

## Section I: Preamble

The Washington Medical Quality Assurance Commission recognizes that principles of quality medical practice dictate that the people of the State of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this rule, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Washington Medical Quality Assurance Commission encourages providers to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All providers should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this rule has been developed to clarify the Commission's position on pain control, particularly as related to the use of controlled substances, to alleviate provider uncertainty and to encourage better pain management.

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

The Commission recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the provider. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Providers should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The Washington Medical Quality Assurance Commission is obligated under the laws of the State of Washington to protect the public health and safety. The Commission recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Commission expects that providers incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Providers should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a provider-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Commission will judge the validity of the provider's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to

control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The Commission will not take disciplinary action against a provider for deviating from this rule when contemporaneous medical records document reasonable cause for deviation. The provider's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life. Deviation from sections of the rule that must or shall be performed will be considered deviation from the standard of care for the purpose of this rule.

## **Section II: Rules**

The Commission has adopted the following criteria when evaluating the provider's treatment of Chronic non-cancer pain (CNCP), including the use of controlled substances:

**Evaluation of the Patient**—A medical history and physical examination shall be obtained, evaluated, and documented in the medical record. The medical record shall document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and a history of substance abuse. It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) or Emergency Department Information Exchange (EDIS) be utilized when available. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

**Medical Records**—The provider shall keep accurate and complete records to include

1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

**Screen for Risk**—The provider should screen for potential comorbidities and risk factors using an appropriate screening tool. (Table 2) Screening should address history of addiction, abuse or aberrant behavior, and underlying psychiatric conditions.

**Treatment Plan**—The written treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the provider should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

**Informed Consent and Agreement for Treatment**—The provider should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient shall receive prescriptions from one provider and one pharmacy whenever possible. Providers shall include indications

for opioid usage on the prescription. If the patient is at high risk for medication abuse or has a history of substance abuse or psychiatric comorbidities, the provider shall use a written agreement between provider and patient outlining patient responsibilities, including

1. urine/serum medication levels screening when requested;
2. number and frequency of all prescription refills; and
3. reasons for which drug therapy may be discontinued (e.g., violation of agreement).
4. Use of single provider to receive prescriptions and one pharmacy whenever possible.
5. Provides written, informed consent to release contract to local emergency departments and pharmacies ;If written consent is given for release to local emergency departments and/or pharmacies, consent also being given to the other clinicians and providers such as pharmacists to report violations of the contract back to the prescribing clinician;
6. Specifies that if the clinician becomes concerned that there has been illegal activity, the clinician may notify the proper authorities;
7. Provides that if the clinician has obtained a written release, ER personnel and other providers shall report violations of the contract back to the doctor who prescribed the controlled substance(s);
8. Specifies that a violation of the contract may result in a tapering and discontinuation of the narcotics prescription;
9. Specifies that it is the responsibility of the patient to be discreet about possessing narcotics and keeping medications in an inaccessible place so that they may not be stolen;
10. If the patient violates the terms of the contract, the violation should be documented. The clinician response to the violation should be documented, as well as the rationale of and changes in the treatment plan;

**Periodic Review**—The provider shall periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the provider's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function shall be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the provider should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Likewise, the clinician should periodically review the course of treatment where psychoactive drugs are used for the treatment of components of chronic pain, e.g., emotional, psychological, or psychosocial stressors, and assess the appropriateness of continued use of the current treatment plan if the patient's progress is unsatisfactory. Periodic review of the State's PMP and EDIE is recommended if available. The provider should consider tapering or discontinuation of treatment when: function or pain does not improve after trial or; there is evidence of significant adverse effects or; there is evidence of misuse, addiction or diversion.

**Consultation**—The provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorders may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

**Dosing Guidelines**—The provider should be familiar with common dosing calculators to determine Morphine Equivalent Dosage (MED).

The provider shall obtain specialty consultation by a practitioner specializing in pain management when the patient's dosage exceeds 120 mg morphine equivalents per day. Consultation may be telephonic, telemedicine, chart review, or face-to-face.

Providers who have met the minimum training and experience as approved by the Commission are exempt from this requirement.

Pediatric patients should be referred to an appropriately trained pediatric pain specialist.

Providers not meeting the minimum training and experience requirement may exceed the 120 mg Morphine equivalent threshold under the following circumstances: A brief illness or injury which requires an escalation in opioid dosage that is expected to be temporary (less than 6 weeks) with expected return to baseline opioid dosages Or; Unavailability of specialty consultation due to geographic or other exigent circumstances Or: Patients' who have obtained specialty consultation and are on stable and on non-escalating dosages of opioids. Or; When all best practices are done and documented and pain and function are improving using validated instruments Or; The patient is following a tapering schedule. Or; For a new patient to a practice who is already at a dose above 120 MED/day, the practitioner should, within 3 months: obtain a consult, or; request records from previous consult or; Document improvements in pain and function.

**Episodic Care**—When evaluating patients for episodic care (Emergency Department, Urgent Care) It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) or Emergency Department Information Exchange (EDIS), or other tracking system be utilized when available. Practitioners are discouraged from providing narcotics for CNP for patients presenting to the Emergency Department or Urgent Care facilities without objective evidence of acute injury. Prescriptions for controlled substances should be written to require photo identification in order to fill. The treatment of patients with chronic pain is not considered an acute health service.

**Reportable Acts** — Generally, information gained as part of the clinician/patient relationship remains confidential. However, the clinician has an obligation to deal with persons who use the clinician to perpetrate illegal acts, such as illegal acquisition or selling of drugs; this may include reporting to law enforcement. Information suggesting inappropriate or drug-seeking behavior, should be addressed appropriately and documented. Use of the PMP is recommended.

**Guidelines**—The providers are referred to the following guidelines:

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain (CNCP)

**Compliance With Controlled Substances Laws and Regulations**—To prescribe, dispense or administer controlled substances, the provider must be licensed in the state and comply with applicable federal and state regulations. Providers are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations. Prescriptions written for controlled substances should be written to require photo identification in order to fill.

**The rules adopted under this section do not apply:**

To the provision of palliative, hospice, or other end-of-life care or;  
To the management of acute pain caused by an injury or surgical procedure or;  
At doses less than 40/60 MED/day.

### **Section III: Definitions**

For the purposes of these guidelines, the following terms are defined as follows:

**Acute Pain**—Acute pain is 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 and less than 3 months duration.

**Addiction**—Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

**Chronic Non-cancer Pain (CNCP)**—Chronic pain is a state in which 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.

**Hospice Care**—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 medical care, pain management and emotional and spiritual support. The emphasis is on comfort, not curing. It can be provided in the patients home as well as freestanding hospice facilities, hospitals, nursing homes and other long-term care facilities.

**Pain**—An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

**Palliative Care**—Palliative care is care that improves the quality of life of patients and their families facing 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.

**Physical Dependence**—Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

**Practitioner specializing in pain medicine**—A practitioner that endorses and supports the guidelines and: is Board certified in pain management (American Board of Pain Medicine, American Board of Anesthesiology) or; Board certified in Physical Medicine and rehabilitation, Psychiatry or Neurology or; Is a pain management practitioner working in a multidisciplinary chronic pain treatment center or; Is a pain management practitioner working in a multidisciplinary academic research facility or; is a pain management practitioner with special training and competence in pain management certified by his/her professional organization or; a provider who is recognized by his or her peers in the community as a pain specialist in chronic pain management and is available for consultation.

**Pseudoaddiction**—The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

**Substance Abuse**—Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

**Tolerance**—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

**Urgent Care Facility**—An urgent care facility is a medical clinic that offers primary and acute health services to the public during stated hours of operation and which must accommodate walk-in patients seeking health services for acute conditions. For purposes of this definition, the treatment of patients with chronic pain is not considered an acute health service.

