

WSMA Pain Management Rule Requirements Checklist JANUARY 2019

In late 2018 and early 2019, the boards and commissions that regulate prescribers in Washington state implemented new rules for treating pain with opioid medications. Use this document to build prompts into your electronic health record (e.g. Epic dot phrase) in order to adjust practice workflow.

Warning: While this checklist is intended to help update practice workflow to ensure success for prescribers and patients under the new rules, it will not ensure compliance with the requirements. The WSMA strongly urges all prescribers to [read the rule](#) to understand requirements in detail. For more WSMA resources, visit the opioid clinical guidance resource center at wsma.org.

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Washington State Pain Management Requirements for Acute Pain

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board and Nursing Care Quality Assurance Commission, require documentation of the following information for acute pain (less than 6 weeks of pain):

- Was the patient notified of risks of use, safe and secure storage, and proper disposal?
- History and physical documented? Was the nature and intensity of pain documented?
- Were other medications considered, including non-opioid medications?
- Was the prescription monitoring program (PMP) checked?
- Was the patient screened for risk factors for overdose?
- Was the smallest dose provided (3 days is preferred, more than 7 days requires documentation as to reason)?
- Did the provider avoid co-prescribing with a sedative agent or document the specific clinical need and risks/benefits?
- Did the provider avoid use of long-acting opioids?
- Did the provider prescribe naloxone to high-risk patients (e.g. co-prescribing, >50MEDs/day)?
- NURSE PRACTITIONER ONLY:** Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Acute Pain Follow-Up

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board, and Nursing Care Quality Assurance Commission require documentation of the following information for acute pain for patients on their second visit (less than 6 weeks of pain):

- Was the patient notified of risks of use, safe and secure storage, and proper disposal?
- History and physical documented? Was the nature and intensity of pain documented?
- Was the patient screened for risk factors for overdose?
- Were other medications considered, including non-opioid medications?
- Was the prescription monitoring program (PMP) checked?
- Was the smallest dose provided (3 days is preferred, more than 7 days requires documentation as to reason)?
- Did the provider avoid co-prescribing with a sedative agent or document the specific clinical need and risks/benefits?
- Did the provider avoid use of long-acting opioids?
- Did the provider prescribe naloxone to high-risk patients (e.g. co-prescribing, >50MEDs/day)?
- Was the patient evaluated for expected recovery and continued opioid use discussed?
- Were objective metrics for treatment success (change in pain, function, diagnostics) documented?
- NURSE PRACTITIONER ONLY:** Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Acute Pain from Operations

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board, and Nursing Care Quality Assurance Commission require documentation of the following information for acute pain related to operative care:

- Was the patient notified of risks of use, safe and secure storage, and proper disposal?
- History and physical documented? Was the nature and intensity of pain documented?
- Was the patient screened for risk factors for overdose?
- Were other medications considered, including non-opioid medications?
- Was the prescription monitoring program (PMP) checked?
- Was the smallest dose provided (3 days is preferred, more than 14 days requires documentation as to reason)?
- Did the provider avoid co-prescribing with a sedative agent or document the specific clinical need and risks/benefits?
- Did the provider avoid use of long-acting opioids?
- Did the provider prescribe naloxone to high-risk patients (e.g. co-prescribing, >50MEDs/day)?
- Nurse Practitioner only: Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Acute Pain from Operations Follow-Up Visits

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board, and Nursing Care Quality Assurance Commission require documentation of the following information for acute pain related to operative care during follow-up visits:

- Was the patient notified of risks of use, safe and secure storage, and proper disposal?
- History and physical documented? Was the nature and intensity of pain documented?
- Was the patient screened for risk factors for overdose?
- Were other medications considered, including non-opioid medications?
- Was the prescription monitoring program (PMP) checked?
- Was the smallest dose provided (3 days is preferred, more than 7 days requires documentation as to reason)?
- Did the provider avoid co-prescribing with a sedative agent or document the specific clinical need and risks/benefits?
- Did the provider avoid use of long-acting opioids?
- Did the provider prescribe naloxone to high-risk patients (e.g. co-prescribing, >50MEDs/day)?
- Was the patient evaluated for expected recovery and continued opioid use discussed?
- Were objective metrics for treatment success (change in pain, function, diagnostics) documented?
- Nurse Practitioner only: Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Subacute Pain

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board, and Nursing Care Quality Assurance Commission require documentation of the following information for subacute pain (6-12 weeks of pain):

Was the patient notified of risks of use, safe and secure storage, and proper disposal on their transition to subacute pain?

History and physical documented? Was the nature and intensity of pain documented?

Was the patient screened for risk factors for overdose, aberrant behaviors, and adverse events?

Were other medications considered, including non-opioid medications?

Was the prescription monitoring program (PMP) checked?

Was the patient screened or referred for evaluation of psychosocial risk factors?

Did the provider avoid co-prescribing with a sedative agent or document the specific clinical need and risks/benefits?

Was the smallest dose provided (more than 14 days requires documentation as to reason)?

Was the consideration of a taper, continuation, or discontinuation documented?

Did the provider prescribe naloxone to high-risk patients (e.g. co-prescribing, >50MEDs/day)?

Did the provider document a treatment plan that includes the following elements:

- Diagnosis
- Effect on function
- Concerns from PMP
- Nonopioid/nonpharmacologic treatment
- Plan for aberrant biologic specimen
- Psychosocial screening results
- Screening for risk of aberrant behavior and adverse events and mitigation plan
- Risk benefit analysis of co-prescribing

NP only: Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Chronic Pain

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board, and Nursing Care Quality Assurance Commission require documentation of the following information for chronic pain (>12 weeks of pain):

Was the patient notified of risks of chronic opioid use, safe and secure storage, and proper disposal on their transition to chronic pain?

History and physical documented? Was the nature and intensity of pain documented?

Was the patient screened for risk factors for overdose, aberrant behaviors, and adverse events?

Were other medications and modalities considered, including non-opioid medications?

Was the patient screened or referred for evaluation of psychosocial risk factors?

Did the provider avoid co-prescribing with a sedative agent (benzodiazepines, barbiturates, sedatives, carisoprodol, and hypnotic medications) or document the specific clinical need and risks/benefits?

Was the smallest effected dose provided?

Was the consideration of a taper, continuation, or discontinuation documented?

Did the provider confirm or prescribe naloxone to high-risk patients (e.g. co-prescribing, or >50MEDs/day)?

Did the provider document a treatment plan that includes the following elements:

- Written agreement for treatment
- Pain-related diagnosis
- Patient compliance with treatment plan
- Effect on function and pain control (using validated tools)
- Concerns from PMP
- Pertinent diagnostic, therapeutic, and laboratory results
- Pertinent consultations
- Current and past treatments for pain
- Nonopioid/nonpharmacologic treatment
- Plan for biologic testing
- Plan for aberrant biologic specimen
- Psychosocial screening results
- Psychiatric screening results
- Review of comorbidities
- Screening for risk of aberrant behavior and adverse events and mitigation plan (Using a risk-assessment tool)
- Assignment of the patient to a risk level: high, moderate, or low risk

- Risk-benefit analysis of co-prescribing
- Rationale for changes in treatment plan
- Consideration for referral, especially if high risk or under 18 years of age
- Pregnant patients: Providers "shall not initiate opioid detoxification without consultation from an addiction medicine provider."
- If >120 MED/day, consultation with a pain management specialist has been ordered and/or completed in the past

Are visit frequency, PMP query, and biologic specimen minimum requirements met?

- High risk: quarterly
- Moderate risk: semiannually
- Low risk: annually
- Aberrant behavior: immediately

The provider writing for long-acting opioids has completed the one-time, 4-hour CME training?

Providers caring for patients on medication-assisted treatment have coordinated care with the MAT prescriber?

Nurse practitioner only: Did the provider document diagnosis on prescription?

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Washington State Pain Management Requirements for Acute Pain

The Washington State Medical Commission, Board of Osteopathy, Podiatric Medical Board and Nursing Care Quality Assurance Commission, require PMP checks at the following intervals:

Washington State Medical Commission	<p>Upon first refill or renewal of an opioids sedative hypnotics Rx for acute pain. <input type="checkbox"/></p> <p>At the time of transition from one phase of pain to another</p> <p>For chronic pain based on risk assessment</p>
Board of Osteopathic Medicine Board	<p>Prior to the issuance of any prescription of an opioid or a benzodiazepine <input type="checkbox"/></p>
Podiatric Medical	<p>Upon the second refill or renewal of an opioid Rx for acute nonoperative pain or acute perioperative pain <input type="checkbox"/></p> <p>At the time of transition from one phase of pain to another</p> <p>For chronic pain based on risk assessment</p>
Nursing Commission	<p>All first Rxs for all opioids unless clinically documented. <input type="checkbox"/></p> <p>First refill if not checked at first Rx.</p> <p>At the time of transition from one phase of pain to another.</p> <p>Time of preoperative assessment for any elective surgery or prior to discharge for nonelective surgery.</p> <p>For chronic pain based on risk assessment.</p>