OPIOID PRESCRIBING—GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist. and ~~the~~ prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required, but physicians and the institution and employers they work with must understand that the medical practice act of Washington and commission rules supersede any federal guidelines relating to the practice of

medicine or prescribing of opioids for pain control. Individualized patient assessment should be the focus of a physician's care. A physician should not rely solely on rigid guidelines to establish dosage limits or to implement tapering of a patient's medication.

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

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

Commented [DB1]: Suggested language from Higginbotham petition: "Add the following language: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by the specific morphine milligram equivalent (MME) guidelines."

Also noted in -905.

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

Commented [DB2]: Distilled language from our Interpretive Statement: WMC IS Opioid Prescribing for MDs & PAs WSR #25-11-078.pdf

These rules are designed to assist physicians in providing appropriate medical care for patients.

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

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist physicians in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

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

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

Physicians

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

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

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

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

(4) The treatment of chronic non-cancer pain except as described in WAC 246-919-905 through -980;

(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;

Commented [DB3]: Suggested language from Higginbotham petition: "Add exemption: Rare diseases-patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National Institutes of Health (NIH) are exempt from the guidelines and/or policies."

NORD's list of 1,500 rare disease: List of Rare Diseases | A-Z Database | NORD

Commented [DB4]: MM: A suggestion from community to consider. See the proposed revisions to that section below for more details related to how this could look.

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

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

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

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050. WSR 25-05-091, 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 phase and into the remission phase.

(5) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or which may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain is ~~considered to be~~ 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~~ ninety-milligram morphine equivalent dose (MED), or more, per day.

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

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

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

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

(13) "Low-risk" is a category of 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~~ 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 patients at moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, ~~past~~ history 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 illnesses.

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

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

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

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

(24) "Subacute pain" is ~~considered to be~~ 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) The physician shall discuss with the patient the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic:

(a) Risks associated with the use of opioids, including the risk of dependence and overdose, as appropriate to the medical condition, the type of patient, and the phase of treatment;

(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments,

whenever reasonable, clinically appropriate, evidence-based alternatives exist;

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

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

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

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

(a) Emergent care;

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

(c) Procedures involving the administration of anesthesia;

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

(e) MAT for substance use disorders.

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

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

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

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

[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017,

18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]

WAC 246-919-870 Use of alternative modalities for pain treatment. The physician shall exercise their professional judgment in selecting appropriate treatment modalities for acute nonoperative, acute perioperative, subacute, or chronic pain including the use of multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist. Patient function and quality of life are the paramount concerns when considering treatment alternatives.

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

WAC 246-919-875 Continuing education requirements for opioid prescribing. (1) To prescribe an opioid in Washington state, a physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids or the opioid

prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the physician's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The hours spent completing training in prescribing ~~of~~ 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.

(4) The physician shall reevaluate the patient who does not follow the expected course of recovery~~,~~ and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC

246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(7) Long-acting or ~~extended~~ extended-release opioids are not indicated for acute nonoperative pain.

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

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

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

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

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

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

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

(4) The physician shall reevaluate a patient who does not follow the expected course of recovery and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(7) Long-acting or ~~extended~~ extended-release opioids are not indicated for acute perioperative pain.

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

(9) If the physician elects to treat a patient with opioids beyond the six-week ~~time~~ period of acute perioperative pain, the physician shall document in the patient record that the patient

is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-919-895 and 246-919-900 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-890, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-919-895 Patient evaluation and patient record—Subacute pain. The physician shall comply with the requirements in this section when prescribing opioids for subacute pain.

(1) Prior to issuing an opioid prescription for subacute pain, the physician shall assess the rationale for continuing opioid therapy as follows:

(a) Conduct an appropriate history and physical examination;

(b) Reevaluate the nature and intensity of the pain;

(c) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-919-985;

(d) Screen the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(e) Obtain a biological specimen test if the patient's functional status is deteriorating or if pain is escalating; and

(f) Screen or refer the patient for further consultation for psychosocial factors if the patient's functional status is deteriorating or if pain is escalating.

(2) The physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following is documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode;

(c) Pertinent concerns discovered in the PMP;

(d) An appropriate pain treatment plan including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

(e) The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;

(f) Results of psychosocial screening or consultation;

(g) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies; and

(h) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

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

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

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

(2) If the physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain that is severe enough to require opioids. During the subacute phase the physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.

(3) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC

246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(4) If the physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the physician shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-919-905 through 246-919-955, shall apply.

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

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

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

(1) An appropriate history including:

(a) The nature and intensity of the pain;

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

Proposed draft language: Nothing in this section shall be construed to require that prescribing or patient care be predetermined solely by a specific MME threshold. MME levels are intended to guide, not mandate, clinical decisions.

Commented [MM6R5]: I believe this is covered in the preamble/intro section.

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

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

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

(e) Whether and how the pain interferes with the patient's activities of daily living, including but not limited to mobility, self-care, occupational or educational functioning, and social engagement.

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

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

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

(c) Pertinent consultations; and

(d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for

characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.

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

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

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

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

(d) Pertinent concerns discovered in the PMP.

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

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

WAC 246-919-910 Treatment plan—Chronic pain. The physician, having recognized the progression of a patient from

the subacute phase to the chronic phase, shall develop an opioid treatment plan as follows:

(1) Treatment plan and objectives including:

(a) Documentation of any medication prescribed;

(b) Biologic specimen testing ordered;

(c) Any labs, diagnostic evaluations, referrals, or imaging ordered;

(d) Other planned treatments; and

(e) Written agreement for treatment as provided in WAC 246-919-915.

(2) The physician shall complete patient notification in accordance with the provisions of WAC 246-919-865 or provide this information in the written agreement.

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

Commented [DB7]: Is this section necessary? MM notes that practitioners would have a treatment plan for any patient with a condition as it is the standard of care.

WAC 246-919-915 Written agreement for treatment—Chronic pain. The physician shall use a written agreement that outlines the patient's responsibilities for opioid therapy. This

written agreement for treatment must include the following provisions:

(1) The patient's agreement to provide samples for biological specimen testing when requested by the physician. Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physicians should not dismiss patients from care on the basis of a biological specimen test result alone;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;

(3) Reasons for which opioid therapy may be discontinued;

(4) The requirement that all opioid prescriptions for chronic pain are provided by a single prescriber or a single clinic, except as provided in WAC 246-919-965 for episodic care;

(5) The requirement that all opioid prescriptions for chronic pain are to be dispensed by a single pharmacy or pharmacy system whenever possible;

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

(7) A violation of the agreement may result in a tapering or discontinuation of the prescription; and

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

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

WAC 246-919-920 Periodic review—Chronic pain. ~~(1)~~ The physician shall periodically review the course of treatment for chronic pain. When conducting periodic reviews of patients receiving chronic opioid therapy, physicians must evaluate all relevant clinical factors, including patient adherence, stability, and functional status. Treatment plans should not be altered or discontinued solely due to the patient exceeding morphine milligram equivalent (MME) dose thresholds or other numeric limits if the patient remains stable and compliant with the treatment plan. Any modifications must be justified by

clinical indications and documented in the patient record to support individualized care and maintain patient safety.

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

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

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

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

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

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

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

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's

Commented [DB8]: This addition 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.

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.

Commented [DB9]: MM suggests that keeping the above edit and deleting this highlighted portion would make the review more flexible and less intrusive on the patient.

[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.

Commented [DB10]: MM suggests changing this to "shall" to make this a requirement, or delete this section entirely.

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

WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain. (1) The physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should

be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.

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

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

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

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

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

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

(e) Participation in peer case presentations, such as Project ECHO (Extension for Community Healthcare Outcomes), an evidence-based tele-mentoring program that connects healthcare providers with specialists to discuss complex cases, or similar programs. 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;

Commented [DB11]: Suggested addition from MM.

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

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

WAC 246-919-935 Consultation—Exemptions for exigent and special circumstances—Chronic pain. A physician is not required to consult with a pain management specialist as defined in WAC 246-919-945 when the physician has documented adherence to all standards of practice as defined in WAC 246-919-905 through 246-

919-925, and when one or more of the following conditions are met:

(1) The patient is following a tapering schedule;

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

(3) The physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or

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

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

WAC 246-919-940 Consultation—Exemptions for the physician—Chronic pain. The physician is exempt from the

consultation requirement in WAC 246-919-930 if one or more of the following qualifications is met:

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

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

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

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

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

WAC 246-919-945 Pain management specialist—Chronic pain. A pain management specialist shall meet one or more of the following qualifications:

(1) If an allopathic physician or osteopathic physician:

(a) Is board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, neurology, rheumatology, or anesthesiology;

(b) Has a subspecialty certificate in pain medicine by an ABMS-approved board;

(c) Has a certification of added qualification in pain management by the AOA;

(d) Is credentialed in pain management by an entity approved by the commission for an allopathic physician or the Washington state board of osteopathic medicine and surgery for an osteopathic physician;

(e) Has a minimum of three years of clinical experience in a chronic pain management care setting; and

(i) Has successful completion of a minimum of at least 18 continuing education hours in pain management during the past

two years for an allopathic physician or three years for an osteopathic physician; and

(ii) Has at least 30 percent of the allopathic physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) If a physician assistant, in accordance with WAC 246-918-895.

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

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

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

[Statutory Authority: RCW 18.71.017 and 2020 c 80. WSR 24-23-042, 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 chronic pain patients will 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;

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

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

(4) Other treatment modalities are indicated;

Commented [DB12]: 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 [DB13]: This proposed language is to add clarity and express the intention of these tapering considerations.

Commented [MM14R13]: This is one of the spots I think it is appropriate to have this. Suggest limiting to here and the intent section.

(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~~ly~~ and

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. Alternation of treatment plans should not occur outside of the circumstances listed in WAC 246-919-950. [NOTE]

(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 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.

Commented [DB15]: Alternate language to the note below, suggested by MM.

Commented [DB16]: Suggested language from Higginbotham petition: "Treatment plans should not be altered or changed unless a violation occurs."

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

(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. [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.~~

~~(2) Pregnant patients.~~ The physician shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment for opioids, such as methadone or buprenorphine, must not be

Commented [DB17]: Edits suggested here from MM with a note that the adolescent and aging populations requirements are basic medicine and keep just the pregnant patients requirements.

discontinued during pregnancy without consultation with a MAT prescribing practitioner.

~~(3) Aging populations. As people age, their sensitivities to and metabolizing of opioids may change. The physician shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.~~

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

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

(1) When providing episodic care for a patient who the physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the physician or their designee, shall review the PMP and document their review and any concerns.

(2) A physician providing episodic care to a patient who the physician knows is being treated with opioids for chronic pain should provide additional analgesics, including opioids when appropriate, to adequately treat acute pain. If opioids are provided, the physician shall limit the use of opioids to the

minimum amount necessary to control the acute pain until the patient can receive care from the practitioner who is managing the patient's chronic pain.

(3) The episodic care physician shall coordinate care with the patient's chronic pain treatment practitioner, if possible. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-919-970 Coprescribing of opioids with certain medications. (1) The physician shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics.

(2) If, because of a prior prescription by another provider, a prescription written by a physician results in a

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

(3) While appropriate clinical rationale and consultation must be documented when prescribing opioids concurrently with other central nervous system depressants, such requirements must not be used as a sole justification for withholding or discontinuing care from patients who are otherwise stable and compliant with their treatment plan. Treatment decisions must be based on medical decision-making that reflects a balanced evaluation of risks, benefits, and patient stability.

Commented [DB18]: MM suggests not including this edit as it is stated in the intent section.

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

WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the physician providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be

receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.

(2) When co-prescribing opioids and medications used for the treatment of opioid use disorder, documentation of clinical rationale and coordination of care is required. However, the presence of MAT or related medications must not be used as the sole reason to deny opioid therapy to patients who are stable, compliant, and for whom such treatment is clinically justified. Individualized treatment decisions must be based on a balanced evaluation of risk, benefit, and patient stability.

Commented [DB19]: Note from MM that this is redundant as it is included in the intent section and the tapering section.

(~~2~~3) 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. The patient is not required to accept or fill the prescription as a condition of continued treatment.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800, 18.71.810 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation. The Prescription Monitoring Program (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 when considered alone and on its merits. Use of the PMP must support safe, coordinated, and informed patient care. PMP data must not be used as the sole justification to withhold,

Commented [DB20]: BOMS: WAC 246-853-785:

Commented [DB21]: The definitions for high, moderate, and low risk should remain if we do not change this.

Commented [DB22]: Supported by RCW 18.71.810: RCW 18.71.810: Opioid drugs—Right to refuse.

Commented [DB23]: BOMS rule: WAC 246-853-790:

taper, or discontinue treatment for patients who are stable and compliant with their treatment plan.

(1) The physician shall register to access the PMP or 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 [DB24]: MM: Suggests deleting (4). Reduced requirement on practitioner and patient. Rely on aberrant behavior standard and requirements in written agreement.

(5) The physician shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.

(6) The physician shall ensure a PMP query is performed when providing episodic care to a patient who the physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-919-965.

(7) If the physician is using an electronic medical record (EMR) that integrates access to the PMP into the workflow of the EMR, the physician shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-919-970.

(8) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the EMR cannot be accessed by the physician or their designee due to a temporary technological or electrical failure.

(9) Pertinent concerns discovered in the PMP shall be documented in the patient record.

(10) The physician must exercise individualized medical decision-making when interpreting and acting on data obtained from the PMP. Any decisions based on PMP findings must be documented in the patient record.

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

Commented [DB25]: MM provided different suggested language: Decisions based on PMP findings must reflect individualized medical decision-making and be documented accordingly.