Nursing Care Quality Assurance Commission (NCQAC)
Meeting Agenda
Friday, August 10, 2018
9:00 AM
SeaTac Crowne Plaza Hotel
Beacon and Capital Room
17338 International Boulevard
Seattle, WA 98188
To attend via webinar, please register for the meeting at:
https://attendee.gotowebinar.com/register/3542994093951480577

Commission Members:	Tracy Rude, LPN, Chair Mary Baroni, PhD, RN Vice-Chair Lois Hoell, MS, MBA, RN, Secretary/Treasurer Gerianne Babbo, EdD, RN Adam Canary, LPN Jeannie Eylar, MSN, RN Edie Higby, Public Member Helen Myrick, Public Member Sharon Ness, RN Donna L. Poole MSN, ARNP, PMHCNS-BC Tiffany Randich, LPN Renee Ruiz, Public Member Laurie Soine PhD, ARNP Yvonne Strader, RN
Assistant Attorney General:	Gail S. Yu, Assistant Attorney General
Staff:	Paula Meyer, Executive Director Karl Hoehn, Legal Manager Chris Archuleta, Management Analyst Amber Bielaski, Policy and Performance Analyst Mary Sue Gorski, PhD, RN, Nursing Research and Advanced Practice
Optional Staff:	Kathy Anderson, Financial Manager Teresa Corrado, LPN, CPM Licensing Manager Mindy Schaffner, PhD, MSN-CNS, RN, Associate Director, Nursing Education & Research Debbie Carlson, MSN, RN, CPM Associate Director, Nursing Practice & Licensing Catherine Woodard, Associate Director, Discipline

If you have questions regarding the agenda, please call the NCQAC office at 360-236-4713.

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than August 3, 2018. If you need assistance with special needs and services, please leave a message with that request at 1-800-525-0127 or, if calling from outside Washington State, call (360) 236-4052. If you have limited English language expertise, call 360-236-4713 before August 3, 2018. TDD may also be accessed by calling the TDD relay service at 711. If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the September 14, 2018 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov .

Smoking is prohibited at this meeting.

I. 9:00 AM Opening – Tracy Rude, Chair – DISCUSSION/ACTION

A. Call to Order
B. Introductions

II. 9:15 AM-9:45 AM Question/Answer Session– Tracy Rude, Chair –DISCUSSION
Opportunity for the public to ask the NCQAC members questions about the Opioid Prescribing Rules prior to opening the hearing and providing formal testimony.

III. 9:45 AM – 11:00 AM ESHB 1427 Opioid Prescribing Rules Public Hearing –Tracy Rude, Chair– DISCUSSION/ACTION

IV. 11:00 AM Closing

PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 02, 2018
TIME: 11:52 AM

WSR 18-14-086

Agency: Department of Health- Nursing Care Quality Assurance Commission

☒ **Original Notice**

☐ **Supplemental Notice to WSR**

☐ **Continuance of WSR**

☒ **Preproposal Statement of Inquiry was filed as WSR** 17-17-142 **; or**

☐ **Expedited Rule Making--Proposed notice was filed as WSR ; or**

☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☐ **Proposal is exempt under RCW .**

Title of rule and other identifying information: (describe subject) Chapter 246-840 WAC. The Nursing Care Quality Assurance Commission (commission) proposes new sections and amendments to existing rule that will establish requirements and standards for prescribing opioid drugs by advanced registered nurse practitioners consistent with the directives of Engrossed Substitute House Bill (EHSB) 1427 (chapter 297, Laws of 2017).

Hearing location(s):			
Date:	**Time:**	**Location:** (be specific)	**Comment:**
08/10/2018	9:00 AM	Crowne Plaza Hotel Beacon and Capital Room 17338 International Blvd Seattle, WA 98188	

Date of intended adoption: 08/10/2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: Amber Zawislak
Address: P.O. BOX 47864
Olympia, WA 98504-7864
Email: https://fortress.wa.gov/doh/policyreview
Fax: 360-236-4738
Other:
By (date) 07/31/2018

Assistance for persons with disabilities:

Contact Amber Zawislak
Phone: 360-236-4785
Fax: 360-236-4738
TTY: (360) 833-6388 or 711
Email: amber.zawislak@doh.wa.gov
Other:
By (date) 07/27/2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The commission proposes to establish new sections within the current Pain Management subchapter of chapter 246-840 WAC to implement the provisions of ESHB 1427. The bill directed five boards and commissions to consider the Agency Medical Directors' Group and the Centers for Disease Control and Prevention guidelines, and to work in consultation with the Washington State Department of Health, the University of Washington, and the professional associations of each profession to develop requirements for prescribing opioid drugs. The commission is also proposing amendments to the current pain management rules to assure alignment with the proposed opioid prescribing rules, increase consistent rule application, and reduce duplication between existing and new rules.

Reasons supporting proposal: The proposed rules are necessary to establish and implement opioid prescribing requirements for advanced registered nurse practitioners. The proposed rules provide a necessary framework and structure for safe, consistent opioid prescribing practice consistent with the directives of ESHB 1427. The proposed rules recognize instances where clinical judgement is appropriate by providing practice guidance without being overly prescriptive, and are designed to reduce the risks associated with opioid use in the management of pain, while increasing public health and safety.

Statutory authority for adoption: RCW 18.79.110 and 18.79.400.

Statute being implemented: ESHB 1427 (chapter 297, Laws of 2017), codified in part as RCW 18.79.800.

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Washington State Nursing Care Quality Assurance Commission

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Amber Zawislak	111 Israel Road SE Tumwater, WA 98504	360-236-4785
Implementation:	Amber Zawislak	111 Israel Road SE Tumwater, WA 98504	360-236-4785
Enforcement:	Catherine Woodard	111 Israel Road SE Tumwater, WA 98504	360-236-4757

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name: Amber Zawislak
Address: PO Box 47864
Olympia, WA 98504
Phone: 360-236-4785
Fax: 360-236-4738
TTY: (360) 833-6388 or 711
Email: amber.zawislak@doh.wa.gov
Other:

☐ No: Please explain:

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW .

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The proposed rules impact clinics and hospitals where advanced registered nurse practitioners (ARNP) practice if the ARNP(s) in the business prescribe opioids for pain management. The proposed rules do not apply to nurses who do not prescribe opioids. The following North American Industrial Classification System (NAICS) six-digit codes, total number of businesses in Washington state in 2013, total combined and average business payroll (rounded to the thousands), and minor cost thresholds have been applied to the proposal:

1. NAICS Code: 621399 Office of Physicians (except mental health specialists)
Total establishments in Washington: 3,120
Total combined annual payroll: $3,744,650,000.00
Average annual payroll (total payroll divided by total establishments): $1,200,208.00
Minor Cost threshold (Average payroll multiplied by .01): $12,002.00

2. NAICS Code: 621399 Offices of All Other Miscellaneous Health Practitioners
Total establishments in Washington: 913
Total combined annual payroll: $103,873,000.00
Average annual payroll (total payroll divided by total establishments): $113,771.84
Minor Cost threshold (Average payroll multiplied by .01): $1,137.71

The commission has analyzed the anticipated costs of compliance for a business at $16.77 for each patient encounter only when an ARNP prescribes opioids, and only if the ARNP performs all of the tasks required in the proposed rules. Many of the tasks in the rules are often performed by other staff (such as medical assistants or licensed practical nurses) at a much lower cost. For example, regarding the following tasks required under the proposed rules at every patient encounter when an opioid is prescribed:

- Documenting patient history and physical condition
- Documenting/updating the patient health record
- Completing a prescription monitoring program (PMP) check

An ARNP performing these tasks would cost the business an estimated $*9.03; or
A medical assistant-certified could perform the same tasks for an estimated $6.87*.

Depending on the patient's phase of pain management, the business may incur the following additional cost:
a. From $0 per patient encounter for a patient whose pain level and function meet the expected course of recovery; up to
b. An estimated $21.50 per patient encounter when a practitioner must seek a consultation with another practitioner regarding specific co-prescribed controlled drugs, or co-prescribing opioids to a patient receiving medication assisted treatment.
Based on these anticipated costs, the commission has determined that the proposed rules would not impose more than minor costs for businesses that must comply.

*Based on United States Department of Labor Statistics, Occupational Employment and Wages 2017 for 29-1069 Physicians and Surgeons, and 31-9092 Medical Assistants.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: 06/29/2018	**Signature:** Paula R. Meyer MSN, RN, FRE
Name: Paula R. Meyer, MSN, RN, FRE	
Title: Executive Director, Nursing Care Quality Assurance Commission	

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-460 Pain management—Intent. ((~~These rules~~)) WAC 246-840-460 through 246-840-4990 govern the use of opioids in the treatment of ((~~patients for chronic noncancer~~)) pain in the acute, perioperative, subacute, and chronic phases. Treatment modalities including opioid use 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 undertreatment or inappropriate treatment of pain. For the purpose of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. In addition to these rules, the nursing commission recommends practitioners adhere to applicable state agency medical directors' group (AMDG) and federal Centers for Disease Control and Prevention (CDC) guidelines for the treatment of pain in all phases.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-463 Exclusions. ((~~The rules adopted under~~)) WAC 246-840-460 through ((~~246-840-493~~)) 246-840-4990 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; or

(4) Procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-465 Definitions. The following definitions ((~~in this section~~)) apply in WAC 246-840-460 through ((~~246-840-493~~)) 246-840-4990, 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 renewals, or obtaining prescriptions for the same or similar drugs from more than one practitioner or other health care provider.

(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 testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.

(4) "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~~)) more than twelve weeks in duration, lasting months or years. Chronic pain includes pain resulting from cancer or treatment in a patient who is two years post completion of curative anti-cancer treatment with no current evidence of disease.

((~~(4) "Comorbidity"~~)) (5) "Comorbidities" means a ((~~pre-existing~~)) preexisting or coexisting physical or psychiatric disease or condition.

((~~(5)~~)) (6) "Episodic care" means medical care provided by ((~~a provider~~)) an advanced registered nurse practitioner other than the designated primary ((~~provider~~)) care practitioner in the acute care setting, for example, urgent care or emergency department.

((~~(6)~~)) (7) "High dose" means ninety milligram morphine equivalent dose (MED), or more, per day.

(8) "High-risk" means 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.

(9) "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)~~))

(10) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW or designated as a state hospital 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.

(11) "Inpatient" means a person who has been admitted to a hospital for more than twenty-four hours.

(12) "Medication assisted treatment (MAT)" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

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

((~~(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, ((~~for example, physicians, osteopathic physicians, physician assistants, advanced registered nurse practitioners, physical therapists, occupational therapists, and other complementary therapies.~~

~~(9)~~)) practitioners, or treatment modalities.

(15) "Multimodal management of pain" means the application of nonopioid analgesic mechanisms, such as, but not limited to, antidepressants, anticonvulsants, anti-inflammatory medications, acetaminophen, interventional procedures, or any nonpharmacological pain treatments.

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

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

(18) "Palliative care" means care that maintains or 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.

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

(20) "Pain management clinic" means a publicly or privately owned facility for which a majority of patients are receiving chronic pain treatment.

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

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

(23) "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.

(24) "Risk assessment tools" means validated tools or questionnaires appropriate for identifying a patient's level of risk for substance use or misuse.

(25) "Subacute pain" means a continuation of pain, of six to twelve weeks in duration.

(26) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-840-4651 Patient notification, secure storage, and disposal. (1) The practitioner shall provide information to the patient educating them of:

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

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

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

(2) The practitioner shall document such notification in the patient record.

(3) 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.

NEW SECTION

WAC 246-840-4653 Use of alternative modalities for pain treatment. The practitioner shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable as evidence-based, clinically appropriate alternatives exist. A practitioner 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 246-840-4655 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an advanced registered nurse practitioner licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids. Additionally, a chronic pain management specialist must meet the continuing education requirements in WAC 246-840-493. The continuing education must be at least four hours in length.

(2) The advanced registered nurse practitioner shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the advanced registered nurse practitioner'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. The four hour course may count toward any NCQAC required continuing education.

NEW SECTION

WAC 246-840-4657 Diagnosis identified on prescriptions. The advanced registered nurse practitioner shall include the diagnosis or the International Classification of Diseases (ICD) code on all opioid prescriptions.

NEW SECTION

WAC 246-840-4659 Patient evaluation and patient record—Acute. Prior to prescribing an opioid for acute nonoperative pain or acute perioperative pain, the advanced registered nurse practitioner 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 type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-840-4661 Treatment plan—Acute nonoperative pain. The advanced registered nurse practitioner 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 advanced registered nurse practitioner shall consider recommending or prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.

(2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 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 advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription must not be in greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 typically indicated for acute nonoperative pain. Should an advanced registered nurse practitioner need to prescribe a long-acting opioid for acute pain, that reason must be documented in the patient record.

(7) Medication assisted treatment (MAT) medications shall not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-840-4970.

(8) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, shall apply.

NEW SECTION

WAC 246-840-4663 Treatment plan—Acute perioperative pain. The advanced registered nurse practitioner 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's record.

(1) The advanced registered nurse practitioner shall consider prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.

(2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 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 advanced registered nurse practitioner 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 three-day supply or less will often be sufficient; more than a fourteen-day supply will rarely be needed for perioperative pain. The advanced registered nurse practitioner 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 advanced registered nurse practitioner may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group (AMDG), the Centers for Disease Control and Prevention (CDC), or the Bree Collaborative.

(4) The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.

(7) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, 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.

NEW SECTION

WAC 246-840-4665 Patient evaluation and patient record—Subacute pain. The advanced registered nurse practitioner 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 an opioid for subacute pain, the advanced registered nurse practitioner 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 type, dosage, and quantity prescribed;

(d) Conduct, or cause the practitioner's authorized designee as defined in WAC 246-470-050 to conduct, a query of the prescription

monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990, to identify any Schedule II-V medications or drugs of concern received by the patient, and document their review and any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the advanced registered nurse practitioner 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 that may be impairing recovery including, but not limited to, depression or anxiety.

(2) The advanced registered nurse practitioner 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;

(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 results and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors that 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 246-840-4667 Treatment plan—Subacute pain. (1) The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated. The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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. The advanced registered nurse practitioner 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 advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.

(5) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-840-467 through 246-840-4940, shall apply.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-467 Patient evaluation and patient record. The advanced registered nurse practitioner shall ((~~obtain,~~)) evaluate((~~,~~)) and document the patient's health history and physical examination in the patient's health record prior to treating for chronic ((~~noncancer~~)) pain.

(1) The patient's health history shall include:

(a) The nature and intensity of the pain;

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

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

((~~(b)~~)) (d) Review of any significant comorbidities; ((~~and~~

~~(c)~~)) (e) Any current or historical substance ((~~abuse~~)) use disorder;

(f) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and

(g) Medication allergies.

(2) ((~~The patient's health history should include:~~

~~(a) A review of any available prescription monitoring program or emergency department-based information exchange; and~~

~~(b) Any relevant information from a pharmacist provided to advanced registered nurse practitioners.~~

~~(3)~~)) The ((~~initial~~)) patient evaluation ((~~shall~~)) prior to opioid prescribing must include:

(a) Appropriate physical examination;

(b) ((~~The nature and intensity of the pain;~~

~~(c) The effect of the pain on physical and psychological function;~~

~~(d)~~)) Consideration of the risks and benefits of chronic pain treatment for the patient;

(c) Medications the patient is taking including indication(s), ((~~date,~~)) type, dosage, ((~~and~~)) quantity prescribed((~~;~~

~~(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:~~

~~(i) History of addiction;~~

~~(ii) Abuse or aberrant behavior regarding opioid use;~~

~~(iii) Psychiatric conditions;~~

~~(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;~~

~~(v) Poorly controlled depression or anxiety;~~

~~(vi) Evidence or risk of significant adverse events, including falls or fractures;~~

~~(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;~~

~~(viii) Repeated visits to emergency departments seeking opioids;~~

~~(ix) History of sleep apnea or other respiratory risk factors;~~

~~(x) Possible or current pregnancy; and~~

~~(xi) History of allergies or intolerances.~~

~~(4) The initial patient evaluation should include:~~

~~(a) Any available diagnostic, therapeutic, and laboratory results; and~~

~~(b) Any available consultations.~~

~~(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:~~

~~(a) The diagnosis, treatment plan, and objectives;~~

~~(b) Documentation of the presence of one or more recognized indications for the use of pain medication;~~

~~(c) Documentation of any medication prescribed;~~

~~(d) Results of periodic reviews;~~

~~(e) Any written agreements for treatment between the patient and the advanced registered nurse practitioner; and~~

~~(f) The advanced registered nurse practitioner's instructions to the patient~~)), and as related to treatment of the pain, efficacy of medications tried;

(d) Review of the prescription monitoring program (PMP) to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-840-4990;

(e) Any available diagnostic, therapeutic, and laboratory results;

(f) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low risk category. The advanced registered nurse practitioner should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high risk;

(g) Any available consultations, particularly as related to the patient's pain;

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

(i) Treatment plan and objectives including:

(i) Documentation of any medication prescribed;

(ii) Biologic specimen testing ordered; and

(iii) Any labs or imaging ordered.

(j) Written agreements, as described in WAC 246-840-475 for treatment between the patient and the advanced registered nurse practitioner;

(k) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

(3) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in subsections (1) and (2) of this section, and all other required components of the patient record, as set out in statute or rule.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-470 Treatment plan. (1) When the patient enters the chronic pain phase, the advanced registered nurse shall reevaluate the patient by treating the situation as a new disease.

(2) The ((~~written~~)) chronic pain treatment plan ((~~shall~~)) must state the objectives that will be used to determine treatment success and ((~~shall~~)) 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.

((~~(2)~~)) (3) After treatment begins, the advanced registered nurse practitioner ((~~should~~)) shall adjust drug therapy to the individual health needs of the patient.

(4) The advanced registered nurse practitioners shall ((~~include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. Advanced registered nurse practitioners shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.~~

~~(3) 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~~)) complete patient notification in accordance with the provisions of WAC 246-840-4651.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-475 Written agreement for treatment. ((~~Chronic noncancer pain patients should receive all chronic pain management pre-~~

~~scriptions from one advanced registered nurse practitioner and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing~~)) The advanced registered nurse practitioner shall use a written agreement for treatment with the patient ((~~outlining patient~~)) who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment ((~~shall~~)) must include:

(1) The patient's agreement to provide biological samples for ((~~urine/serum medical level screening~~)) biological specimen testing when requested by the advanced registered nurse practitioner;

(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 ((~~drug~~)) opioid therapy may be discontinued ((~~(e.g., violation of agreement)~~));

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

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

((~~(5)~~)) (6) The patient's agreement to not abuse ((~~alcohol or use other medically unauthorized substances;~~

~~(6)~~)) substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The advanced registered nurse practitioner to release the agreement for treatment to:

(i) Local emergency departments((~~,~~));

(ii) Urgent care facilities((~~, and~~));

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

(iv) Pharmacies((~~; and~~)).

(b) Other practitioners to report violations of the agreement ((~~back~~)) to the advanced registered nurse practitioner treating the patient's chronic pain and to the prescription monitoring program (PMP);

((~~(7) A written authorization that the advanced registered nurse practitioner may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;~~

~~(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;~~

~~(9)~~)) (8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

((~~(10)~~)) (9) Acknowledgment that, if the patient violates the terms of the agreement, the violation and the advanced registered nurse practitioner's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-477 Periodic review. (1) The advanced registered nurse practitioner shall periodically review the course of treatment for chronic ((~~noncancer~~)) pain((~~, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.~~

~~(1)~~)). The frequency of visits, biological testing, and prescription monitoring program (PMP) queries are determined based on the patient's risk category:

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

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

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

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

(e) More frequently at the advanced registered nurse practitioner's discretion.

(2) During the periodic review, the advanced registered nurse practitioner shall determine:

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

(b) If pain, function, or quality of life have improved ((~~or~~)), diminished, or are maintained using objective evidence((~~, considering any available information from family members or other caregivers~~));

and

(c) If continuation or modification of medications for pain management treatment is necessary based on the advanced registered nurse practitioner's evaluation of progress towards treatment objectives.

((~~(2)~~)) (3) Periodic or patient evaluations must also include:

(a) History and physical examination 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 246-840-4990 and subsection (1) of this section.

(4) The advanced registered nurse practitioner shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The advanced registered nurse practitioner shall consider tapering, changing, or discontinuing treatment ((~~when:~~

~~(a) Function or pain does not improve after a trial period;~~

~~(b) There is evidence of significant adverse effects;~~

~~(c) Other treatment modalities are indicated; or~~

~~(d) There is evidence of misuse, addiction, or diversion.~~

~~(3) The advanced registered nurse practitioner should periodically review information from any available prescription monitoring program or emergency department-based information exchange.~~

~~(4) The advanced registered nurse practitioner should periodically review any relevant information from a pharmacist provided to the~~

~~advanced registered nurse practitioner~~)) in accordance with the provisions of WAC 246-840-4935.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-485 Consultation—Recommendations and requirements. (1) The advanced registered nurse practitioner shall consider and document referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic ((~~noncancer~~)) pain patients who are under eighteen years of age((~~,~~)) or who are ((~~at risk for medication misuse, abuse, or diversion~~)) potential high-risk patients. The management of pain in patients with a history of substance ((~~abuse~~)) use 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 ((~~for adults~~)) is one hundred twenty milligrams morphine equivalent dose (MED)(((~~oral~~))). ((~~In the event~~)) If an advanced registered nurse practitioner prescribes a dosage amount that meets or exceeds the mandatory consultation threshold of one hundred twenty milligrams MED ((~~orally~~)) per day, a consultation with a pain management specialist as described in WAC 246-840-493, 246-853-750, 246-854-330, 246-817-965, 246-918-880, 246-919-940, or 246-922-750 is required, unless the consultation is exempted under WAC 246-840-487 or 246-840-490. ((~~Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.~~

~~(a)~~)) The mandatory consultation shall consist of at least one of the following:

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

((~~(ii) A telephone~~)) (b) A consultation between the pain management specialist and the advanced registered nurse practitioner;

((~~(iii) An electronic consultation between the pain management specialist and the advanced registered nurse practitioner; or~~

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

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

((~~(b) An~~)) (3) The advanced registered nurse practitioner shall document each ((~~mandatory~~)) consultation with the pain management specialist. Any written record of ((~~the~~)) a consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the pain management specialist provides a written record of the consultation to the advanced registered nurse practitioner, the advanced registered nurse practitioner shall maintain it as part of the patient record.

((~~(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist as defined in WAC 246-840-493, at any time. For the purposes of WAC 246-840-460 through 246-840-493, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.~~)) (4) The advanced registered nurse practitioner shall use great caution when prescribing opioids to children and adolescents with chronic pain; appropriate referral to a specialist is encouraged.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-487 Consultation—Exemptions for exigent and special circumstances. An advanced registered nurse practitioner is not required to consult with a pain management specialist as ((~~described~~)) defined in WAC 246-840-493 when ((~~he or she~~)) the advanced registered nurse practitioner has documented adherence to all standards of practice as defined in WAC 246-840-460 through 246-840-493, and when any one or more of the following conditions apply:

(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 ((~~or below~~)) their baseline dosage level or below;

(3) The advanced registered nurse practitioner documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalency dosage (MED) per day without first obtaining a consultation; or

(4) The advanced registered nurse practitioner documents the patient's pain and function is stable, and the patient is on a nonescalating dosage of opioids.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-490 Consultation—Exemptions for the advanced registered nurse practitioner. The advanced registered nurse practitioner is exempt from the consultation requirement in WAC 246-840-485 if one or more of the following qualifications are met:

(1) The advanced registered nurse practitioner is a pain management specialist under WAC 246-840-493;

(2) The advanced registered nurse practitioner has successfully completed, within the last two years, a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organization((~~, with~~)). At

least two of these hours must be dedicated to ((~~long-acting opioids, to include methadone~~)) substance use disorder;

(3) The advanced registered nurse practitioner is a pain management practitioner working in a multidisciplinary chronic pain ((~~treatment center,~~)) clinic or a multidisciplinary academic research facility; or

(4) The advanced registered nurse practitioner has a minimum three years of clinical experience in a chronic pain management ((~~setting~~)) clinic, and at least thirty percent of ((~~his or her~~)) the advanced registered nurse practitioners' current practice is the direct provision of pain management care.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-493 Pain management specialist. A pain management specialist, functioning as a consultant for the prescribing of chronic opioid therapy, shall meet ((~~one or more of~~)) the following qualifications:

(1) ((~~If a physician or osteopathic physician:~~

~~(a) 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; or~~

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

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

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

~~(i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and~~

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

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

~~(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.~~

~~(3) If an advanced registered nurse practitioner (ARNP):~~

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

~~(b)~~)) Credentialed in pain management by a Washington state nursing care quality assurance commission-approved ((~~national professional association, pain association, or other~~)) certifying or credentialing entity((~~;~~

~~(c)~~)); or

(2) Meet all of the following:

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

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

((~~(d)~~)) (c) At least thirty percent of the ((~~ARNP's~~)) advanced registered nurse practitioner's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

((~~(4) If a podiatric physician:~~

~~(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or~~

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

~~(c) Credentialed in pain management by a Washington state podiatric medical board, approved national professional association, pain association, or other credentialing entity; and~~

~~(d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.~~))

NEW SECTION

WAC 246-840-4935 Tapering requirements. The advanced registered nurse practitioner 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 plan is unsatisfactory. The advanced registered nurse practitioner shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(1) The patient requests;

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

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

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) There is continued dose escalation with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-840-4940 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medication(s) changes to a new advanced registered nurse practitioner, the advanced registered nurse practitioner shall query the prescription monitoring program (PMP). It is normally appropriate for the new advanced registered nurse practitioner to initially maintain the patient's current opioid

doses. Over time, the advanced registered nurse practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An advanced registered nurse practitioner's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-840-485 and the tapering requirements of WAC 246-840-4935 if:

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

(b) The patient's dose is stable and 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 to one hundred twenty milligram 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 246-840-485 and 246-840-4935 shall apply.

NEW SECTION

WAC 246-840-4950 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 advanced registered nurse practitioner shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

(2) Pregnant patients. Use of medication assisted treatment (MAT) opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 246-840-4955 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the advanced registered nurse practitioner knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the advanced registered

nurse practitioner shall review the prescription monitoring program (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 advanced registered nurse practitioner providing episodic care to a patient who the advanced registered nurse practitioner 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 advanced registered nurse practitioner 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 episodic care advanced registered nurse practitioner shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

(4) The episodic care advanced registered nurse practitioner shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the episodic care advanced registered nurse practitioner, when practicable.

NEW SECTION

WAC 246-840-4960 Coprescribing with certain medications. (1) The advanced registered nurse practitioner shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment and discussion of risks with the patient:

(a) Benzodiazepines;
(b) Barbiturates;
(c) Sedatives;
(d) Carisoprodol; or
(e) Nonbenzodiazepine hypnotics 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 advanced registered nurse practitioner 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 246-840-4970 Coprescribing of opioids for patients receiving medication assisted treatment (MAT). (1) Where practicable, the advanced registered nurse practitioner providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving medication assisted treatment (MAT) shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

(2) The advanced registered nurse practitioner 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 operative intervention.

NEW SECTION

WAC 246-840-4980 Coprescribing of naloxone. (1) The advanced registered nurse practitioner shall confirm or provide a current prescription for naloxone when fifty milligrams MED or above, or when prescribed to a high-risk patient.

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

NEW SECTION

WAC 246-840-4990 Prescription monitoring program—Required registration, queries, and documentation. (1) The advanced registered nurse practitioner shall register to access the prescription monitoring program (PMP) or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The advanced registered nurse practitioner is permitted to delegate performance of a required PMP query to an authorized designee, as defined in WAC 246-470-050.

(3) At a minimum, the advanced registered nurse practitioner shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

(a) First opioid prescription for acute pain unless clinical exception is documented; such exceptions should be rare, occurring in less than ten percent of the first prescriptions;

(b) First refill for acute pain if not checked with initial prescription due to documented clinical exception;

(c) Time of transition from acute to subacute pain;

(d) Time of transition from subacute to chronic pain; and

(e) Time of preoperative assessment for any elective surgery or prior to discharge for nonelective surgery.

(4) For chronic pain management, the advanced registered nurse practitioner shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

(a) For a high-risk patient, a PMP query shall be completed at least quarterly.

(b) For a moderate-risk patient, a PMP query shall be completed at least semiannually.

(c) For a low-risk patient, a PMP query shall be completed at least annually.

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

(6) The advanced registered nurse practitioner shall ensure a PMP query is performed when providing episodic care to a patient who the advanced registered nurse practitioner knows to be receiving opioids for chronic pain, in accordance with WAC 246-840-4955.

(7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the advanced registered nurse practitioner due to a temporary technological or electrical failure. The query shall be completed as soon as technically feasible.

(8) 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 246-840-473	Informed consent.
WAC 246-840-480	Long-acting opioids, including methadone.
WAC 246-840-483	Episodic care.