



RULE-MAKING ORDER PERMANENT RULE ONLY

CR-103P (December 2017) (Implements RCW 34.05.360)

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DATE: October 01, 2018

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WSR 18-20-087

Agency: Department of Health- Board of Osteopathic Medicine and Surgery

Effective date of rule:

Permanent Rules

31 days after filing.

Other (specify) (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

Yes No If Yes, explain:

Purpose: Chapter 246-853 WAC--Osteopathic physicians and surgeons and chapter 246-854 WAC--Osteopathic physician assistants. The Board of Osteopathic Medicine and Surgery (board) has adopted new sections, amendments, and repeal of sections to existing rules that establish requirements and standards for prescribing opioid drugs by osteopathic physicians and osteopathic physicians assistants. The adopted rules provide a necessary framework and structure for safe, consistent opioid prescribing practice that comply with the directives of Engrossed Substitute House Bill (ESHB) 1427.

Citation of rules affected by this order:

New: WAC 246-853-675, 246-853-680, 246-853-685, 246-853-690, 246-853-695, 246-853-700, 246-853-705, 246-853-710, 246-853-715, 246-853-720, 246-853-725, 246-853-730, 246-853-735, 246-853-740, 246-853-745, 246-853-750, 246-853-755, 246-853-760, 246-853-765, 246-853-770, 246-853-775, 246-853-780, 246-853-785, and 246-853-790; WAC 246-854-255, 246-854-260, 246-854-265, 246-854-270, 246-854-275, 246-854-280, 246-854-285, 246-854-290, 246-854-295, 246-854-300, 246-854-305, 246-854-310, 246-854-315, 246-854-320, 246-854-325, 246-854-330, 246-854-335, 246-854-340, 246-854-345, 246-854-350, 246-854-355, 246-854-360, 246-854-365, and 246-854-370.
Repealed: WAC 246-853-663, 246-853-664, 246-853-665, 246-853-666, 246-853-667, 246-853-668, 246-853-669, 246-853-670, 246-853-671, 246-853-672, and 246-853-673; WAC 246-854-243, 246-854-244, 246-854-245, 246-854-246, 246-854-247, 246-854-248, 246-854-249, 246-854-250, 246-854-251, 246-854-252, and 246-854-253.
Amended: WAC 246-853-660, 246-853-661, and 246-853-662; WAC 246-854-240, 246-854-241, and 246-854-242
Suspended: None

Statutory authority for adoption: RCW 18.57.800 and 18.57A.800.

Other authority: ESHB 1427 (Chapter 297, Laws of 2017), codified as part of RCW 18.57.800 and 18.57A.800.

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-14-088 on 07/02/2018 (date).

Describe any changes other than editing from proposed to adopted version: 1) WAC 246-853-662 and WAC 246-854-242. The board is adding definitions of "low-risk", "high-risk", and "cancer-related pain" to the rule. These terms are used in the rule, so definitions were added for clarification.

2) WAC 246-853-750 and WAC 246-854-330. The board will refer to WAC sections of the other professions' rules describing pain management specialist qualifications rather than list out the requirements for other practitioners in the osteopathic rules. This change ensures that if changes are made to other professions' pain management specialist requirements, the osteopathic rules will remain accurate.

3) WAC 246-853-695, 246-853-700, 246-853-710 and WAC 246-854-275, 246-854-280, 246-854-290. The board changed "normal course of recovery" to "expected course of recovery" in sections related to treatment plans for acute and subacute pain. The board determined that the word "normal" is subjective and not defined. The board is replacing it with the word "expected" because that word better indicates that it is up to the practitioner to determine whether the course of recovery is proceeding according to expectations.

4) WAC 246-853-735 and WAC 246-854-315. The board removed the sentence that reads "Any written record of a consultation by the pain management specialist must be maintained as a patient record by the specialist" in the Consultation - Recommendations and requirements sections. This change was made because not all pain management specialists are osteopathic practitioners and this may establish a requirement for non-osteopathic practitioners in the osteopathic rules.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

| | | | | | | |
|----------------------------------|-----|-----------|---------|----------|----------|-----------|
| Federal statute: | New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
| Federal rules or standards: | New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
| Recently enacted state statutes: | New | <u>48</u> | Amended | <u>6</u> | Repealed | <u>22</u> |

The number of sections adopted at the request of a nongovernmental entity:

| | | | | | |
|-----|----------|---------|----------|----------|----------|
| New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
|-----|----------|---------|----------|----------|----------|

The number of sections adopted in the agency's own initiative:

| | | | | | |
|-----|----------|---------|----------|----------|----------|
| New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
|-----|----------|---------|----------|----------|----------|

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

| | | | | | |
|-----|----------|---------|----------|----------|----------|
| New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
|-----|----------|---------|----------|----------|----------|

The number of sections adopted using:

| | | | | | | |
|--------------------------------|-----|-----------|---------|----------|----------|-----------|
| Negotiated rule making: | New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
| Pilot rule making: | New | <u>0</u> | Amended | <u>0</u> | Repealed | <u>0</u> |
| Other alternative rule making: | New | <u>48</u> | Amended | <u>6</u> | Repealed | <u>22</u> |

Date Adopted: 08/22/2018

Name: Catherine Hunter, DO

Title: Chair

Signature:



OPIOID PRESCRIBING—GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-660 ((Pain management—)) Intent and scope. ((These rules)) WAC 246-853-660 through 246-853-790 govern the ((use of opioids in the treatment of patients for chronic noncancer)) prescribing of opioids in the treatment of pain.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-661 Exclusions. ((The rules adopted under)) WAC 246-853-660 through ((246-853-673)) 246-853-790 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care; ((or
- (2) The management of acute pain caused by an injury or surgical procedure.))
- (3) The treatment of inpatient hospital patients. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-662 Definitions. The definitions in this section apply in WAC ((246-853-600)) 246-853-660 through ((246-853-673)) 246-853-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(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. ((It is generally time-limited, often less than three months in duration, and usually less than six months.

(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its

development and manifestations. It is characterized by behaviors that include:

- ~~(a) Impaired control over drug use;~~
- ~~(b) Craving;~~
- ~~(c) Compulsive use; or~~
- ~~(d) Continued use despite harm.~~

~~(3)) Acute pain is considered to be 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 resulting from cancer in a patient who is less than two years postcompletion of curative anti-cancer treatment with current evidence of disease.

(5) "Chronic (~~noncancer~~) pain" means a state in which (~~noncancer~~) pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years(~~(-~~

~~(4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.~~

~~(5) "Episodic care" means medical care provided by a provider other than the designated primary provider in the acute care setting, for example, urgent care or emergency department.~~

(6)) Chronic pain may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anticancer treatment with no current evidence of disease.

(6) "High-dose" means ninety milligrams MED, or more, per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

(8) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. (~~Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as free-standing hospice facilities, hospitals, nursing homes, or other long-term care facilities.~~

~~(7))~~

(9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(10) "Low-risk" means a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than a fifty milligram morphine equivalent dose.

(11) "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.

(12) "Moderate-risk" means a category of patient at a 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 and ninety milligram morphine equivalent doses.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

~~((8))~~ (14) "Multidisciplinary pain clinic" means a (clinic or office) facility that provides comprehensive pain management and (may) include care provided by multiple available disciplines, practitioners, or treatment modalities (for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, physical therapy, occupational therapy, or other complementary therapies.

~~(9))~~.

(15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative" means care that improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(22) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(23) "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 characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-853-675 Patient notification, secure storage, and disposal. (1) The osteopathic physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

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

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

NEW SECTION

WAC 246-853-680 Use of alternative modalities for pain treatment. The osteopathic physician shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

NEW SECTION

WAC 246-853-685 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic 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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

WAC 246-853-690 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic 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, including date, type, dosage and quantity prescribed.

NEW SECTION

WAC 246-853-695 Treatment plan—Acute nonoperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

(3) If the osteopathic 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) A three-day supply or less will often be sufficient.

(b) More than a seven-day supply will rarely be needed.

(c) The osteopathic 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 osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall 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 includes, at a minimum:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function;

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician need to prescribe a long-acting opioid for acute pain, the osteopathic physician must document the reason in the patient record.

(7) An osteopathic physician shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-853-780.

(8) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic 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 246-853-705 and 246-853-710 shall apply.

NEW SECTION

WAC 246-853-700 Treatment plan—Acute perioperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic 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.

For more specific best practices, the osteopathic physician may refer to clinical practice guidelines.

(4) The osteopathic physician shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall 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 includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(6) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician must prescribe in accordance with WAC 246-853-775.

(7) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-853-705 and 246-853-710 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.

OPIOID PRESCRIBING—SUBACUTE PAIN

NEW SECTION

WAC 246-853-705 Patient evaluation and patient record. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

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

(c) Inquire about other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-853-790 to identify

any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are 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 significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP and any concerns the osteopathic physician may have;

(d) All medications the patient is known to be prescribed or taking;

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

(f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

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

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

(j) All other required components of the patient record, as established in statute or rule.

(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 planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-853-710 Treatment plan—Subacute pain. (1) The osteopathic physician shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase

and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic 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. The osteopathic physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician shall prescribe in accordance with WAC 246-853-775.

(5) If the osteopathic physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic 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 in WAC 246-853-715 through 246-853-760 shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

WAC 246-853-715 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

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

(iii) Current and past treatments for pain, including medications and their efficacy;

(iv) Review of any significant comorbidities;

(v) Any current or historical substance use disorder;

- (vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and
- (vii) Medication allergies.
- (b) Evaluation. The patient evaluation prior to opioid prescribing must include:
 - (i) Appropriate physical examination;
 - (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
 - (iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;
 - (iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-853-790;
 - (v) Any available diagnostic, therapeutic, and laboratory results;
 - (vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The osteopathic physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk.
 - (vii) Any available consultations, particularly as related to the patient's pain;
 - (viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
 - (ix) Treatment plan and objectives including:
 - (A) Documentation of any medication prescribed;
 - (B) Biologic specimen testing ordered; and
 - (C) Any labs or imaging ordered;
 - (x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician; and
 - (xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

NEW SECTION

- WAC 246-853-720 Treatment plan.** (1) When the patient enters the chronic pain phase, the osteopathic physician shall reevaluate the patient by treating the situation as a new disease.
- (2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include:
 - (a) Any change in pain relief;
 - (b) Any change in physical and psychosocial function; and
 - (c) Additional diagnostic evaluations or other planned treatments.
- (3) After treatment begins, the osteopathic physician shall adjust drug therapy to the individual health needs of the patient.
- (4) The osteopathic physician shall complete patient notification in accordance with the provisions of WAC 246-853-675.

NEW SECTION

WAC 246-853-725 Written agreement for treatment. The osteopathic physician shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

(1) The patient's agreement to provide biological samples for biological specimen testing when requested by the osteopathic physician;

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

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

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

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The osteopathic physician to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-853-660 through 246-853-790, refills are subject to the same limitations and requirements as initial prescriptions.

NEW SECTION

WAC 246-853-730 Periodic review. (1) The osteopathic physician shall periodically review the course of treatment for chronic pain. The osteopathic physician shall base the frequency of visits, biologi-

cal testing, and PMP queries, in accordance with the provisions of WAC 246-853-790 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 or aberrant behavior; and

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

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

- (a) The patient's compliance with any medication treatment plan;
- (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
- (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

- (a) History and physical exam related to the pain;
- (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-853-790 and subsection (1) of this section.

(4) The osteopathic physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-853-755.

NEW SECTION

WAC 246-853-735 Consultation—Recommendations and requirements.

(1) The osteopathic 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. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-853-740 or 246-853-745, an osteopathic physician who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-853-750. 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 consultation between the pain management specialist and the osteopathic physician;

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

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

(3) The osteopathic physician shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician, the osteopathic physician shall maintain it as part of the patient record.

(4) The osteopathic physician shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

NEW SECTION

WAC 246-853-740 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician is not required to consult with a pain management specialist as defined in WAC 246-853-750 when the osteopathic physician has documented adherence to all standards of practice as defined in WAC 246-853-715 through 246-853-760, 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 expected return to their baseline dosage level or below;

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

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

NEW SECTION

WAC 246-853-745 Consultation—Exemptions for the osteopathic physician. An osteopathic physician is exempt from the consultation requirement in WAC 246-853-735 if one or more of the following qualifications are met:

(1) The osteopathic physician is a pain management specialist under WAC 246-853-750;

(2) The osteopathic physician has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

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

(4) The osteopathic physician has a minimum 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.

NEW SECTION

WAC 246-853-750 Pain management specialist. (1) A pain management specialist shall meet one or more of the following qualifications:

(a) An osteopathic physician shall be 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, rehabilitation medicine, neurology, rheumatology, or anesthesiology;

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

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

(d) Be credentialed in pain management by an entity approved by the board; or

(e) Have a minimum of three years of clinical experience in a chronic pain management care setting including:

(i) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past three years for an osteopathic physician; and

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

(2) An osteopathic physician assistant shall meet requirements in WAC 246-854-330.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

NEW SECTION

WAC 246-853-755 Tapering requirements. (1) The osteopathic physician shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

- (a) The patient requests;
- (b) The patient experiences a deterioration in function or pain;
- (c) The patient is noncompliant with the written agreement;
- (d) Other treatment modalities are indicated;
- (e) There is evidence of misuse, abuse, substance use disorder, or diversion;
- (f) The patient experiences a severe adverse event or overdose;
- (g) There is unauthorized escalation or doses; or
- (h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-853-760 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-853-735 and the tapering requirements of WAC 246-853-755 if:

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

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as 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 dose in excess of one hundred twenty milligrams MED.

(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 246-853-735 and 246-853-755 shall apply.

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-853-765 Special populations—Patients twenty-five years of age or under, pregnant patient, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic 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.

NEW SECTION

WAC 246-853-770 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician providing episodic care to a patient who the osteopathic physician knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

WAC 246-853-775 Coprescribing of opioids with certain medications. (1) The osteopathic physician must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-853-780 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

(2) The osteopathic physician shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

NEW SECTION

WAC 246-853-785 Coprescribing of naloxone. (1) The osteopathic physician shall confirm or provide a current prescription for naloxone when high dose opioids are prescribed.

(2) The osteopathic physician should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-853-790 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or of a benzodiazepine.

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

(5) In cases of technical or electrical failure, the osteopathic physician shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

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

REPEALER

The following sections of the Washington Administrative Code are repealed:

| | |
|-----------------|----------------------------------------------------------------|
| WAC 246-853-663 | Patient evaluation. |
| WAC 246-853-664 | Treatment plan. |
| WAC 246-853-665 | Informed consent. |
| WAC 246-853-666 | Written agreement for treatment. |
| WAC 246-853-667 | Periodic review. |
| WAC 246-853-668 | Long-acting opioids, including methadone. |
| WAC 246-853-669 | Episodic care. |
| WAC 246-853-670 | Consultation—Recommendations and requirements. |
| WAC 246-853-671 | Consultation—Exemptions for exigent and special circumstances. |

WAC 246-853-672 Consultation—Exemptions for the
osteopathic physician.
WAC 246-853-673 Pain management specialist.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-240 ((Pain management)) Intent and scope. ((These rules)) WAC 246-854-240 through 246-854-370 govern the ((use of opioids in the treatment of patients for chronic noncancer)) prescribing of opioids in the treatment of pain. Nothing in these rules in any way restricts the current scope of practice of osteopathic physician assistants as set forth in chapters 18.57 and 18.57A RCW and the working agreements between the osteopathic physician and the osteopathic physician assistant, which may include pain management.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-241 Exclusions. ((The rules adopted under)) WAC 246-854-240 through ((246-854-253)) 246-854-370 do not apply to:

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care; ((or
(2) The management of acute pain caused by an injury or surgical procedure.))
- (3) The treatment of inpatient hospital patients. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-242 Definitions. The definitions in this section apply ((in)) to WAC 246-854-240 through ((246-854-253)) 246-854-370 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(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. ((It is generally time limited, often less than three months in duration, and usually less than six months.

(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:

- (a) Impaired control over drug use;
- (b) Craving;

~~(c) Compulsive use; or~~

~~(d) Continued use despite harm.~~

~~(3)) Acute pain is considered to be 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 resulting from cancer in a patient who is less than two years postcompletion of curative anticancer treatment with current evidence of disease.

(5) "Chronic (~~noncancer~~) pain" means a state in which (~~noncancer~~) pain persists beyond the usual course of an acute disease or healing of an injury, or that 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 may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anticancer treatment with no current evidence of disease.

~~((4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.~~

~~(5) "Episodic care" means medical care provided by a provider other than the designated primary provider in the acute care setting, for example, urgent care or emergency department.)~~

(6) "High-dose" means ninety milligrams, MED, or more per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

(8) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. (~~Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as free-standing hospice facilities, hospitals, nursing homes, or other long-term care facilities).~~)

~~((7)) (9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.~~

(10) "Low-risk" means a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than a fifty milligram morphine equivalent dose.

(11) "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.

(12) "Moderate-risk" means a category of patient at a 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 and ninety milligram morphine equivalent doses.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

((+8)) (14) "Multidisciplinary pain clinic" means a ~~(clinic or office)~~ facility that provides comprehensive pain management and ~~((may))~~ includes care provided by multiple available disciplines, practitioners, or treatment modalities~~((; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, physical therapy, occupational therapy, or other complementary therapies))~~.

((+9)) (15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative" means care that improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(22) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(23) "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 characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-854-255 Patient notification, secure storage, and disposal. (1) The osteopathic physician assistant shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and

phase of treatment. The osteopathic physician assistant shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

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

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

NEW SECTION

WAC 246-854-260 Use of alternative modalities for pain treatment. The osteopathic physician assistant shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician assistant may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

NEW SECTION

WAC 246-854-265 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic physician assistant'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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

WAC 246-854-270 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic physician assistant 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, including date, type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-854-275 Treatment plan—Acute nonoperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

- (1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.
- (2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.
- (3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in a quantity greater than needed for the expected duration of pain severe enough to require opioids.
 - (a) A three-day supply or less will often be sufficient.
 - (b) More than a seven-day supply will rarely be needed.
 - (c) The osteopathic physician assistant 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 osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall 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 includes, at a minimum:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician assistant need to prescribe a long-acting opioid for acute pain, the osteopathic physician assistant must document the reason in the patient record.

(7) An osteopathic physician assistant shall not discontinue medication assistant treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-854-360.

(8) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic physician assistant 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 246-854-285 and 246-854-290 shall apply.

NEW SECTION

WAC 246-854-280 Treatment plan—Acute perioperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.

(2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic physician assistant 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. For more specific best practices, the osteopathic physician assistant may refer to clinical practice guidelines.

(4) The osteopathic physician assistant shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall 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 includes, at a minimum:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and
- (d) Additional planned diagnostic evaluations or other treatments.

(6) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant must prescribe in accordance with WAC 246-854-355.

(7) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-854-285 and 246-854-290 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.

OPIOID PRESCRIBING—SUBACUTE PAIN

NEW SECTION

WAC 246-854-285 Patient evaluation and patient record. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician assistant shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

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

(c) Inquire regarding other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-854-370 to identify

any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician assistant determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician assistant treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are 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 significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The results of any queries of the PMP and any concerns the osteopathic physician assistant has;

(d) All medications the patient is known to be prescribed or taking;

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

(f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

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

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

(j) All other required components of the patient record, as established in statute or rule.

(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 planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-854-290 Treatment plan—Subacute pain. (1) The osteopathic physician assistant shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the

subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician assistant shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The osteopathic physician assistant shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant shall prescribe in accordance with WAC 246-854-355.

(5) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-854-295 through 246-854-340, shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

WAC 246-854-295 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician assistant shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

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

- (iii) Current and past treatments for pain, including medications and their efficacy;
- (iv) Review of any significant comorbidities;
- (v) Any current or historical substance use disorder;
- (vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and
- (vii) Medication allergies.
- (b) Evaluation. The patient evaluation prior to opioid prescribing must include:
 - (i) Appropriate physical examination;
 - (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
 - (iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;
 - (iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-854-370;
 - (v) Any available diagnostic, therapeutic, and laboratory results;
 - (vi) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low-risk category. The osteopathic physician assistant should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;
 - (vii) Any available consultations, particularly as related to the patient's pain;
 - (viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
 - (ix) Treatment plan and objectives including:
 - (A) Documentation of any medication prescribed;
 - (B) Biologic specimen testing ordered; and
 - (C) Any labs or imaging ordered.
 - (x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician assistant; and
 - (xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

NEW SECTION

WAC 246-854-300 Treatment plan. (1) When the patient enters the chronic pain phase, the osteopathic physician assistant shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include, at a minimum:

- (a) Any change in pain relief;
- (b) Any change in physical and psychosocial function; and
- (c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the osteopathic physician assistant shall adjust drug therapy to the individual health needs of the patient.

(4) The osteopathic physician assistant shall complete patient notification in accordance with the provisions of WAC 246-854-255.

NEW SECTION

WAC 246-854-305 Written agreement for treatment. The osteopathic physician assistant shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

(1) The patient's agreement to provide biological samples for biological specimen testing when requested by the osteopathic physician assistant;

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

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

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

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician assistant to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The osteopathic physician assistant to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician assistant treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-854-240 through 246-854-370, refills are subject to the same limitations and requirements as initial prescriptions.

NEW SECTION

WAC 246-854-310 Periodic review. (1) The osteopathic physician assistant shall periodically review the course of treatment for chronic pain. The osteopathic physician assistant shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-854-370 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 or aberrant behavior; and
- (e) More frequently at the osteopathic physician assistant's discretion.

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

- (a) The patient's compliance with any medication treatment plan;
- (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
- (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician assistant's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

- (a) History and physical exam related to the pain;
- (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-854-370 and subsection (1) of this section.

(4) The osteopathic physician assistant shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician assistant shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-854-335.

NEW SECTION

WAC 246-854-315 Consultation—Recommendations and requirements.

(1) The osteopathic physician assistant 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. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-854-320 or 246-854-325, an osteopathic physician assistant who

prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-854-330. 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 consultation between the pain management specialist and the osteopathic physician assistant;

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

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

(3) The osteopathic physician assistant shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician assistant, the osteopathic physician assistant shall maintain it as part of the patient record.

(4) The osteopathic physician assistant shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

NEW SECTION

WAC 246-854-320 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician assistant is not required to consult with a pain management specialist as defined in WAC 246-854-330 when the osteopathic physician assistant has documented adherence to all standards of practice as defined in WAC 246-854-295 through 246-854-340, 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 expected return to their baseline dosage level or below;

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

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

NEW SECTION

WAC 246-854-325 Consultation—Exemptions for the osteopathic physician assistant. An osteopathic physician assistant is exempt

from the consultation requirement in WAC 246-854-315 if one or more of the following qualifications are met:

(1) The osteopathic physician assistant is a pain management specialist under WAC 246-854-330;

(2) The osteopathic physician assistant has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

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

(4) The osteopathic physician assistant has a minimum of three years 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.

NEW SECTION

WAC 246-854-330 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) An osteopathic physician assistant shall have a delegation agreement with a physician pain management specialist and meet all of the following educational requirements and practice requirements:

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

(b) Credentialed in pain management by an entity approved by the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;

(c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(d) At least thirty percent of the osteopathic physician assistant's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) An osteopathic physician shall meet requirements in WAC 246-853-750.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

NEW SECTION

WAC 246-854-335 Tapering requirements. (1) The osteopathic physician assistant shall assess and document the appropriateness of

continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician assistant shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

- (a) The patient requests;
- (b) The patient experiences a deterioration in function or pain;
- (c) The patient is noncompliant with the written agreement;
- (d) Other treatment modalities are indicated;
- (e) There is evidence of misuse, abuse, substance use disorder, or diversion;
- (f) The patient experiences a severe adverse event or overdose;
- (g) There is unauthorized escalation or doses; or
- (h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-854-340 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician assistant's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-854-315 and the tapering requirements of WAC 246-854-335 if:

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

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as 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 dose in excess of one hundred twenty milligrams MED.

(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 246-854-315 and 246-854-335 shall apply.

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-854-345 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician assistant shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician assistant shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician assistant shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic physician assistant 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.

NEW SECTION

WAC 246-854-350 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician assistant shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician assistant providing episodic care to a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician assistant shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician assistant providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician assistant providing episodic care shall coordinate care with the patient's chronic pain treatment prac-

titioner if that person is known to the osteopathic physician assistant providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

WAC 246-854-355 Coprescribing of opioids with certain medications. (1) The osteopathic physician assistant must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician assistant prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-854-360 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

(2) The osteopathic physician assistant shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

NEW SECTION

WAC 246-854-365 Coprescribing of naloxone. (1) The osteopathic physician assistant shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed.

(2) The osteopathic physician assistant should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-854-370 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician assistant shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician assistant may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician assistant shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or a benzodiazepine.

(4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician assistant or their authorized designee due to a temporary technical or electrical failure.

(5) In cases of technical or electrical failure, the osteopathic physician assistant shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

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

REPEALER

The following sections of the Washington Administrative Code are repealed:

| | |
|-----------------|---------------------|
| WAC 246-854-243 | Patient evaluation. |
| WAC 246-854-244 | Treatment plan. |
| WAC 246-854-245 | Informed consent. |

WAC 246-854-246 Written agreement for treatment.
WAC 246-854-247 Periodic review.
WAC 246-854-248 Long-acting opioids, including
methadone.
WAC 246-854-249 Episodic care.
WAC 246-854-250 Consultation—Recommendations and
requirements.
WAC 246-854-251 Consultation—Exemptions for exigent and
special circumstances.
WAC 246-854-252 Consultation—Exemptions for the
osteopathic physician assistant.
WAC 246-854-253 Pain management specialist.