WASHINGTON Medical Commission
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Virtual via Teams Webinar

## Wednesday, October 29, 2025 – 1 pm to 3 pm

## Opioid Prescribing—General Provisions for MDs & PAs

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

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| 5. Better Prescribing, Better Treatment (BPBT) Program Presentation<br>*Dr. Nathan Schlicher, Physician Lead, Washington State Medical Association, will present on the BPBT program, a clinician-led initiative providing prescribing feedback and one-on-one coaching to support safe opioid prescribing and improved patient care.*<br>Program Overview | |
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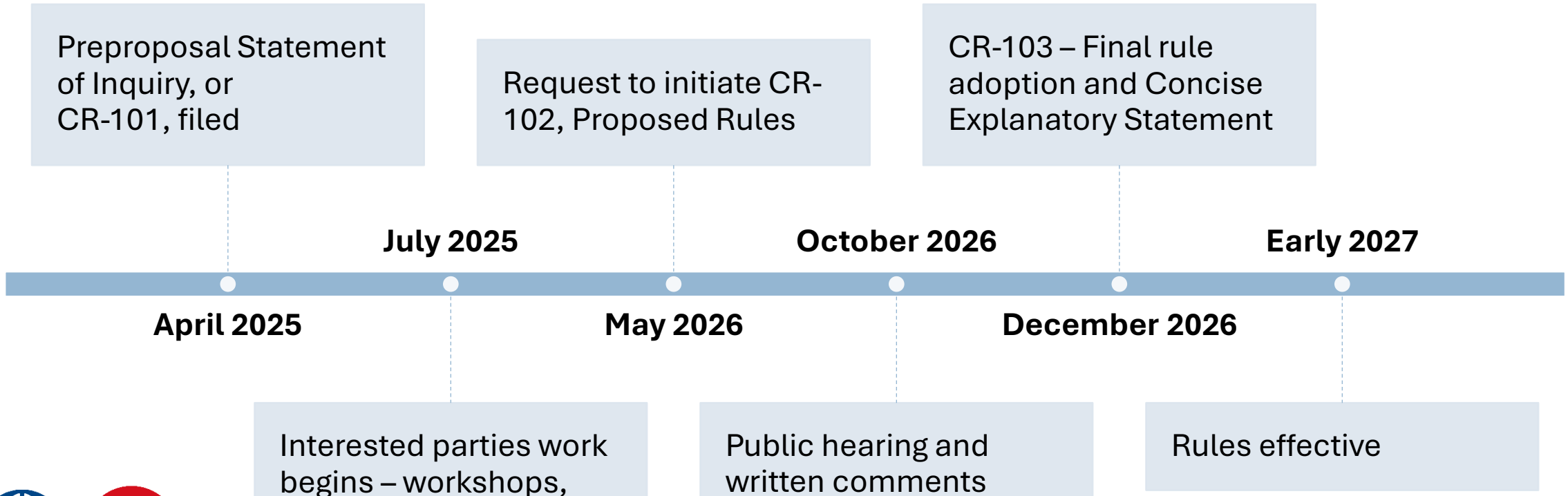
# Proposed Rule Development Timeline

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# Tapering Considerations WAC 246-919-950

Current language: WAC 246-919-950:

There are several proposed versions of this subsection, which are included in the materials.

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# Tapering Considerations WAC 246-919-950 (cont.) WashPIP Proposal

*A cohort of chronic pain patients will not need their opioid analgesic medications tapered or discontinued.*

*Physician is exempt from requiring involuntary tapering or discontinuation of prescribed opioid analgesic medications for a chronic pain patient where:*

*- Patient is in compliance with the treatment plan*

*- Patient demonstrates an ongoing benefit and functional stability*

*- Patient has no history of aberrant behavior or adverse events*

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# Tapering Considerations WAC 246-919-950 (cont.) WashPIP Proposal (cont.)

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

***The decision to taper or discontinue opioid analgesic therapy must be based on individualized patient care and clinical judgement, and must be clearly documented in the patient record.***

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## WAC 246-919-950

## Tapering considerations—Chronic pain.

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

(1) The patient requests;

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

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

(4) Other treatment modalities are indicated;

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

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

(7) There is unauthorized escalation of doses; or

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

[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.]

This proposed language incorporates all suggested revisions.

**WAC 246-919-950 Tapering considerations—Chronic pain.** ~~Not all~~(1) A cohort of chronic pain patients will ~~need their~~not require opioid ~~prescriptions tapered~~tapering, reduction, or discontinuation. Patients who are stable on long-term opioid therapy and adherent to their treatment plan should not be subjected to tapering solely to meet a guideline or policy limit. Reducing medication in a manner that destabilizes a clinically stable patient may place the patient at undue risk and fall below the standard of care.

(2) Nothing in this section shall be construed to require a physician to initiate involuntary tapering or discontinuation of opioid therapy for a chronic pain patient who is stable, compliant with the treatment plan, and demonstrating ongoing benefit and functional stability.

(2) Tapering decisions must be individualized, clinically indicated, and based on shared decision-making with documented rationale. The physician shall (should?) not mandate tapering of opioid therapy for chronic pain patients unless the risks of

**Commented [DB1]:** This addition incorporates the intent of WashPIP's proposal - it's just written differently.

Here's WashPIP's proposal:
*Physician is exempt from requiring involuntary tapering or discontinuation of prescribed opioid analgesic medications for a chronic pain patient where:*
*- Patient is in compliance with the treatment plan*
*- Patient demonstrates an ongoing benefit and functional stability*
*- Patient has no history of aberrant behavior or adverse events*

continued therapy clearly outweigh the benefits and clinically appropriate alternatives are available.

(3) When tapering is clinically appropriate, it must follow an individualized plan developed collaboratively with the patient.

(4) Relying on medical decision making and patient-centered treatment, the physician ~~shall~~ should consider tapering or referral for a substance use disorder evaluation when any of the following occur:

(~~1~~a) The patient requests tapering;

(~~2~~b) Pain or function worsens despite optimized opioid therapy and not due to expected disease progression;~~The patient experiences a deterioration in function or pain~~;

(~~3~~c) ~~The patient is noncompliant with the written agreement~~ The patient is not adhering to the written agreement, prompting reassessment and implementation of appropriate risk-mitigation strategies before tapering is considered;

(~~4~~d) Other treatment modalities are indicated; any tapering must occur within a shared, documented plan that allows return

to a previously effect opioid regimen if treatment goals are not achieved;

(~~5~~e) ~~There is e~~Evidence of misuse, abuse, substance use disorder, or diversion is present;

(~~6~~f) The patient experiences a severe adverse event related to prescribed opioids, or there is confirmed overdose or concurrent illicit substance use;

(~~7~~g) ~~There is unauthorized escalation of doses~~The patient escalates doses without authorization; or

(~~8~~h) The patient ~~is receiving an escalation in~~continues to receive escalating opioid ~~dosage~~ doses without ~~no~~ improvement in ~~their~~ pain or function.

(5) Any decision to taper or discontinue opioid analgesic therapy must be based on individualized patient care, clinical judgment, and must be clearly documented in the patient record. The tapering plan must include the following:

(a) Gradual dose reduction;

(b) Active monitoring for withdrawal symptoms or adverse outcomes, including increased pain, anxiety, or suicidal ideation; and

(c) Clear documentation of the clinical rationale and patient-reported impact to ensure continuity and transparency of care.

**WAC 246-919-950 Opioid tapering considerations—Chronic pain patients.**

(1) A cohort of chronic pain patients will not require opioid tapering, reduction, or discontinuation.

(2) Tapering decisions must be individualized, clinically indicated, and based on shared decision-making with documented rationale.

(a) Physicians must not taper solely to meet policy or guideline thresholds.

(b) Physicians shall not mandate tapering unless the risks clearly outweigh the benefits and appropriate alternatives are available.

(c) When tapering is appropriate, it must follow an individualized plan developed collaboratively with the patient.

(3) Relying on medical decision-making and patient-centered care, the physician shall consider tapering or referral for a substance use disorder evaluation when any of the following occur:

(a) The patient requests tapering;

(b) Worsening pain or function occurs despite optimized opioid therapy, not attributable to expected disease progression;

(c) The patient is noncompliant with the written agreement, prompting reassessment and implementation of appropriate risk mitigation strategies;

(d) Other treatment modalities are indicated; any tapering must occur as part of a shared, documented plan that allows the patient to return to an effective opioid regimen if treatment goals are not met;

(e) Evidence of misuse, abuse, substance use disorder, or diversion is present;

(f) The patient experiences a severe adverse event directly linked to prescribed opioids, or there is clear evidence of overdose or concurrent illicit substance use;

(g) Unauthorized escalation of doses occurs; or

(h) The patient is receiving escalating opioid doses with no improvement in pain or function.

(4) Any tapering plan must include:

(a) Gradual dose reduction;

(b) Monitoring for withdrawal symptoms or adverse effects; and

(c) Clear documentation of clinical rationale and patient-reported impact to ensure continuity and transparency of 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 246-919-950 Tapering considerations—Chronic pain.** A cohort of chronic pain patients will not require opioid tapering, reduction, or discontinuation. Tapering decisions must be individualized, clinically indicated, and based on shared decision-making with documented rationale. Physicians must not taper solely to meet policy or guideline thresholds. The physician shall not mandate tapering of opioid therapy for chronic pain patients unless the risks clearly outweigh the benefits and appropriate alternatives are available.

When tapering is appropriate, it must follow an individualized plan developed collaboratively with the 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 worsening of pain or function despite optimized opioid therapy, not attributable to the expected progression of their condition;

(3) The patient is noncompliant with the written agreement, prompting reassessment and implementation of appropriate risk mitigation strategies before considering any tapering;

(4) Other treatment modalities are indicated, tapering should occur as part of a shared, documented plan that allows the patient to 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 linked to prescribed opioids, or there is clear evidence of overdose or concurrent illicit substance use;

(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 must include gradual dose reduction, monitoring for withdrawal or adverse effects, and clear documentation of clinical rationale and patient-reported impact to ensure continuity and transparency of 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.]

**OPIOID PRESCRIBING—GENERAL PROVISIONS**

**WAC 246-919-950 Tapering considerations—Chronic pain.** 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. Suggested addition from Higginbotham redline (comment #111): 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)Patient-initiated requests for tapering;

(2) Inadequate achievement of patient specific pain or function goals despite optimization of opioid therapy and not related to expected progression based on diagnosis;

(3) 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;

(7) There is unauthorized escalation of doses.

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.]

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

Commented [DB1]: Approved 9/22

Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the

commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

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

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be

**Commented [DB2]:** Dr. Stanos suggests adding the following here but it may be more appropriate elsewhere (maybe in a new section?): Buprenorphine, a partial agonist, may be used for both the management of opioid use disorder (MOUD), chronic pain, and tapering depending on the patient's needs and diagnoses. The care of patients on buprenorphine for chronic pain and maintenance therapy for MOUD requiring additional analgesia for acute pain and/or planned surgical interventions should be coordinated between the primary prescriber with the provider managing acute pain and/or a planned surgical intervention. Physicians should be aware of the evolving understanding of the unique pharmacology of buprenorphine, the range of formulations available (i.e. topical, sublingual, and submucosal), and evidence-based strategies to manage patients on maintenance therapy for MOUD or those using buprenorphine for chronic pain who require additional analgesia for acute or planned surgical or medical interventions.

adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids Suggested addition from Dr. Stanos (comment #112): analgesics and are not the same as Suggested addition from Dr. Stanos: addiction opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids Suggested addition from Dr. Stanos (comment #112): analgesics for other than legitimate medical purposes poses a threat to the individual and society Suggested change from Dr. Stanos (comment #112): and that~~.~~ The inappropriate prescribing of controlled substances, including opioids Suggested addition from Dr. Stanos (comment #112): analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances Suggested addition from Dr. Stanos (comment #112): including monitoring

the prescription monitoring database, integrating urine monitoring, educating patients about safe storage and disposal of unused medications, and the need for availability of naloxone in emergency circumstances to reverse a potential opioid overdose.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids Suggested addition from Dr. Stanos (comment #112): , opioid agonists and partial agonist analgesics, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must ~~exist~~exist, and ~~the~~ prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required. The medical practice act of Washington and

commission rules supersede any conflicting federal or state guidelines relating to the practice of medicine or prescribing of opioids for pain control. Establishing blanket dosing limits and forced tapering based on federal guidelines and not individualized patient assessment and need will be deemed a violation of the standard of care.

The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

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

**Commented [MM3]:** Language from Sierra AGO.

**Commented [DB4]:** Revised from the 7/30 workshop. Needs discussion and decision.

**Commented [MM5]:** 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 [DB6R5]:** This language was not included in the 7/30 draft so it will need review and discussion.

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

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

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

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

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

The practice of medicine involves not only ~~the science~~science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not Suggested change from Dr. Stanos (comment #112): ~~guarantee~~ assure an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist physicians in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

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

**Physicians**

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

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

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

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

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

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

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

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

(Suggested language from WashPIP (comment #115): Patients with high-impact chronic pain, as defined in WAC 246-919-852, where the patient is in compliance with the treatment plan, demonstrates ongoing benefit, functional stability, and absence of evidence of misuse or diversion.)

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

**Commented [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.

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

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

(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

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

Suggested addition from Higginbotham redline (comment #111)

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

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

Suggested addition from Higginbotham redline (comment #111) (9) The continued care of legacy or stable, compliant patients receiving long-term opioid therapy, when treatment has been effective and no evidence of aberrant behavior exists.

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

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

(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 [DB12]: 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.

Suggested addition from Higginbotham redline (comment #111)

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

(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.

**Commented [DB13]:** 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 [DB14]:** This phrase is not used in the redline suggestions from P3/Higginbotham. As such, there is no need to define it. In the Rationale from the redline in the Definitions section, it states adding this definition would "give formal weight to WMC interpretive statements." This phrase is also not used in either of the opioid prescribing interpretive statements.

~~(9) "High dose" means a ninety milligram~~ninety-milligram ~~morphine equivalent dose (MED), or more, per day.~~

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

~~(10) "High-risk" is a category of patient~~patients ~~at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or 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.

**Commented [DB15]:** 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 [DB16]:** 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."

**Commented [DB17]:** 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 [DB18]:** 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.

~~(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.~~

Suggested addition from Higginbotham redline (comment #111)

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

(14) "Medication assisted treatment" or "MAT" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

~~(15) "Moderate-risk" is a category of patient~~patients ~~at moderate risk of opioid-induced morbidity or mortality, based on~~

**Commented [DB19]:** 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 [DB20]:** Suggested rewrite of this proposed definition: "Legacy patient" means a patient continuing on a stable and clinically appropriate opioid regimen initiated by a previous provider.

**Commented [DB21]:** If we include this definition, this should be removed - guidelines are a guide and not a requirement so any previous guidelines would be irrelevant to these rules.

**Commented [DB22]:** If we include this definition, this sentence should be moved to section 955 "Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician."

~~factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history~~history ~~of substance use disorder or abuse, aberrant behavior, and dose of opioids between fifty to ninety milligram morphine equivalent doses per day.~~

(16) "Morphine equivalent dose" or "MED" means a ~~conversion of various opioids to a morphine equivalent dose using the agency medical directors' group or other conversion table approved by the commission~~standardized measurement expression the potency of opioids in terms of an equivalent dose of morphine. MED is considered the same as morphine milligram equivalent or MME.

(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,

**Commented [DB23]:** 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 [DB24]:** 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/

codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone when used to treat pain.

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

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

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

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

(22) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71, 18.71B or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.~~57A~~ 71C RCW, or a podiatric physician licensed under chapter 18.22 RCW.

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

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

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

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

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

(a) Emergent care;

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

(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

**Commented [MM25]:** Should be standard practice. Recommend we keep.

**Commented [MM26]:** To follow format established in these rules, exemptions should be listed first.

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.

Suggested addition from Higginbotham redline (comment #111) 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 judgement, 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.]

**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.

Suggested addition from Higginbotham redline (comment #111)

(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.

Commented [DB27]: Editing remark: we can't use "and/or" in rule. Suggest using "or" here.

(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 [MM28]: 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

**Commented [MM29]:** Does the data still support this? My recollection is that this was a suboxone issue.

**Commented [MM30]:** Keep this no matter what. Major intersection between incarcerated population and ED visits discontinuing these medications to their detriment.

governing the treatment of subacute pain in WAC 246-919-895 and 246-919-900 shall apply.

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

**WAC 246-919-890 Treatment plan—Acute perioperative pain.** The physician shall comply with the requirements in this section when prescribing opioids for perioperative pain.

(1) The physician should consider prescribing nonopioids as the first line of pain control in patients, unless not clinically appropriate, in accordance with the provisions of WAC 246-919-870.

(2) The physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-919-985.

(3) If the physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A ~~three~~seven-day supply or less will often be sufficient. The physician shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical

documentation in the patient record to justify the need for such a quantity.

(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.

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

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

**Commented [MM31]:** Does the data still support this statement? For every procedure?

**Commented [MM32]:** Keep.

**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 [MM33]: 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. | WMC's proposed revisions to this suggested 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.

The physician shall include in the patient's record:

(1) An appropriate Suggested addition from Higginbotham redline (comment #111) 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

Suggested replacement for (c) from Higginbotham redline (comment #111) (c) 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.

Suggested replacement for (d) from Higginbotham redline (comment #111) (d) Past or current opioid therapy, including any successful prior use that may inform ongoing care decisions;

Suggested addition from Higginbotham redline (comment #111) (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) Suggested addition from Higginbotham redline (comment #111) An Appropriate physical examination.

(3) Ancillary information and tools to include: Suggested change from Higginbotham redline (comment #111) 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; Suggested change from Higginbotham redline (comment #111) (a) 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.~~

Commented [DB34]: If we eliminate the definitions of these risk categories, we can eliminate this requirement. d

Suggested change from Higginbotham redline (comment #111)

(d) Individualized treatment goals established through shared decision-making, reflecting patient preferences and disease-specific needs.

Commented [DB35]: Instead of preferences, I suggest "goals."

(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;

Suggested change from Higginbotham redline (comment #111)

(b) Consideration of the risiks and benefits of initiating or

continuing opioid treatment in the context of the patient's condition, clinical goals, and prior response to care;

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

Suggested change from Higginbotham redline (comment #111)

(c) Functional or symptom-related rationale supporting ongoing prescribing; and

(d) Pertinent concerns discovered in the PMP.

Suggested change from Higginbotham redline (comment #111)

(d) notable finding from the PMP review.

(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

Commented [MM36]: Do we need to say this? What practitioner would not have a treatment plan for ANY patient with a condition? Is that not the standard of care?

Commented [DB37R36]: Micah is suggesting we delete this section.

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

Suggested addition from Higginbotham redline (comment #111)

(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.

(fe) 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:

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

(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;

**Commented [MM38]:** 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.

Suggested change from Higginbotham redline (comment #111)

(1) 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;

Suggested change from Higginbotham redline (comment #111)

(3) A clear outline of clinical circumstances under which opioid therapy may be involuntarily modified, tapered, or discontinued.

(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. Suggested addition from Higginbotham redline (comment #111) it should also note that an

alternate pharmacy may be used without penalty when necessary due to supply or other unforeseen issue(s);

(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;

Suggested change from Higginbotham redline (comment #111)

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

**Commented [DB39]:** If this is approved, do we need to explain what an extreme violation or circumstance would be?

**Commented [DB40]:** Editing note: We can't use "and/or" in rule. Suggest using "or" in this case.

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

~~(1) The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-919-985, must be determined based on the patient's risk category:~~

~~(a) For a high-risk patient, at least quarterly;~~

~~(b) For a moderate-risk patient, at least semiannually;~~

~~(c) For a low-risk patient, at least annually;~~

~~(d) Immediately upon indication of concerning aberrant behavior; and~~

~~(e) More frequently at the physician's discretion.~~

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

**Commented [DB41]:** 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 [MM42R41]:** Leaving this and deleting the rest to make the review more flexible and less intrusive on the patient.

~~(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 [MM43]: Either make this mandatory (shall) or we should delete.

Commented [KK44R43]: 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~~. Suggested change from P3 Alliance/Higginbotham (comment #116): (1) Consultation with a pain management specialist should be required with the prescriber's clinical evaluation identifies risk factors such as:

- Unexpected dose escalation not tied to functional or clinical improvement.

- Indicators of high risk (e.g., overdose history, active substance use disorder, psychiatric instability or diversion concerns).

(2) 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.

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

(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;

Suggested change from P3 Alliance/Higginbotham (comment #116): (3) Exemptions remain in place for cancer, palliative, hospice, (high-impact chronic pain, and legacy) patients as provided in WAC 246-919-851.

(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

**Commented [MM45]:** 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 [MM46]:** Keep. Maintains flexibility for practitioner.

**Commented [DB47]:** Note from Higginbotham redline (comment #111): *Consistent with our prior recommendation to eliminate the fixed-MED pain specialist consultation requirement, we recommend removing this section entirely if that trigger is no longer in effect. If the consultation threshold remains, our proposed revisions to this section are outlined below.*

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: Suggested change from Higginbotham redline (comment #111) delete the first paragraph and replace with "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 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;

Suggested change from Higginbotham redline (comment #111) (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 physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or

Suggested change from Higginbotham redline (comment #111)

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

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

Suggested change from Higginbotham redline (comment #111)

(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.

[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 [DB48]: Suggest changing this word to "definition" as -852 is the definitions section and does not include requirements.

Commented [MM49]: Keep. Maintains flexibility.

Commented [DB50]: Note from Higginbotham redline (comment #111): Consistent with our prior recommendation to eliminate the fixed-MED pain specialist consultation requirement, we recommend removing this section entirely if that trigger is no longer in effect. If the consultation threshold remains, our proposed revisions to this section are outlined below.

(1) The physician is a pain management specialist under WAC 246-919-945;

(2) The physician has successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders;

(3) The physician is a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or

(4) The physician has a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.

Suggested addition from Higginbotham redline (comment #111)

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

**Commented [DB51]:** If Commissioners would like this added, I suggest the following instead: "The patient meets the definition of a legacy patient, and referral is not expected to alter care or would risk treatment interruption."

[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 [MM52]: 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 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.

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;

**Commented [DB53]:** 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 [MM54R53]:** 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.

**Commented [DB55]:** This proposed language is to add clarity and express the intention of these tapering considerations.

**Commented [MM56R55]:** This is one of the spots I think it is appropriate to have this. Suggest limiting to here and the intent section.

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

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

(4) Other treatment modalities are indicated;

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

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

(7) There is unauthorized escalation of doses; or

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, 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."

Suggested change from Higginbotham redline (comment #111):

The new physician shall:

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

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

Suggested alternate language to petition proposal:

Alteration of treatment plans should not occur outside of the circumstances listed in WAC 246-919-950.

(2) A physician's treatment of a new ~~high dose~~ chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-919-930 if:

(a) The patient was previously being treated with a dosage of opioids in excess of ~~a one~~one hundred twenty milligram MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and non-escalating;

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

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

Suggested change from Higginbotham redline (comment #111):

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

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

Commented [DB57]: Should we include "risk assessment" in this section?

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-919-930 shall apply if or until the patient qualifies for exemption from these rules under WAC 246-919-851.

Suggested change from Higginbotham redline (comment #111):

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

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

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

**OPIOID PRESCRIBING—SPECIAL POPULATIONS**

**WAC 246-919-960 Special populations—~~Children or adolescent patients, p~~Pregnant patients~~, and aging populations.~~** ~~(1) Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.~~

Suggested change from Higginbotham redline (comment #111):

**Commented [MM58]:** Is this needed? The adolescent is basic medicine and the geriatric is too. I would consider leaving (2) due to the MAT/pregnancy complication.

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

Commented [DB59]: This sentence is not necessary and contradictory to the exclusions section. If Commissioners decide to keep this suggested language in this first paragraph, this sentence will need to be revised.

(12) 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 [MM60]: 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. Suggested addition from Higginbotham redline (comment #111): Coordination efforts and relevant communication shall be documented. When immediate coordination is not possible, the physician shall ensure continuity of care by clearly documenting

rationale for prescribing decisions and any instructions provided to the patient.

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

**OPIOID PRESCRIBING—COPRESCRIBING**

**WAC 246-919-970 Coprescribing of opioids with certain medications.** (1) The physician shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making: Suggested change from Higginbotham redline (comment #111): (1) The physician may prescribe opioids in combination with the following medications when clinically indicated, based on an individualized assessment of benefits and risks, and with documented rationale in the medical record:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

Commented [DB61]: Is this already standard of care and required?

Commented [MM62]: Chemistry has not changed so this should stay.

(e) Nonbenzodiazepine hypnotics.

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

(2) If, because of a prior prescription by another provider, a prescription written by a physician results in a combination of opioids and medications described in subsection (1) of this section, the physician issuing the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care. Suggested addition from Higginbotham redline (comment #111): Coordination efforts and care planning should be document, but shall not delay necessary treatment.

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

**WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment.** (1) Where ~~practicable~~feasible, the physician providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.

(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.~~

**Commented [MM63]:** Referenced previously in patient counseling. Delete.

**Commented [DB64R63]:** I could not find this referenced in these rules besides this subsection. I think we need to keep this and expand it a bit since we are proposing no longer using high-, moderate-, or low-risk.

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

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

Suggested change from Higginbotham redline (comment #111): The physician shall confirm or provide a current prescription for naloxone when prescribing opioids to a patient who is determined, based on individualized clinical assessment, to be at elevated risk of overdose. This assessment and rationale must be documented in the patient's medical record. Factors that may increase risk include, but are not limited to:

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

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

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

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

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

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

**OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM**

**WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation.** The PMP is a powerful tool for clinicians and patients, but its limitations must be understood and accepted. For these reasons, the Legislature has seen fit to limit access to licensees, patients, relevant regulatory authorities, and law enforcement as the data 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 [MM65]: Placing this to head off PH researchers and SAO issues like we experienced a couple of years ago.

Commented [DB66]: Approved 9/22

(1) The physician shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe Schedule II-V medications in Washington state.

(2) The physician is permitted to delegate performance of a required PMP query to an authorized designee.

(3) At a minimum, the physician shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-919-970 at the following times:

(a) Upon the first refill or renewal of an opioid prescription for acute nonoperative pain or acute perioperative pain;

(b) The time of transition from acute to subacute pain; and

(c) The time of transition from subacute to chronic pain.

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

~~(a) For a high-risk patient, a PMP query shall be completed at least quarterly;~~

~~(b) For a moderate-risk patient, a PMP query shall be completed at least semiannually; and~~

~~(c) For a low-risk patient, a PMP query shall be completed at least annually.~~

**Commented [MM67]:** Reduced requirement on practitioner and patient. Rely on aberrant behavior standard and requirements in written agreement.

**Commented [DB68]:** Comment that this should be kept if long term stable chronic pain patients are not exempt.

(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.

Suggested change from Higginbotham redline (comment #111):

**Commented [MM69]:** 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 [MM70]:** This is standard of care so moving to should in response to comments received.

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

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

# Higginbotham redline (comment #111) Proposed new subsections

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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# Higginbotham redline (comment #111) Proposed new subsections (cont.)

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.

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# Death with Dignity Act

Q: Does the exemption for end-of-life care apply to Washington's Death with Dignity Act?

A: No – The Death With Dignity statute (RCW 70.245) and its implementing rules (WAC 246-978) create a separate regulatory framework for authorization, documentation, safeguards, and legal protections for providers who follow that process. When a patient meets the Death With Dignity requirements physicians follow RCW 70.245 and WAC 246-978.

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# Can Rules Limit What Goes in the Medical Record?

- No laws prevent a board or commission from specifying required record content.
- Regulations focus on what must be documented, not what can be included.
- Physicians can add information reflecting their clinical judgment.

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# Next Steps

- Additional workshops
  - 5th workshop – February 23, 2026 @ 1 pm – Register Here
  - 6th workshop – March 23, 2026 @ 1 pm – Register Here

Opioid Prescribing Rules Page:

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

Please feel free to provide written comments to:

medical.rules@wmc.wa.gov

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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

# Comments from the WMC Rules page
# July 29-August 18

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

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

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

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

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

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

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

# Comment #110 Attachments

Discussions on High-impact chronic pain

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

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

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

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

High-impact chronic pain should

- First, be acknowledged,
- Second, defined

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

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

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

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

Pain Management Collaboratory High Impact Chronic Pain (HICP) Recommendations

National Pain Strategy

## Appendix D. Chronic pain screener questions

| Definition | Item | Criteria |
|---|---|---|
| Pain on at least half the days for 6 months | Over the last six months, on about how many days have you had pain?<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/

CDC 2023 Testimony. https://www.cdc.gov/washington/testimony/2023/t20230621.htm

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

# Comment #112

Consideration of including language related to buprenorphine

Steven Stanos, DO Aug 24, 2025

WAC 246-919-850 ((Pain management—))**Intent and scope**.
((These)) The rules in WAC 246-919-850 through 246-919-985 govern the ((use)) prescribing of opioids in the treatment of ((patients for chronic noncancer)) pain.
The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of ((this)) these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.
The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain((,)) including acute ((or)), perioperative, subacute, and chronic((, and it is especially urgent for patients who experience)) pain ((as a result of terminal illness)). All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing ((controlled substances)) opioids (including traditional opioid agonists [i.e. hydrocodone, oxycodone, morphine, and tramadol) and partial agonists, such as buprenorphine, ~~including~~ All physicians should become knowledgeable about co-occurring prescriptions. Accordingly, ((this rule has been developed to)) these rules clarify the commission's position on pain control, particularly as related to the use of opioid agonist and partial-agonist analgesics, to alleviate physician uncertainty and to encourage better pain management. Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, ((and)) or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioids such as traditional agonists (i.e. hydrocodone, oxycodone, morphine, tramadol, etc.), and partial agonist (i.e. buprenorphine) ~~((analgesics))~~are analgesics that may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery ((and chronic pain, whether due to cancer or non-cancer origins)). Buprenorphine, a partial agonist, may be used for both the management of opioid use disorder (MOUD), chronic pain, and tapering depending on the patient's needs and diagnoses. The care of patients on buprenorphine for chronic pain and maintenance therapy for MOUD requiring additional analgesia for acute pain and/or planned surgical interventions should be coordinated between the primary prescriber with the provider managing acute pain and/or a planned surgical intervention. Physicians should be aware of the evolving understanding of the unique pharmacology of buprenorphine, the range of formulations available (i.e. topical, sublingual, and submucosal), and evidence-based strategies to manage patients on maintenance therapy for MOUD or those using buprenorphine for chronic pain who require additional analgesia for acute or planned surgical or medical interventions.

The commission will refer to current clinical prac-
[ 1 ] OTS-9762.2tice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge ((and)), scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians

should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids ((analgesics)) and are not the same as ((addiction)) opioid use disorder.

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

[ 2 ] OTS-9762.2The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to these rules will not ((assure)) guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist ((practitioners)) physicians in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. For more specific best practices, the physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease
Control and Prevention, or the Bree Collaborative.

# Comment #113

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

To Whom It May Concern,

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

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

Key Support and Recommendations

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

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

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

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

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

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

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

Thank you for your consideration.

Sincerely,

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

# Comments from the WMC Rules page

## August 25

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

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

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

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

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

Comment #115

External Email

Good morning Amelia,

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

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

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

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

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

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

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

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

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

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

Thank you so much,

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

Comment #116

# P3 Alliance – Addendum Submission

Re: WAC 246-919-930 Consultation Requirements

To: Washington Medical Commission

From: P3 Alliance

September 15, 2025

## Primary Request (on record)

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

## Purpose of This Addendum

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

## Legal Authority

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

## Clinical Evidence

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

## Patient Harm

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

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

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

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

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

## Conclusion

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

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

Respectfully submitted,

P3 Alliance
Maria Higginbotham
Tamera Stewart

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

From September 16 to October 20, 2025

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

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

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

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

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

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

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

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

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

U.S. PAIN FOUNDATION

Comment #121

# BEHIND THE NUMBERS

## WHAT IT REALLY MEANS TO LIVE WITH CHRONIC PAIN

## 2025 NATIONAL SURVEY REPORT

# TABLE OF CONTENTS

# INTRODUCTION & METHODOLOGY

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

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

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

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

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

# SCOPE AND SCALE OF PAIN

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

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

## Key Findings:

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

## Pain Is Multifaceted—And Rarely Isolated

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

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

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

## Specific Patterns of Overlap Reveal the Need for Comprehensive Care

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

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

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

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

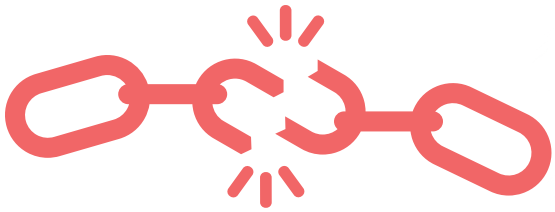
# THE FULL IMPACT OF CHRONIC PAIN

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

## Physical and Functional Impact

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

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



## Emotional and Social Disruption

The psychological toll is also severe:

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

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

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

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

## Differences Across Populations

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

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

## Stigma Still Shapes the Pain Experience

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

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

Common experiences included being labeled:

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

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

# THE MENTAL HEALTH TOLL—AND THE POWER OF PEER SUPPORT

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

## Psychological Distress Is the Norm, Not the Exception

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

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

## Emotional Isolation and Lack of Support

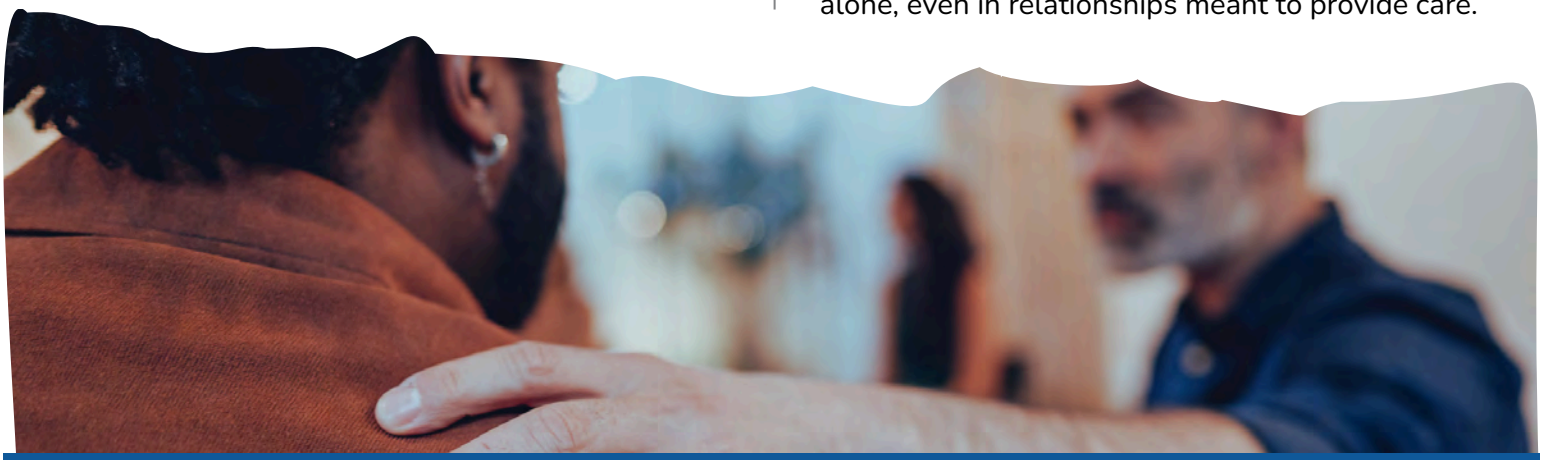
The emotional burden of chronic pain is intensified by social isolation. **90%** of respondents said they had missed social events in the past year due to their pain. Even more concerning, only **28%** said their family and friends are **very supportive**.

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

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

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

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



## Peer Support: A Path to Belonging and Validation

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

## Utilization and Impact

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

Reported benefits included:

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

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

## Who's Participating—And Who's Missing Out

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

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

## Why People Haven't Joined

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

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

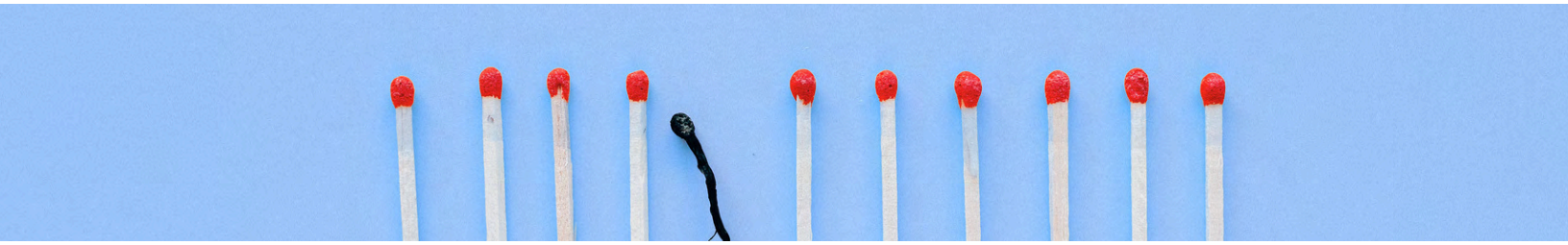
When asked what made a peer support group effective, respondents emphasized:

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

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

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

# CAREGIVING AND THE INVISIBLE WORKLOAD



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

## The Support Gap

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

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

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

### Caregiver Access by Income

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

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

# THE DIAGNOSTIC JOURNEY: TRUST, DELAYS, AND DISMISSAL

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

## How Long It Took

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

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

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

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

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

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

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

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

And for many, that road is unending.

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

## Most Common Suspected But Undiagnosed Conditions

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

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

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

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

## What Delays Diagnosis?

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

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

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

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

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

# GEOGRAPHIC AND STRUCTURAL BARRIERS TO PAIN CARE

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

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

## States with the Highest Reported Geographic Gaps

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

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

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

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

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

**GENERAL HEALTH CARE ACCESS ≠ CHRONIC PAIN CARE ACCESS.**

# COVERAGE WITHOUT CARE: THE HEALTH INSURANCE PARADOX

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

Survey respondents reported a wide range of insurance types:

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

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

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

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

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

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

## Disproportionate Impact on Low- and Middle-Income Households

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

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

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

## Bureaucratic Hurdles and Delays

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

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

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

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

## Frequency of Care Closely Tracked With Income

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

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

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

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

# NAVIGATING A FRAGMENTED SYSTEM: THE REALITIES OF PAIN MANAGEMENT

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

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

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

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

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

## Self-Management Is the Norm, Not the Exception

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

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

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

## Restorative Therapies Play a Key Role

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

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

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

## Complementary and Integrative Health: Cost and Access Matter

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

Several trends were noted among lower-income participants:

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

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

## Mind-Body Approaches Are Desired, But Disjointed

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

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

# PATIENTS WANT ACCESS TO A BROAD RANGE OF TREATMENTS.

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

## Prescription and OTC Medications: Widespread Use, Mixed Results

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

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

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

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

## Barriers to Opioid Access: Systemic and Unequal

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

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

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

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

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

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

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

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

## Neuromodulation: Noninvasive, Yet Underused

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

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

## Interventional Treatments Are Common—But Communication is Lacking

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

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

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

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

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

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

# CLINICAL TRIALS AND THE CHRONIC PAIN COMMUNITY

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

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

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

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

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

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

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

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

# THE MISSING PIECE: PATIENT EDUCATION

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

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

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

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

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

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

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

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

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

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

# ADVOCACY, REPRESENTATION, AND POLICY REFORM

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

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

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

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

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

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

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

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

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

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

## THE CHRONIC PAIN COMMUNITY IS READY TO LEAD.

# WHAT'S NEXT: NINE RECOMMENDATIONS FOR SYSTEMIC CHANGE

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

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

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

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

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

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

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

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

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

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

# CONCLUSION: A ROADMAP AND A WARNING


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

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

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

**This report is both a warning and a roadmap.**

It warns what happens when pain is ignored.

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

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

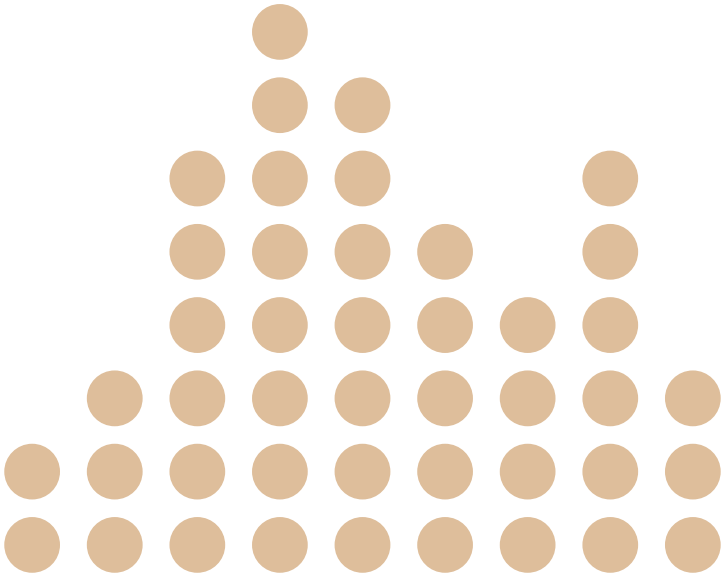
# ACKNOWLEDGEMENTS

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

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

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

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




U.S. PAIN
FOUNDATION

Comment #122

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

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

Good afternoon,

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

Effected population:

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

Identified issue:

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

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

Thank you,

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

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

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

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

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

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

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

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

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

External Email

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mims

Comment #124

To: Washington Medical Commission

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

Dear Members of the Washington Medical Commission,

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

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

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

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

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

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

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

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

With gratitude and respect,

Vicki Sulfaro

Comment #125

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

External Email

To the Members of the Washington State Medical Commission,

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

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

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

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

Thank you for your attention to this issue.

Respectfully,

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

# 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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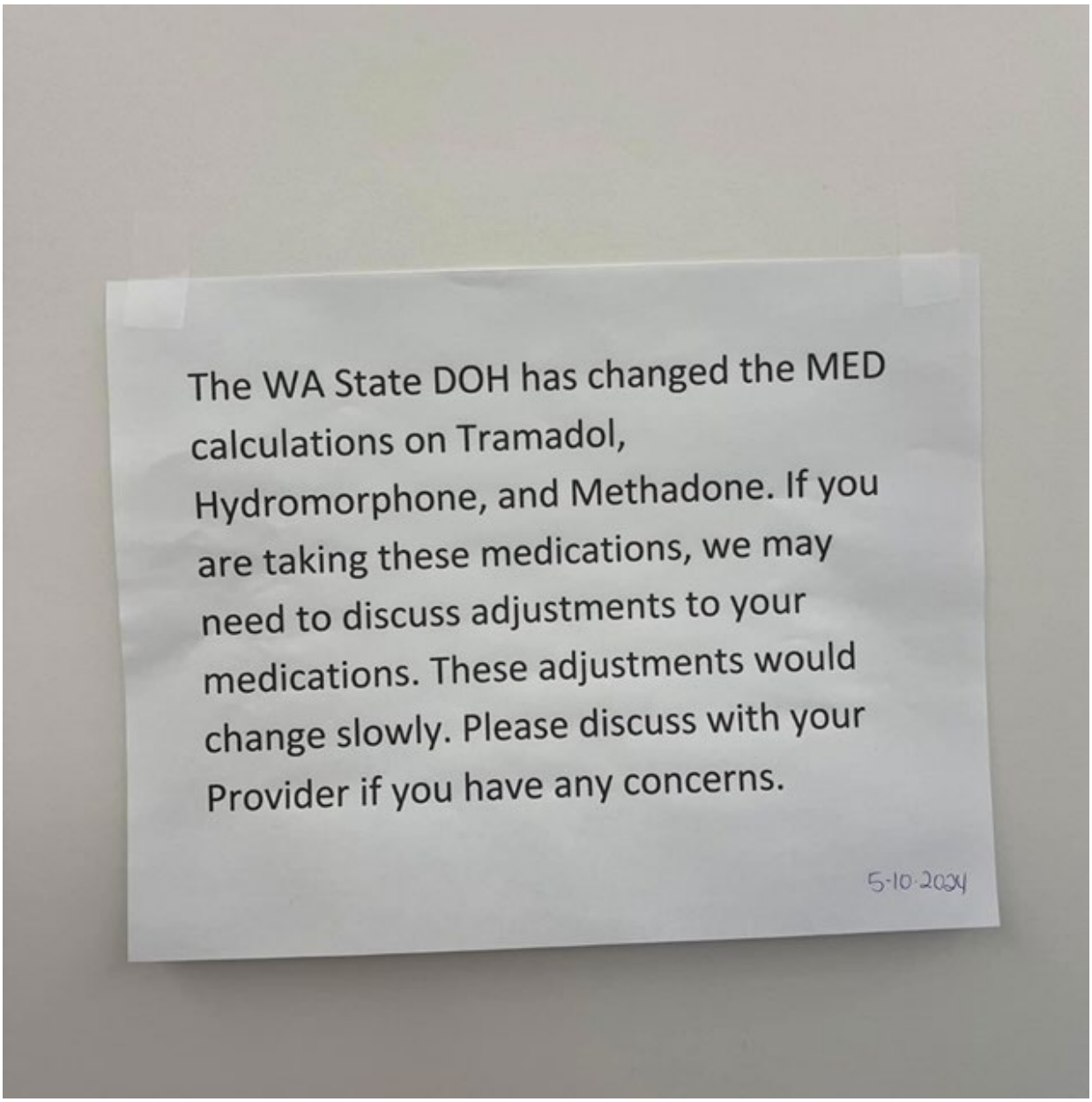
External Email

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

Changes in chronic noncancer pain treatment have led to decreases in prescribing of opioids and increases in the availability of medical cannabis, despite its federal prohibition. Patients may face barriers to establishing new care with a physician based on use of these treatments. We compared physician willingness to accept patients based on prescription opioid, cannabis, or other pain treatment use. This study of 36 states and Washington, DC, with active medical cannabis programs surveyed physicians who treat patients with chronic noncancer pain between July 13 and August 4, 2023. Of 1000 physician respondents (34.5% female, 63.2% White, 78.1% primary care), 852 reported accepting new patients with chronic pain. Among those accepting new patients with chronic pain, more physicians reported that they would not accept new patients taking prescription opioids (20.0%) or cannabis (12.7%) than those taking nonopioid prescription analgesics (0.1%). In contrast, 68.1% reported willingness to accept new patients using prescribed opioids on a daily basis. For cannabis, physicians were more likely to accept new patients accessing cannabis through medical programs (81.6%) than from other sources (60.2%). Access to care for persons with chronic noncancer pain appears to be the most restricted among those taking prescription opioids, although patients taking cannabis may also encounter reduced access"
Full study in link below:
https://academic.oup.com/healthaffairsscholar/article/2/6/qxae086/7691431?login=false

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**Brief Report**

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

# Access to care for patients with chronic pain receiving prescription opioids, cannabis, or other treatments

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## Abstract

Changes in chronic noncancer pain treatment have led to decreases in prescribing of opioids and increases in the availability of medical cannabis, despite its federal prohibition. Patients may face barriers to establishing new care with a physician based on use of these treatments. We compared physician willingness to accept patients based on prescription opioid, cannabis, or other pain treatment use. This study of 36 states and Washington, DC, with active medical cannabis programs surveyed physicians who treat patients with chronic noncancer pain between July 13 and August 4, 2023. Of 1000 physician respondents (34.5% female, 63.2% White, 78.1% primary care), 852 reported accepting new patients with chronic pain. Among those accepting new patients with chronic pain, more physicians reported that they would not accept new patients taking prescription opioids (20.0%) or cannabis (12.7%) than those taking nonopioid prescription analgesics (0.1%). In contrast, 68.1% reported willingness to accept new patients using prescribed opioids on a daily basis. For cannabis, physicians were more likely to accept new patients accessing cannabis through medical programs (81.6%) than from other sources (60.2%). Access to care for persons with chronic noncancer pain appears to be the most restricted among those taking prescription opioids, although patients taking cannabis may also encounter reduced access.

**Key words:** access to care; prescription opioids; opioid analgesics; cannabis; medical marijuana; survey; primary care; chronic pain.

## Introduction

The treatment landscape for chronic noncancer pain, which impacts more than 1 in 5 Americans,[1] has undergone significant shifts over the last decade. Treatment with prescription opioids has broadly declined in response to changing clinical guidelines and other policies designed to curb opioid misuse,[2] and the use of cannabis for chronic pain management has increased with state legalization of cannabis for medical conditions.[3] Contemporary guidelines emphasize the use of nonopioid, non-cannabis options as first-line treatment for chronic noncancer pain.[4-6] Anecdotally, there is stigma around prescription opioid use for chronic pain.[7] As physicians move away from treating pain with opioids, they may be less willing to accept new patients using prescription opioids to manage pain. Physicians may also be uncomfortable managing patients using cannabis, given that its use is not guideline-concordant and remains prohibited under federal law.

Consequently, patients with chronic noncancer pain may face barriers to initiating treatment with a physician if they use prescription opioids or cannabis for pain management. While caring for patients with chronic pain has been cited as one of the most difficult issues encountered by physicians, no studies have examined how access varies based on patients' use of different types of pain treatments.[8] To address these gaps, this investigation analyzed a national survey of US physicians treating patients with chronic noncancer pain in states with active medical cannabis programs in 2023. This study assessed physicians' willingness to accept new patients with chronic pain using prescription opioids, cannabis, and nonopioid prescription analgesics.

## Data and methods

In this cross-sectional web survey, we examined a national sample of physicians practicing in the 36 states and Washington, DC, with active medical cannabis programs in July–August 2023. Ipsos fielded the survey using the SurveyHealthcareGlobus physician survey panel. This opt-in panel includes approximately 800 000 US physicians (~75% of active US physicians) recruited from the American Medical Association (AMA) Masterfile, hospital directories, and other verified medical directories of physicians. For this study, physicians with specialties that commonly treat chronic noncancer pain (family medicine, internal medical, general medicine, anesthesiology, neurology, physical medicine,

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and rehabilitation) were included in the survey sample if they reported spending 50% or more of their professional time caring for patients, if they cared for 100 or more patients in the past year, and if they cared for any patients with chronic noncancer pain in an outpatient clinical setting in the past year. A screening survey identified eligible physicians, who were then invited via email to participate in a survey on "chronic non-cancer pain management." The survey was fielded from July 13, 2023, to August 4, 2023 (additional details in the eMethods). Respondents received an incentive between $20 and $30 for their participation in the survey.

We first asked physicians about their behaviors of whether they were accepting any new patients with chronic noncancer pain. Among physicians who responded "yes" to accepting new patients with chronic noncancer pain, we examined responses to the following questions about type of pain treatment: "Do you currently accept new patients with chronic noncancer pain who are managing their pain with [prescription opioids, cannabis, nonopioid prescription analgesics]?" Physicians who reported accepting new patients using opioids were asked about their preferences of whether they would accept patients who take prescribed opioids "on a daily basis" for pain. Physicians who reported accepting new patients using cannabis were asked whether they would accept "patients accessing cannabis through the state medical cannabis program" and/or "patients using cannabis obtained from sources other than the state medical cannabis program." Survey questions only allowed for binary (yes/no) responses. We calculated the proportion responding "yes" to each of these items.

All analyses incorporated survey sampling weights to generate estimates representative of physicians in the 36 states and Washington, DC, included in the sample, with the AMA physician Masterfile data used as the sample weighting benchmark. The variables analyzed in this report did not have missing data. The Weill Cornell Medical College Institutional Review Board approved this study.

## Results

Of 1372 physicians identified as eligible, 1000 (73%) completed the full survey (median age [SD], 52 [11.3] years; 34.5% female; 35.9% non-White) (eFigure S1). Most identified as primary care physicians (78.1%), and nearly half of physicians (46.5%) treated a panel with a proportion of patients with chronic pain between 1% and 33% (eTable S1). Only 26.7% of physicians reported completion of their state's authorization process for formally recommending patients for use of cannabis through the state program.

Overall, 82.8% of physicians reported currently accepting any new patients with chronic pain. Among this group, 20.0% (95% CI, 16.8%–23.2%) of physicians were not willing to accept new patients taking prescription opioids and 12.7% (95% CI, 9.9%–15.4%) were not willing to accept new patients taking cannabis. In contrast, 0.1% (95% CI 0.0%–0.2%) of physicians were unwilling to accept new patients taking nonopioid prescription analgesics (Figure 1). Physician characteristics did not differ among those who were not willing to accept patients taking prescription opioids when compared with those who were not willing to accept patients taking cannabis (eTable S2).

The proportion of physicians willing to accept new patients with chronic pain varied based on characteristics of analgesic use (Figure 2). For prescription opioids, while 80.0% (95% CI, 76.8%–83.2%) reported willingness to accept patients using any prescription opioids, 68.1% (95% CI, 64.4%–71.9%) reported willingness to accept new patients taking prescription opioids on a daily basis. For cannabis, physicians were more likely to accept patients accessing cannabis through medical cannabis programs (81.6%; 95% CI, 78.5%–84.7%) than those using cannabis obtained from other sources (60.2%; 95% CI, 56.1%–64.2%).

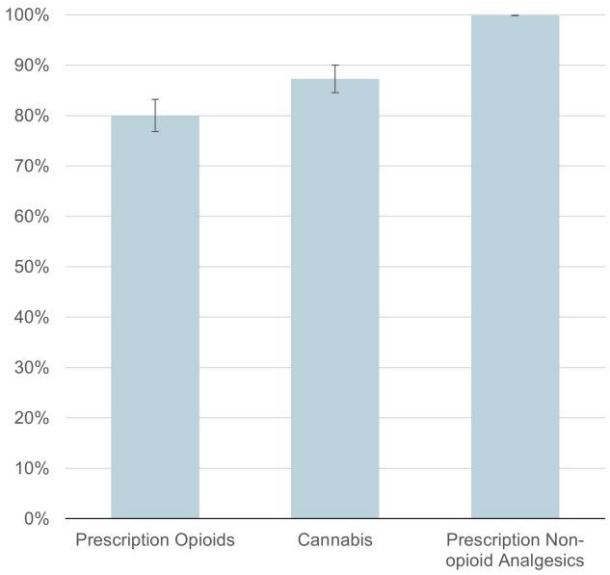


**Figure 1.** Proportion of physicians accepting new patients with chronic noncancer pain by type of existing chronic pain treatment. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13, 2023, to August 4, 2023, among respondents willing to accept new patients with chronic noncancer pain ($n = 852$). Measures signify the proportion responding "yes" to the question: "Do you currently accept new patients with chronic noncancer pain who are managing their pain with [prescription opioids, cannabis, nonopioid prescription analgesics]?" Error bars show 95% CIs. Results account for sampling weights.

## Discussion

Among physicians actively accepting new patients with chronic pain, 20.0% were unwilling to accept a new patient taking prescription opioids, while 12.7% were unwilling to accept a new patient taking cannabis. In contrast, few physicians (0.1%) were unwilling to accept a new patient taking nonopioid prescription analgesics. Physician acceptance of new patients was lower for patients using prescribed opioids on a daily basis and higher for those using cannabis obtained from medical programs compared with cannabis from other sources.

These findings build upon the small number of state-based studies that have uncovered reluctance among physicians to treat new patients taking prescription opioids.[9,10] A phone-based audit survey of primary care clinics in Michigan found that 41% of 79 clinics that were contacted would not accept new patients receiving prescription opioids as a treatment for chronic pain.[10] Study findings also suggest that people using medical cannabis for pain management may face access barriers. This lack of access could inadvertently encourage patients to seek nonmedical treatments for their chronic pain, given that relief of pain is the most commonly reported reason for misuse of controlled substances.[11] In response to concerns

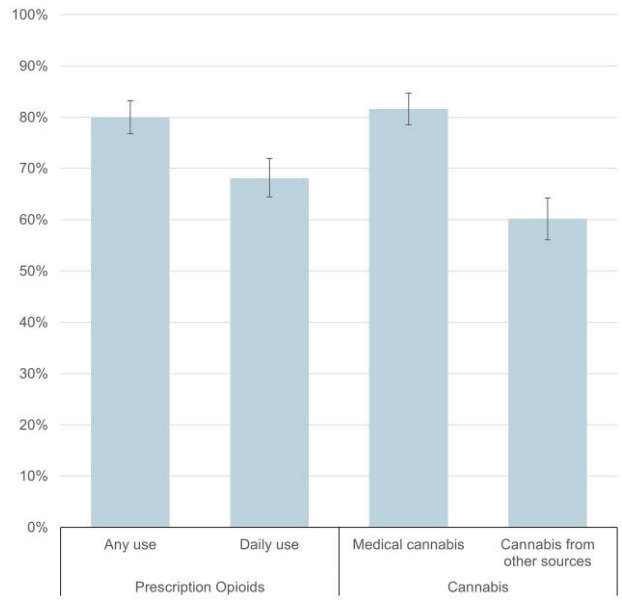


**Figure 2.** Proportion of physicians willing to accept new patients with chronic noncancer pain by frequency of prescription opioid use and source of cannabis for pain management. Measures are from a survey of physicians fielded by Ipsos using the SurveyHealthcareGlobus panel fielded from July 13,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

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## Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

## Access to data and data analysis

Dr. Stone had full access to all the data in the study, analyzed the data, and takes responsibility for the integrity of the data and the accuracy of the data analysis.

## Data availability

The data will not be shared per the data use agreement with Ipsos, which only allows access by the study team.

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