STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

NOTICE OF ADOPTION
INTERPRETIVE STATEMENT

Title of Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants | INS2023-03

Issuing Entity: Washington Medical Commission

Subject Matter: Opioid prescribing for Allopathic Physicians and Physician Assistants reaffirming the importance of clinical judgment and standard of care.

Effective Date: March 3, 2023

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Interpretive Statement

WASHINGTON Medical Commission
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Title:	Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants	INS2023-03
References:	RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-935	
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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

The Intent and Scope section of both the physician opioid prescribing rule, WAC 246-919-850, and the physician assistant opioid prescribing rule, 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 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 review the Intent and Scope Section. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire opioid prescribing rule set by the Commission.

Background

In 2011, the Commission established rules for managing chronic, noncancer pain to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. Since 2011, the Legislature and Commission have made changes on the management of chronic pain to improve patient care and safety.

In 2018, at the direction of the Legislature,[1] the Commission created 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 existing rules for managing chronic pain as well.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a physician to inform a patient that the patient has the right to refuse an opioid prescription for any reason and to require documentation and clarification regarding honoring that refusal.[2]

Additionally, in 2022, the Commission amended the rules to state the rules do not apply to the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities, and residential habilitation centers.[3]

Analysis

The opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) describe the Commission's intent and scope of the rules as follows:

> The [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.
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> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages [practitioners] 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 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.
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> Inappropriate pain treatment may result from a [practitioner'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

[1] Engrossed Substitute House Bill 1427.
[2] RCW 18.71.810; WAC 246-919-865(1)(e); WAC 246-918-815(1)(d).
[3] WAC 246-919-851(5); WAC 246-918-801(5).

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 [practitioners] incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

[Practitioners] 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 [practitioner]-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

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

These rules are designed to assist [practitioners] 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.

For more specific best practices, the [practitioner] 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.

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 morphine equivalent dose (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 RCW 18.71.450[4] 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

[4] ESHB 2876, effective June 10, 2010.

practitioner obtain a pain specialist consultation before continuing 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 practitioner should obtain a consultation when warranted. In WAC 246-919-930(2) and WAC 246-918-880(2), the threshold for mandatory consultation is set at 120 mg MED for adult patients. However, WAC 246-919-930(1) and WAC 246-918-880(1) reference, more generally, additional evaluation that *may* be needed to meet treatment objectives. This section makes specific reference to evaluation of patients under age 18 who are at risk, or who are potential high-risk patients. However, other circumstances may call for a consultation with a pain management specialist for patients who have not yet met the "consultation 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 patient's dose is stable and nonescalating;
    - The patient has a history of compliance with written agreements and treatment plans; and
    - The patient has 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;
- There is evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- There is unauthorized escalation of doses;
- The patient is receiving an authorized escalation of dose with no improvement in pain or function.

A practitioner treating a patient on a stable, nonescalating dose with positive impact on function would not be required to seek additional consultation with a pain specialist. Additionally, there is no upper MED limit in Washington State or federal law. The Commission's opioid prescribing rules represent the only legal requirement and cite a 120 mg MED "consultation threshold" for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. The rules do not prohibit practitioners from referring a patient to a pain specialist before patients reach the "consultation threshold," nor do they prevent a practitioner from self-imposing a smaller MED limit for their patients.

For practitioners not considered pain management specialists treating patients over the 120 mg MED "consultation threshold," there are several options to satisfy the exemption to the consultation requirement, including but not limited to:

- Receiving a peer-to-peer consult with a pain management specialist;
- Participating in an electronic (audio/video) case consult with the University of Washington (UW) Telepain, the Washington Health Care Authority (HCA) Opioid Hotline, or other pain consulting service;
- Documenting in a chart note the attempt to get a consult but the lack of success in attaining one; and

  Successfully completing a minimum of twelve category I continuing education hours in chronic pain management within the previous four years with at least two of those hours dedicated to substance use disorders.

The practitioner should document the outcomes, reasoning, and discussions with the patient as outlined in the rules and described in this interpretive statement in the patient's medical record as part of the normal course of medical practice.