



EXTRA! EXTRA!

Information about Opioid Prescribing and Monitoring

Medical Commission Chair Response to the New Opioid Rules

Alden Roberts, MD, MMM, FACS

In 2017, the legislature passed Engrossed Substitute House Bill 1427, which basically said that there is a prescribing problem that aggravates the opioid problem in this country. They were correct, and they charged the prescribing entities to fix it.

To the legislature's credit, they let practitioners do so rather than trying to fix it themselves. They did not say that the cause of the "opioid epidemic" was bad doctors or bad prescribing, and that statement would have been patently incorrect. However, they did have expectations which, if we had not addressed, they certainly would have.

One of the big problems in developing rules of this type is that it is really difficult to work on a pain

management process in which best practice isn't the goal. Regulatory bodies cannot make rules designed to achieve "best practice," because not everyone agrees on what best practice looks like, because best practices change with new information, and not every patient follows the pathway that best practice recommendations are based on. Rules are designed to assess what is minimally acceptable practice. You are encouraged to review the best practices from the AMDG, CDC, and Bree Collaborative.

The majority of changes in these rules revolves around three areas:

1. Registration and use of the PMP;
2. Acute non-operative pain and Acute perioperative pain;



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3. The transitions between acute and subacute pain and subacute and chronic pain;

There are minimal changes around the treatment of chronic pain.

Registration and use of Prescription Monitoring Program (PMP):

1. Providers who prescribe schedule II-V medications must be registered with the PMP or otherwise have access to the PMP through their work. A lot of folks may need to learn how to access and use this service. The DOH website has a walkthrough and videos to help you through the process. *Continued on next page*



Prescription Monitoring Program

The WMC has been made aware that the WA PMP is not the easiest program to sign-up for, or access, when it is not integrated into the EMR. WA PMP was developed and is maintained by the Department of Health. Your Medical Commission has no authority to modify or replace the current system.

Full Story on Page 4



Opioid Prescribing and Monitoring FAQ

We know that you must have more questions than this PDF can provide, so we have created a FAQ with some of our most common questions. If you would like to request the Medical Commission answer your questions in person, send us an email.

Answers on Page 6



Program Manager Words of Wisdom

The new opioid prescribing rules for allopathic physicians and physician assistants will be effective January 1, 2018. We have begun our education efforts regarding the changes to opioid prescribing. I encourage you to contact me with any questions you may have about these new rules.

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2. Providers for whom the PMP is integrated with their EMR need to check the PMP every time opioids or sedatives are prescribed.
3. Providers for whom the PMP is not integrated into their EMR have less stringent requirements because the process is cumbersome, time consuming and can be very frustrating. But while these providers don't have to check the PMP every time, best practice is to do so, if possible.

Acute Non-operative pain and Acute Perioperative Pain

Acute Non-operative pain and Acute Perioperative Pain are new areas for pain rules. The problem that is being addressed in the treatment of acute non-operative and perioperative pain has several origins:

1. There are many problems for which opioids have been prescribed in the past for which opioids are not the best choice of treatment. Alternatives to opioids should be considered when appropriate.
2. Leftover opioids are problematic. Most of us don't know how many pills our patients take after surgery or after an ankle fracture. For example: After a surgery I had, I received 60 oxycodone and used two. There are a few recent studies that look at this, and AMDG has established recommendations based on literature for this problem. While more than 1/2 of substance use disorder patients say that they started on prescription opioids, those opioids were often originally prescribed for someone else.
3. It is really easy for an operative patient or an injured patient to continue to get refills of opioids for a much longer time than intended, and safety checks are usually neglected.
4. The co-prescribing of opioids and sedatives, while fairly common after injury or surgery, is a dangerous combination. The rules say don't do this unless you are able to document why this is appropriate.

The Transition Areas: Acute to Subacute, and Subacute to Chronic

This brings us to the third major change in the rules: the transition from acute pain to subacute pain that occurs at 6 weeks of pain, and from subacute pain to chronic pain at 12 weeks.

While these durations of pain are by definition arbitrary, these are high risk periods, and patients need to be reassessed regarding the effectiveness of the pain medication at around 6 weeks, when they enter the subacute phase of pain, and again at 12 weeks when they enter the chronic phase of pain. Thoughtless renewal of pain medications in these patients is problematic and can lead to substance use disorder.

Treating patients in pain

Pain is like any other symptom or disease, but most of us haven't had very much training in how to optimally take care of patients in pain. As a surgeon, my training consisted of how to write a prescription.

The goal of practitioners who take care of patients in pain should be to learn how to take excellent care of those patients, during the acute phase, the subacute phase, and in some practices, the chronic phase. Practitioners need to manage their own continuing medical education based on the patients they see.

For a lot of reasons, many practices have already ceased to care for patients with chronic pain. Fear of discipline should not be one of those reasons, but it appears to be. As with most disciplinary actions initiated by the Medical Commission, sanctions surrounding treatment of chronic pain involve treatment that most practitioners (and many lay people) would recognize as clearly being well below standard of care. Fear of the rules or of disciplinary action should not be used as an excuse to not manage these patients.

In conclusion, there are four major take-aways that I think are important.

1. Learn how to treat pain well. The purpose of these rules is to avoid inappropriate treatment of pain. This includes non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments.
2. The Medical Commission has no interest in disciplining good physicians and physician assistants who are trying to do a good job, but as with any other disease process, providers may need to justify and document why they are managing things the way they are.
3. There are a few changes to the management of chronic pain, but not all that many. However, there are new sections that relate to the management of acute non-operative pain, acute perioperative pain, and the transitions to subacute and chronic pain. You need to be familiar with these changes.
4. And finally, practitioners need to register with the Prescription Monitoring Program, and to use the PMP appropriately for their circumstances.

Changes to Opioid Prescribing and Monitoring



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Purpose:

The Washington Medical Commission has revised and updated opioid prescribing rules. This one sheet provides high level information regarding these changes that will assist you in providing appropriate medical care for patients.

Important Terms:

For the purpose of these rules:

- Inappropriate treatment of pain includes non-treatment, under treatment, overtreatment and the continued use of ineffective treatments.
- Pain includes: acute, perioperative, subacute and chronic. These rules do not apply to palliative, in-patient hospital care, procedural medications and cancer related treatments.
- Children and adolescent patients should be treated based on weight of the patient and adjust the dosage accordingly.

What you need to know:

- These rules will be effective January 1, 2019.
- Prescriptions must not be written for more than is needed for effective pain control. The rules provide specific timelines for each phase of pain, you must document the justification for such a quantity.
- [PMP](#) checks are required at first refill/renewal, during a pain phase transition and periodically based on the patients risk level.
- Prescribing opioids must be based on clear documentation of unrelieved pain.

What you need to do to prescribe opioids:

- Give the patient resources regarding the risks associated with opioids as well as the safe storage and disposal of opioids, at the first issuance of an opioid prescription and when the patient transitions to another pain phase.
- Complete 1 hour of opioid prescribing CME by the end of your next full CME reporting period after January 1, 2019.

Additional resources:

[Agency Medical Director's Group](#)

[The Centers for Disease Control and Prevention](#)

[Bree Collaborative](#)

[WMC Pain Info](#)

Rumor Busting

Rumor: You will no longer be able to prescribe opioids for chronic pain patients.

Fact: These rules do not change your ability to prescribe opioids to chronic pain patients. These rules do not impose a prescribing limit. In fact, you can prescribe up to 120 MED without the need to consult a pain management specialist. As in the [2012 Pain Management Rules](#), when prescribing in excess of 120 MED first consult with a pain management specialist and document such in the patient record.

Important Information about the Prescription Monitoring Program (PMP)



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PMPs continue to be among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk. Although findings are mixed, evaluations of PMPs have illustrated changes in prescribing behaviors, use of multiple providers by patients, and decreased substance abuse treatment admissions.

The Medical Commission has been made aware that the Washington PMP is not the easiest program to sign-up for, or access, when it is not integrated into the EMR. [Washington's PMP](#) was developed and is maintained by the Department of Health. Your Medical Commission has no authority to modify or replace the current system.

Resources

While the Medical Commission has no authority or ability to make the PMP easier for you to use, we would like to point out a few resources that may make registering and accessing the PMP easier.

- If you need assistance, [email the PMP Program](#)
- [Registration instructions](#)
- [PMP Training Guide for Healthcare Practitioners](#)
- YouTube video: "[How to obtain a SAW account](#)"
- YouTube video: "[How to Register for PMP Access](#)"
- YouTube video: "[Practitioner Overview and Tutorial Compilation](#)"
- [Provider FAQ](#)

Notice:

If you received a brochure like the one on the right, please be advised, it does NOT contain the requirements for MDs and PAs. The WMC Opioid Prescribing booklet (read it here) with new rules for MDs and PAs will arrive to your mailbox soon. Make sure you are signed up to receive opioid updates via email at: <https://goo.gl/B5FHn3>.

Ease of Use Project

The PMP is working with our state Health Information Exchange (HIE) providing connectivity and [deploying solutions for seamless interfaces](#) between electronic medical record systems and the PMP. Healthcare providers who don't have access to this technology still need access to the PMP, and in a way that isn't overly burdensome or cumbersome. Solutions to make PMP web portal access easier, can't wait.

DOH is gathering feedback and evaluating options in collaboration with providers and professional associations. [Be a part of developing solutions](#) that effectively balance the need for security with ease of use to support provider use of the PMP in Washington.

PMP Reporting

As part of [ESHB 1427](#), the PMP is required to report on PMP usage to the provider, the governor's office and the appropriate committees of the legislature. As a registered user of the PMP you may receive the "Opioid Prescriber Feedback Report" (example on page 5). This should not cause you anxiety or alarm. This is simply an informational report for you to use as a self-assessment tool. If you think the information on the report is inaccurate, you should [email](#) the PMP as soon as possible.



2018 Washington State Opioid Prescribing Requirements



Guide for Pharmacists

Pharmacy Related Highlights

- Engrossed Substitute House Bill 1427 passed in 2017, requiring opioid prescribing requirements be written in response to the statewide opioid crisis.
- The new requirements for advanced registered nurse practitioners, osteopathic physicians, osteopathic physician assistants, and podiatric physicians become effective November 1, 2018.
- The requirements for allopathic physician assistants and MDs become effective January 1, 2019. The new requirements for dentists have not yet been adopted.
- The new opioid prescribing rules do not apply to treatment for cancer-related pain, inpatient hospital patients, procedural pre-medications, or palliative, hospice, or other end-of-life care.
- Health care practitioners must confirm or provide naloxone when prescribing opioids to a high risk patient or as clinically indicated (ARNP requirement for naloxone when 50 MED or above).
- Pharmacists with a Collaborative Drug Therapy Agreement for pain management prescriptions should consider the appropriate prescribing rules for their partnering practitioner.

Prescriber Name:

Specialty:

NPI #:

No. of patients aged ≤20 years:

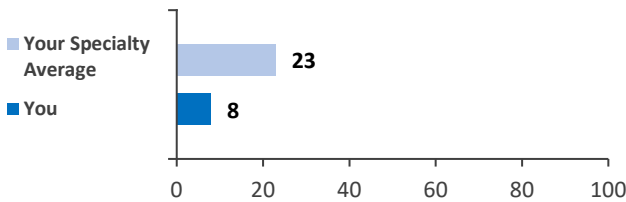
No. of patients aged ≥21 years:

Reporting Period: 01/2018–04/2018



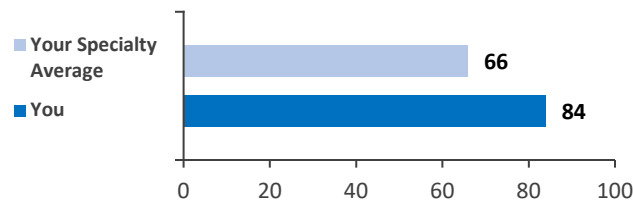
Washington State Opioid Prescriber Feedback Report

You are receiving this feedback report from the Washington State Department of Health because at least one of your prescribing measures below lies at or above the 95th percentile of all prescribers within your specialty. This report is authorized by Engrossed Substitute House Bill 1427, and in partnership with the Washington State Hospital Association, the Washington State Medical Association, and the Washington State Health Care Authority. The purpose of this report is to self-assess your opioid prescribing practices compared to those of your peers. Please review the following metrics based on your prescribing data in the Prescription Monitoring Program (PMP), and see recommendations for improving care on page 2.



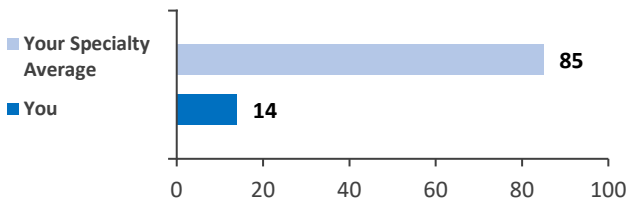
% ACUTE OPIOID PRESCRIPTIONS >18 DOSES FOR PEDIATRIC PATIENTS

Number of acute (<60 days' supply) opioid prescriptions for pediatric patients (≤20 years) containing >18 doses divided by the total number of acute opioid prescriptions for pediatric patients containing any dose in the current quarter



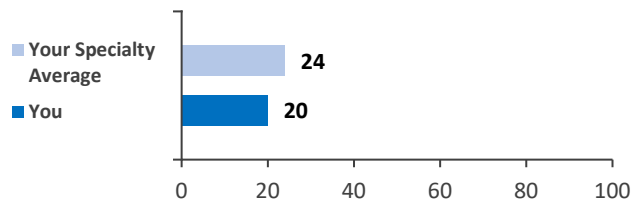
% ACUTE OPIOID PRESCRIPTIONS >42 DOSES FOR ADULT PATIENTS

Number of acute (<60 days' supply) opioid prescriptions for adult patients (≥21 years) containing >42 doses divided by the total number of acute opioid prescriptions for adults containing any dose in the current quarter



% NEW PATIENTS WITH >7 DAYS' SUPPLY OF OPIOIDS

Number of patients with a new (no opioid prescription in the previous quarter) opioid prescription with >7 days' supply (but less than 60) in the current quarter divided by the total number of patients with a new opioid prescription in the current quarter



% PATIENTS WITH CONCURRENT OPIOID AND SEDATIVE PRESCRIPTIONS

Number of patients who receive ≥1 day(s) of overlapping opioid and sedative prescriptions in the current quarter divided by the total number of patients with an opioid prescription in the current quarter

Healthcare providers should check the PMP before prescribing controlled substances.

You can connect your EHR for seamless access – www.doh.wa.gov/healthit



New Opioid Rules FAQ



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The following is a list of common questions we have received regarding the new opioid prescribing and monitoring rules. This is not an exhaustive list. For more information, please visit the WMC opioid prescribing website <http://go.usa.gov/xPbbr>.

Q: Do MDs and PAs have to register with the Prescription Monitoring Program (PMP)?

A: Yes. If you prescribe opioids in Washington you must register with the PMP or demonstrate proof of access to the program. Learn how to register at <https://go.usa.gov/xPpyF>.

Q: Is there a Continuing Medical Education (CME) requirement if I prescribe opioids?

A: Yes. If you prescribe opioids in Washington you must complete a continuing medical education course. The course is one-time for at least one-hour. It must be completed by the end of your first full CME reporting period after January 1, 2019. Or, it may be reported during your first full CME reporting period after getting your license

Q: When should I check the data in the Prescription Monitoring Program (PMP)?

A: PMP query must be completed at points in the process:

- At the first refill or renewal of an opioid prescription;
- At each pain treatment transition phase;
- Periodically based on the patients risk level;
- For episodic care of a patient currently on opioids for chronic pain.

Q: Will these rules impact all types of pain management?

A: No. These rules do not apply when treating patients with cancer related pain, palliative, hospice, end-of -life care, inpatient hospital patients, or procedural pre-medications. There are documentation and assessment requirements for other types of pain including: acute (0-6 weeks), perioperative (surrounding the performance of surgery), subacute (6 to 12-weeks) and chronic (months or years).

Q: What is the “inappropriate treatment of pain?”

A: The rules for prescribing opioids state, “The inappropriate treatment of pain is a departure from standards of practice.” For the purpose of these rules that includes:

- Nontreatment;
- Undertreatment;
- Overtreatment, and;
- The continued use of ineffective treatments.

Q: What changes will be applied to chronic pain patients?

A: Prescribing opioids for chronic pain patients has only minor changes. A PMP check is required at specific points in the process (see “When should I check the data in the Prescription Monitoring Program (PMP)?”). If a patient is considered high-risk, which is defined in the rule, then a prescription for naloxone must also be written for the patient. As far as the chronic pain patient is concerned, nothing has changed for them. You can still prescribe over 120 MED if you document the reason in the patient record.

Q: How do I stay informed about opioid prescription rules or get involved?

A: We have created an email update to keep people informed. [Sign up](#) to receive updates on rulemaking delivered to your inbox. You can [send us specific questions](#) on the pain management rules or [request an educational presentation](#) for your organization.



Daidria Amelia Underwood Program Manager

The new opioid prescribing rules for allopathic physicians and physician assistants will be effective January 1, 2019. We have begun our education efforts regarding the changes to opioid prescribing. I encourage you to contact me with any questions you may have about these new rules.

Most of the questions I have received so far are about the changes for chronic pain patients. Prescribing opioids for chronic pain patients has only minor changes:

- Checking the Prescription Monitoring Program (PMP) is required either:
 - at first refill/renewal;
 - periodically based on patient risk level;
 - when co-prescribing with certain medications; or
 - at every prescription if the PMP is integrated into the EHR.
- If a patient is considered high-risk, which is defined in the rule, then a prescription for naloxone must also be written for the patient.

As far as the chronic pain patient is concerned, nothing has changed for them. You can still prescribe over 120 MED if you document the reason in the patient record.

Some other important changes:

- To prescribe opioids you must register for the PMP unless you can provide proof you have access to the PMP through your EHR.
- There is a new requirement to complete one hour of CME on opioid prescribing best practices. This requirement can also be fulfilled if you review the new rules.
- In the 2012 Pain Management rules, when prescribing in episodic care, there is a requirement to include the ICD code on the prescription. This will no longer be required as of January 1, 2019. However, keep in mind that if you don't include the ICD code you may receive a call from the pharmacy asking for the code. You can provide it to them but it is no longer a requirement after January 1, 2019 and it's only currently a requirement for episodic care prescriptions.

I welcome your feedback and questions about these rules. Please contact me at (360) 236-2727 or medical.rules@doh.wa.gov.

Let the Medical Commission Answer your Questions In Person

Part of the Medical Commission's mandate is to educate providers and patients on the work of the commission and the emerging issues in health care.

We are traveling around the state to educate prescribers and patients about the changes to opioid prescribing and monitoring that will be a result of these new rules. We welcome the opportunity to speak to your organization, no matter how large or small. [Contact us](#) to make a request.

Format

In general, we have been providing one hour sessions. There is a 15-20 min overview of the new rules and then the rest of the time is spent answering your specific questions.

Upcoming Sessions

We are holding a [twitter town hall](#) on November 20th. This is an excellent opportunity to ask questions and have the Medical Commission provide answers in a rapid fire format.

Any speaking engagement that is open to the public will be posted on our [Facebook page](#). If you are interested, please consider joining one of these public sessions.

