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**NOTICE OF ADOPTION OF AN INTERPRETIVE STATEMENT**

**Title of Interpretive Statement:** Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants (INS2019-01)

**Issuing Entity:** Washington Medical Commission

**Subject Matter:** Opioid Prescribing

**Effective Date:** March 8, 2019

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# Interpretive Statement

Title:	Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants	INS2019-01
References:	<a href="#">RCW 18.71.800</a> ; <a href="#">RCW 18.71A.800</a> ; <a href="#">WAC 246-919-850</a> through <a href="#">WAC 246-919-985</a> ; <a href="#">WAC 246-918-800</a> through <a href="#">WAC 246-918-990</a>	
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Approved By:	Alden Roberts, MD, Chair (signature on file)	

## Description of the Issue

The Washington Medical Commission (Commission) is aware of concerns by practitioners that the Commission’s opioid prescribing rules are inflexible and do not allow for variation based on patient presentation. The Commission is also aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids.

## Interpretive Statement

[WAC 246-919-850](#)—Intent and scope, and its corresponding Washington Administrative Code for allopathic physician assistants ([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. The Commission in [WAC 246-919-850](#) and [WAC 246-918-800](#) encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

It is important to note that the rules are not inflexible and recognize the importance of sound clinical judgment. Those concerned about the use of the word “shall” within the rules are encouraged to consider the Intent Section. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire opioid prescribing ruleset by the Commission. The intent provision explicitly states that the rules are not inflexible and repeatedly recognizes the importance of clinical judgment.

## Background

The Commission established rules for managing chronic, noncancer pain in 2011 to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. In 2017, [Engrossed Substitute House Bill 1427](#) required the Commission to create new rules regarding opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids. The Commission made minor modifications to the current chronic pain rules in 2018 as well. Opioid prescribing rules for all phases of pain are effective January 1, 2019.

## Analysis

The new opioid prescribing rules describe the Commission's intent and scope of the rules as follows:

"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 [practitioners] should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing opioids, including co-occurring prescriptions. ...

... 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.

These rules are designed to assist [practitioners] in providing appropriate medical care for patients. The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist [practitioners] 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.”

## Commonly Asked Questions

### *1. What is episodic care and how does it apply to my practice?*

For the purpose of these rules, episodic care usually includes patients seen in an emergency department or urgent care facility for chronic pain when complete medical records are not available. Additionally, patients seen in an ambulatory care setting with complaints associated with chronic pain whose complete medical records are not available would also be covered by this rule. However, some healthcare systems and clinics may have an associated urgent care facility with complete availability of medical records. These facilities would be excluded from the definition of episodic care for the purposes of these rules.

### *2. Does the rule define the entire standard of care for the management of pain?*

No. The contents of the rules do address some important elements of the standard of care for pain management, but they do not define the entire standard of care. The rules are not exhaustive. The standard of care (current practice guidelines articulated by expert review) will continue to control circumstances and issues not addressed by the rule.

### *3. Is the 120 mg. (MED) “consultation threshold” a maximum dose under the rules?*

No. The 120 mg. (MED) threshold is a triggering dose, intended to alert the practitioner to the fact that prescribing at this dose or higher significantly increases the potential for morbidity and mortality, and requires a consultation with a pain specialist unless the practitioner or circumstances are exempted under the rules. The articulation of this dose in the rules is consistent with the legislature’s requirement in ESHB 2876 to adopt rules that contain a dosage amount that must not be exceeded without pain specialist consultation.

Some have referred to the 120 mg. (MED) threshold (or “triggering”) dose as a “maximum dose”. The rules do not provide a maximum dose. They simply require, absent an exemption, that the practitioner obtain a pain specialist consultation before continuing on to prescribe opioids at a level that is associated with significant increases in opioid-related overdoses and deaths.

### *4. Is the 120 mg. (MED) “consultation threshold” the minimum dosage at which a consultation should be obtained under the rules?*

No. A physician or physician assistant should obtain a consultation when warranted. In [WAC 246-919-860\(2\)](#) and [WAC 246-918-810\(2\)](#), the threshold for mandatory consultation is set at 120 mg. (MED) for adult patients. However, [WAC 246-919-860\(1\)](#) and [WAC 246-918-810\(1\)](#) reference, more generally, additional evaluation that may be needed to meet treatment objectives. This provision

makes specific reference to evaluation of patients under age 18 who are at risk, as well as patients with co-morbidity psychiatric disorders. However, other circumstances may call for a consultation with a pain management specialist for patients who have not yet met the threshold dose.

#### Specific Guidance from the Rules

[WAC 246-919-955](#) and [246-918-905](#) provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- New patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:
  - The patient was previously being treated for the same conditions;
  - The dose is stable and nonescalating;
  - There is a history of compliance with written agreements and treatment plans; and
  - There is documented function improvements or stability at the presenting dose.

[WAC 246-919-950](#) clearly explains that tapering would be expected for chronic pain patients when:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- Evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- Unauthorized escalation of doses;
- An authorized escalation of dose with no improvement in pain or function.

A patient on a stable, non-escalating dose with positive impact on function would be exempt from any need for additional consultation with a pain specialist regarding treatment. Additionally, there is no upper MED limit in Washington State or federal law. The Centers for Disease Control (CDC) has a 90 MED descriptor in their guidelines, which, while a valid indication for consultation, does not have the force of law in Washington. The Commission's opioid prescribing rules represent the only legal requirement and cite a 120 MED consultation threshold for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. For those practitioners not considered pain management specialists treating patients over the 120 MED consultation threshold, there are several options to satisfy the exemption consultation requirement, including but not limited to:

- Receive a peer-to-peer consult with a pain management specialist;
- Participate in an electronic (audio/video) case consult such as the University of Washington (UW) Telepain or the Washington Health Care Authority (HCA) Opioid Hotline;
- Chart note documenting the attempt to get a consult but lack of success in attaining one;
- For a full list of options to satisfy the exemption consultation requirement, please see the rules.

For all of these options, documenting the outcomes or reasoning in the patient medical record satisfies the consultation exemption and would be part of the normal course of medical practice to do so.