Managing Chronic Nonmalignant Pain in Patients with Addiction:
Barriers, Risks and Recommendations

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the master's project of Karen S. Rawlins find it satisfactory and recommend that it be accepted.

Chair

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Gratitude is an art of painting an adversity into a lovely picture. – Kak Sri

For all of my professors, mentors, preceptors, counselors and teachers, thank you for your patience and tutoring, and may this journey one day become a lovely picture.
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**Dedication**: For my family – for truly there are no words to describe my grateful heart, my debt of gratitude, my love and admiration for each of you. This journey would not have been possible without your support and your love and I will forever be in your service and your debt.
Managing Chronic Nonmalignant Pain in Patients with Addiction:
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Abstract

Primary care providers face significant risks and barriers when considering opioid pain medication therapy for their patients with chronic nonmalignant pain who also have addiction issues. While opioids are considered the most effective analgesic medications for chronic pain, increasing rates of abuse, misuse, diversion and addiction are being reported. Expert recommendations and guidelines advocate utilization of a universal precautions model for all patients in the treatment of chronic pain, use of screening tools for addiction, mental health and aberrant drug-related behaviors, appropriate risk stratification and monitoring and thorough documentation of analgesia, affect, aberrant behaviors, activity and adverse effects. By adhering to recognized standards of care, providers can overcome common barriers and provide safe, effective pain management care for their patients with chronic nonmalignant pain who may also have a history of addiction.

Keywords: chronic pain, nonmalignant pain, opioid analgesics, opioids, addiction, aberrant drug-related behaviors, urine toxicology, monitoring
Managing Chronic Nonmalignant Pain in Patients with Addiction:

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Despite a growing body of evidence supporting the use of opioid medication for moderate to severe chronic nonmalignant pain (Chou et al., 2009; Smith & Bruckenthal, 2010) primary care providers are often reluctant to prescribe opioid analgesia for their patients with chronic pain (Barry et al., 2010; Gallagher & Rosenthal, 2008). Patients with addiction issues face an even less receptive audience with their providers regarding the treatment of their pain (Butler & Sheridan, 2010). In a special report section of the annual *The Chartbook on Trends in Health for Americans* (2006), data from a variety of national health surveys was compiled and analyzed by the Secretary of the Department of Health and Human Services and presented to the President and Congress of the United States (U.S.). Survey data from the compilation report estimates there are over 76 million people in the U.S. who are afflicted with chronic pain, defined in the report as pain lasting longer than 3 months (US Department of Health and Human Services [DHHS], 2006). This means that more people suffer from chronic pain than from diabetes, heart disease and cancer combined (Arnstein, 2010). The American Pain Foundation reports nearly half of all people suffering from chronic pain receive no treatment (American Pain Foundation [APF], 2008). Chronic pain is associated with higher rates of depression, anxiety and substance abuse (Dewar, Osborne, Mullett, Langdeau, & Plummer, 2009), insomnia, sexual dysfunction, essential hypertension (Gourlay, 2011), as well as disruptions in memory and concentration, emotional lability (Arnstein, 2010), poor performance, lost productivity and frustration (Stanos, 2007).

The under-treatment of pain is especially problematic for patients with addiction, as the physiological need for relief of pain may actually trigger relapse to active addiction (Gourlay,
Heit, & Almahrezi, 2005) and behaviors used by patients in an attempt to cope with undertreated pain may be misinterpreted by providers as drug-seeking or addictive in nature (Elander, Marczewska, Amos, Thomas & Tangayi, 2006). Behaviors such as requests for early refills, frequent, unauthorized dose escalations or emergency room visits for complaints of chronic pain, and other aberrant behaviors may be signs of addiction, or they may represent pseudoaddiction. Pseudoaddiction is a condition that represents a failure of the provider to adequately treat a patient’s pain which resolves when effective analgesia is achieved (ASAM, 2001; ASPMN, 2002; FSMB, 2004). Pseudoaddiction can be a significant barrier to effective opioid therapy if the provider lacks knowledge and training in differentiating it from active addiction (Finney, 2010; Webster & Fine, 2010). The Federation of State Medical Boards of the United States (FSMB, 2004) states in its revised policy that the medical board considers “...inappropriate treatment, including the under-treatment of pain, a departure from an acceptable standard of practice.” (p. 1).

Addressing the often deleterious physical and psychological effects of chronic pain is further complicated by biases and stigmatization of patients within the healthcare setting where labels such as “drug-seeker”, “abuser”, or “addict” may be used to justify less effective analgesia, chronic under-treatment of pain, and a lack of therapeutic referrals for mental health, addiction, physical rehabilitation or other medical or surgical specialties (Butler & Sheridan, 2010; Fishman, 2007). Providers have an ethical obligation to provide adequate analgesia for all their patients (ASPMN, 2002) although utilization is often limited by the challenge of managing risk for abuse, misuse, addiction, and diversion of opioid medications (ASAM, 2001; Upshur, Luckmann, & Savageau, 2006). Consensus guidelines and recommendations for the management of chronic nonmalignant pain in patients with addiction are available from several national
organizations. These materials can assist providers in structuring competent and effective pain management regimes while reducing the risks associated with prescribing opioid medications (Chou et al., 2009).

While providers are expected to address and treat pain in all patients, and can face legal challenges to their license if they fail to do so (D’Arcy, 2007; FSMB, 2004), there are also a growing number of laws being enacted across the nation related to the serious problems of abuse, diversion and the over- or indiscriminate prescribing of scheduled medications (Ostrom, 2012). According to data from the Centers for Disease Control and Prevention (CDC), between 1999 and 2004 unintentional poisoning deaths related to opioid prescription drugs rose 142%, while heroin related overdose was down 9% (CDC, 2007). The CDC reports that in 2007 there were approximately 27,000 unintentional drug overdose deaths in the United States which equates to one death every 19 minutes (CDC, 2012).

Emergency room visits for drug-related issues have risen sharply since 2004 with prescribed opioids (especially oxycodone and methadone) topping the list of misused drugs (DAWN Report, 2009). Of added concern to providers is the reality that if an autopsy indicates a patient died from an overdose of a prescribed medication, the prescriber can be charged with a crime. In 2001, a family physician in Florida was charged with murder, racketeering and drug trafficking when one of his patients died of an overdose involving oxycodone (Adams, 2001; Arnstein, 2010). That same year 13 lawsuits were filed in Virginia, Kentucky, Ohio and West Virginia against Purdue Pharma and individual doctors for prescribing OxyContin (Adams, 2001).

Providers face many challenges in deciding whether or not to treat patients who have chronic nonmalignant pain with opioid medications. Lack of education and training in pain
management and addiction, fear of regulatory punishment either for under-treating or inappropriately treating pain, along with increasing risks for abuse, misuse, diversion and addiction, makes the decision to accept pain patients a difficult one for many providers.

**Statement of Purpose**

The aims of this paper are to: (a) discuss chronic pain and the use of opioid therapy for patients with addiction; (b) identify common treatment barriers and risks associated with opioid therapy for patients with a history of or current addiction issues; (c) summarize the literature that advocates utilization of expert recommendations and a universal precautions model for all patients in the treatment and management of chronic pain; and (d) suggest use of an easy-to-use reference with screening tools designed to help practitioners meet new state of Washington requirements for examination, monitoring and documentation in the management of chronic, nonmalignant pain with opioid pain medications.

**Conceptual Framework**

Virginia Henderson’s Need Theory contains fourteen components of health and four major concepts (Henderson, 1991). The four major concepts include the individual, environment, health and nursing. Henderson believed the individual has needs that are components of health and that the individual may require assistance to achieve health and independence. Her theory considers the patient has biological, psychological, sociological and spiritual components and that their mind and body are inseparable and interrelated (individual). Nursing care requires promotion of conditions which will allow the patient to perform the fourteen components of health to their highest independent degree possible (environment). Health may be challenged by age, cultural background, physical, emotional and intellectual capacities. It is the role of the nurse to encourage promotion of health and prevention and cure of disease for each individual
according to their individual capacity (health). Nurses strive to make patients whole or complete, and assist patients in performing life activities. Henderson believed nurses should be scientific problem solvers and gain the knowledge necessary to provide individualized care to their patients (nursing).

It is generally the goal of pain management to restore patients to some degree of improved function while minimizing risks associated with treatment (D’Arcy, 2007). Patients with addiction pose an additional challenge for the provider to balance adequate and effective analgesia with the risk for relapse and addiction. Within the conceptual framework of Henderson’s nursing theory (1991), 14 components of health are outlined which can serve as a useful guide for evaluating function as the nurse provider cares for patients with chronic nonmalignant pain. The 14 components are:

- Breathe normally. Eat and drink adequately.
- Eliminate body wastes.
- Move and maintain desirable postures.
- Sleep and rest.
- Select suitable clothes-dress and undress.
- Maintain body temperature within normal range by adjusting clothing and modifying environment.
- Keep the body clean and well-groomed and protect the integument.
- Avoid dangers in the environment and avoid injuring others.
- Communicate with others in expressing emotions, needs, fears, or opinions.
- Worship according to one’s faith.
- Work in such a way that there is a sense of accomplishment.
• Play or participate in various forms of recreation.
• Learn, discover, or satisfy the curiosity that leads to normal development and health and use the available health facilities.

Henderson’s 14 concepts of health provide an effective template for evaluating patient function, while encouraging the nurse to incorporate a holistic, biopsychosocial model of care which is an approach supported by current research (Savage, 2009; Stanos, 2007). This conceptual framework forms the basis of the following literature review and subsequent recommendations for providing effective pain management for patients struggling with addiction issues.

Search Strategies

CINAHL, PubMed and PsycINFO electronic databases were searched using keywords: “pain management,” “addiction,” “barriers,” “opioid analgesics,” and “chronic pain.” Additional search criteria included the parameters “peer-reviewed” and “journal article.” Journal article reference lists from this initial search were also culled for frequently cited articles of import and significance relevant to the review topic.

Review of the Literature

Chronic Pain

Although almost everyone experiences pain, there are distinct differences between acute and chronic pain. While acute pain serves a vital purpose in warning us of injury or illness, chronic pain serves no known useful purpose (Arnstein & St. Marie, 2010; Fishman, 2007). According to the guidelines formulated by the Institute for Clinical Systems Improvement and published by the Agency for Healthcare Research and Quality (AHRQ) (2009), chronic pain is defined as “…persistent pain, which can be either continuous or recurrent and of sufficient
duration and intensity to adversely affect a patient’s well-being, level of function, and quality of life,” (p. 1) and is generally considered pain which lasts longer than 6 months (D’Arcy & McCarberg, 2007). Stanos (2007) notes that poor performance and frustration can be linked to the repeated interruptions undertreated pain can cause in daily life. Costs of chronic pain to society are high as people with chronic pain are more than two times more apt to miss work, have decreased productivity, and apply for worker’s compensation and disability more often than workers without chronic pain (Finney, 2010). Wilsey, Fishman, Ogden, Tsodikov, & Bertakis (2008) report chronic pain being the chief complaint of approximately 11% of emergency department patient visits which are very expensive and a poor use of already strained healthcare resources. Common comorbidities of chronic pain include mental and substance use disorders which are associated with a higher risk for abuse and diversion (Edlund, Steffick, Hudson, Harris & Sullivan, 2007; Modesto-Lowe, Johnson, & Petry, 2007). Adequate screening for co-morbid conditions is imperative before treating patients with chronic pain using opioid medications, to ensure appropriate risk stratification, effective monitoring and appropriate referrals when needed (Edlund, 2007; Fishbain, 2008; Passik, 2009).

Undertreated or untreated acute pain has the potential to cause chronic pain through N-methyl d-aspartate (NMDA) receptor activation, apoptosis, and other neurophysiologic changes (Millard, 2007). NMDA receptors can become sensitized to nerve signals from the sites of tissue or nerve injury leading to a cascade of changes in cell function throughout the nervous system, including amplification and persistence of pain. Substance P, an inflammatory neuropeptide that coexists with the excitatory NMDA, is activated along with NMDA when pain is ineffectively treated, and has been demonstrated to play a role in pain, nociception, mood disorders, anxiety and stress (Ren & Dubner, 1999). These brain function changes are similar to those found in
other neurological conditions known to cause cognitive deficits such as autism, Alzheimer’s
disease, depression, schizophrenia and attention deficit hyperactivity disorder (Baliki, Geha,
Apkarian, & Chialvo, 2008). Chronic pain can also lead to deficits in memory and concentration,
and to a low threshold for frustration, anger and depression (Arnstein, 2010).

Treating chronic pain in patients with addiction has the potential to improve individual
functioning in many areas including memory, mental health, attention, addictive disease, job
performance, and well-being and to reduce costs to society from decreased productivity,
disability and overuse of emergency departments for undertreated pain.

**Opioid Therapy for Chronic Pain in Patients with Addiction**

In the United States opioid medications are some of the most frequently prescribed drugs
with over ten million Americans (approximately 5% of the population) taking opioids in any
given week (Kelly et al., 2008). Antidepressants, by comparison, are the most frequently
prescribed drugs in American with approximately 11% of the population taking them in any
given year (Mojtabai & Olfson, 2011). The use of opioid medications in chronic nonmalignant
pain is supported by national consensus guidelines written cooperatively by many professions
including addiction, nursing, psychology, anesthesiology, neurology, pediatrics, family practice,
surgery and others (AHRQ 2009; ASAM, 2001; ASPMN 2002; Chou et al., 2009; FSMB 2004).
Opioids are considered the most effective class of pain medication (Passik, 2009; Savage, 2009)
with constipation being the main adverse effect when used chronically (Furlan, 2006; Gallagher
& Rosenthal, 2008; Portenoy, 1996). However, patients with addiction present a particular
challenge to primary care providers, who have an ethical obligation to treat all patients suffering
from chronic pain, and who treat the majority of patients with chronic pain (ASPMN, 2002;
Barry et al., 2010; Becker, Meghani, Barth, Wiedemer, & Gallagher, 2009).
Patients with chronic pain who have a history of addiction, or who are currently addicted, should not be summarily considered ineligible for treatment with opioid medications. Although active addiction may be an absolute contraindication for opioid pain medication (Gourlay, 2005), such patients can be referred to addiction specialists for treatment, if they are amenable to such a referral, and can be re-evaluated when their addiction is considered treated and in remission. For those who have a history of addiction, risk stratification by obtaining a careful history, physical exam, and appropriate screening assessments can guide the provider in structuring an appropriate treatment plan with individualized monitoring, compliance testing, education, agreements and other accountability measures (Gourlay, 2005).

According to Gourlay (2005) the three goals for treating patients with addiction are (a) to reduce stigma, (b) contain risk, and (c) improve care. By communicating effectively and compassionately with patients that the goal of a complete, thorough and honest history and physical is not to deny care, but to formulate the safest and most effective treatment plan, providers can partner with their patients in achieving maximal function and analgesia while minimizing risks (Arnstein, 2010). Unfortunately, providers and patients alike face several significant issues when considering treatment with opioid medication. There are many inherent risks and barriers when prescribing opioids for the treatment of chronic nonmalignant pain.

**Barriers to Opioid Therapy**

Frequently cited barriers to effectively managing chronic pain with opioids are the fear of regulatory punishment, and inadequate education and training in pain management and chemical dependency (Arnstein, & St. Marie, 2010; D’Arcy & McCarberg, 2007; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002; Portenoy 1996).
**Fear of regulatory punishment.** The Model Policy for the Use of Controlled Substances for the Treatment of Pain by the Federation of State Medical Boards of the United States, Inc. (2004) addresses fear of regulatory punishment. Many state laws protect providers from prosecution for opioid prescribing if they have adhered to accepted, published guidelines and state standards of practice. Alleviating pain is mandated by The Joint Commission as part of their accreditation process and demands healthcare providers adequately assess and treat pain. However, laws such as those recently enacted in the State of Washington also highlight the responsibility providers must accept for the possible consequences of providing opioid medications to patients in pain. As the problems of misuse, abuse and diversion increase, it is incumbent upon all providers to be aware, educated and mindful of the risks involved, and to become familiar with the regulations governing the use of opioid medications in their own states.

The state of Washington has attempted to address some of these issues with new rules on opioid prescribing that has many physicians expressing fear and concern. Washington’s requirements for a higher level of documentation and examination in order to prescribe opioid medications are leading to some providers abandoning patients currently on opioid pain medications, and to their refusing to accept any new patients into their practices who might require opioid pain medications. Physicians have recently testified before lawmakers in this state regarding their reluctance to treat patients with pain out of fear of the new rules (Ostrom, 2012). Dr. J. Thompson, chief medical officer of the University of Washington’s Division of Pain Medicine, thinks the next 2-5 years will be very painful for patients, providers and the system, as the desire and legal mandate to treat pain is carefully balanced with the growing problems of abuse and diversion (Ostrom, 2012).
Inadequate education & knowledge in pain management & co-morbidities. Providers often feel ill-prepared to handle the risk for addiction with the prescribing of opioids for chronic pain, citing a lack of education and training in addiction and the use of opioids in general (Upshur, et al., 2006). Providers may fear that prescribing opioids for patients with chronic pain may actually cause addiction in a person in whom no addiction has ever been manifest. Gourlay (2012) notes there is no evidence for or against being able to “create” an addict. He further notes that it is important to employ a rational, universal precautions approach for all patients with chronic pain which sets careful limits, appropriate boundaries and includes effective pharmacotherapy when needed.

Fishbain, Cole, Lewis, Rosomoff, and Rosomoff (2008) point out there is often disagreement as to what addiction is, leading to difficulty identifying individuals who are truly addicted vs. those who have developed dependence or pseudoaddiction, a state where patients seek relief of under-treated pain which can resemble addiction (FSMB, 2004). Poorly defined terms in the literature further contribute to the ambiguity. In 2001 the American Society of Addiction Medicine (ASAM), the American Academy of Pain Medicine (AAPM), and the American Pain Society (APS) convened to develop a set of definitions related to opioids, pain and addiction. Their consensus statement, which clarifies terms necessary for clear communication within and between disciplines regarding the treatment of chronic pain and addiction, offers the following definitions:

Addiction. A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continue use despite harm, and craving.
Physical Dependence. A state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance. A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.

Pseudoaddiction. A term which has been used to describe patient behavior that may occur when pain is undertreated. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

In a White Paper published by the Nurse Practitioner Healthcare Foundation in 2010, three additional terms which are useful in the discussion of chronic pain management with opioids are defined as:

Substance misuse. The use of any drug in a manner other than how it is indicated or prescribed.

Substance abuse. Is the use of any substance when such use is unlawful, or when such use is detrimental to the user or others.

Aberrant drug-related behaviors. Those behaviors suggesting the presence of abuse or addiction.

Comorbidities are common in patients with chronic pain. Reid et al. (2002) concluded the lifetime prevalence of psychiatric conditions such as depression, anxiety and addictive disorders was 3-6 times higher among those treated for chronic pain than those in other primary care populations. Hudson, Edlund, Steffick, Tripathi, and Sullivan (2008) report findings of higher rates of mental health disorders among patients receiving opioids for chronic pain due to
nonmalignant processes, as well as multiple other chronic conditions, than in same-age non-users of opioid medications.

It is important for providers to become familiar with current recommendations and guidelines for pain management, understand the terms commonly used in pain management settings, and to become comfortable with the laws and regulations surrounding the prescribing of opioid medications.

**Risks Associated with Opioid Prescribing**

The risks associated with opioid prescribing include abuse, misuse and diversion of opioid medications, aberrant drug-related behaviors and addiction. Providers understandably have concerns about the risks of prescribing opioids to their patients with chronic pain, especially if they also have addiction issues. Starrels et al., (2010) points out that opioid misuse is a growing problem and must be addressed through more research and improved opioid prescribing strategies.

**Abuse, misuse, diversion and addiction.** Between 2004 and 2008 the Drug Abuse Warning Network (DAWN) data reveals a 111% increase in emergency room visits for the nonmedical use (misuse) of several commonly prescribed opioid medications, and the misuse of opioids as the number one cause of poisoning. Maxwell (2011) points out that while popular belief is that people who abuse opioids obtain their pills illegally from the internet or from drug dealers on the street, the majority of prescription opioid medication that is misused comes from friends and family who receive their drugs from a single prescriber. This is an onerous responsibility for prescribers who may want to provide effective pain management for their patients, but for whom the risks of their patients abusing and/or diverting opioid medication may seem too great.
Addiction is a rare risk among patients treated with opioid pain medications, but unfortunately is one reason many providers choose not to treat pain with opioids (ASAM, 2001). Research has consistently revealed a very low risk of a patient developing addiction while receiving chronic opioid analgesic medications from an estimated 0.19% rate among those with no previous history of addiction, to 3.27% among those with personal or family history of addiction (Fishbain, 2008; Portenoy, 1996). This can be compared to prevalence estimates of substance dependence or abuse in the general population which is around 9% (SAMHSA, 2008). Evidence supports the position that using opioids for the management of chronic pain does not lead to high rates of addiction, however, providers must be vigilant in assessing, diagnosing and managing patients on opioid medications so those who do abuse, divert or become addicted can be identified early and provided with appropriate intervention and referrals. Effective monitoring strategies can help ensure both patient safety and treatment success for patients with chronic pain, while minimizing the risk for abuse, misuse, diversion, and addiction.

**Aberrant drug-related behaviors.** There are many aberrant drug-related behaviors providers must be aware of with any patient receiving opioids for pain management. Finney (2010) describes these behaviors as frequent late-night visits to the emergency room, lost or stolen prescriptions, use of multiple names, stealing or forging prescriptions, diverting or selling prescriptions, patients focusing on a particular medication despite the offer of an alternative and despite experiencing uncomfortable side effects from the requested medication. Providers must be prepared to monitor their patients carefully for aberrant drug-related behaviors and addiction, not only to reduce risk to their patients, but to protect themselves from liability. It is important to assess patients carefully when aberrant drug-related behaviors surface, to determine if the
behaviors are the result of addiction or abuse, inadequately treated pain (pseudoaddiction), or some other medical or psychological condition.

The challenge for providers is to overcome common barriers to opioid medication management, while mitigating the potential for abuse and addiction, enabling them to provide effective chronic pain management treatment for all their patients. Published guidelines and expert recommendations can assist providers in overcoming these barriers and in handling the risks involved with opioid prescribing. This is critical if we are to adequately address the needs of the large numbers of patients who suffer from chronic pain and who may also have a history of or current addiction issues.

**Recommendations for Treatment Management**

Managing chronic pain requires diligence from providers to ensure adequate levels of analgesia and function are achieved with their pain management patients, while also mitigating the risks of abuse, misuse, addiction and diversion (Starrels, 2010). National guidelines have been published by a number of organizations all of which aim to assist providers of all professions with these dual aims. While there is an unfortunate paucity of research to empirically validate recommendations, expert panels have carefully reviewed the available evidence and formulated consensus guidelines aimed at optimizing benefits and reducing risk (Chou et al., 2009).

The following two suggestions for primary care providers and/or specialists are advocated by several expert panels and address the issue of providing safe management of patients with chronic pain who may also suffer from past or present addiction issues (AHRQ, 2009; ASAM, 2001; ASPMN, 2002; Chou et al., 2009; FSMB, 2004).
not take any new pain management patients, and current chronic pain patients are being referred to specialists in as many cases as possible. There seems to be a mass exodus of providers away from providing chronic opioid pain management for their patients.

The president of the Washington State Medical Association (WSMA), recently testified to state lawmakers that, “I think that (the new law) has spooked a lot of physicians to where they are no longer willing to write prescriptions for these conditions,” (Ostrom, 2012, February 10, p. 1). Denny Maher, director of legal affairs for the WSMA states, “A lot of what we are hearing is physicians are afraid to take care of patients or they have concerns about taking care of patients because of the documentation requirements and the examination requirements,” (Ostrom, 2012, February 10, p. 1). At the same hearing, two patients told the committee members they had been abruptly cut off of their pain management treatment because of the new law and have been struggling ever since to find new providers. Dr. Jeff Thompson, chief medical officer of the states’ Medicaid program, said of doctors, “They’re scared, and they need some help, and they need some tools…” (Ostrom, 2012, February 10, p. 2).

To partially address this need, the basic requirements of the new Washington law (WAC 246) have been summarized into a document which can be copied for use in practice (Appendix B). The overview provides the PCP with a summary of the legal requirements for the management of chronic noncancer pain in Washington. Descriptions of several validated screening tools for the provider to use in monitoring their chronic pain patients are included in Appendix A. The new rules contained in WAC 246 are summarized in Appendix B, and a listing of the most well-respected clinical practice guidelines and recommendations can be found on page 18 of this paper. These resources can assist providers in offering safe, evidence-based,
compassionate and effective chronic pain management care when prescribing opioid medications for their patients with chronic nonmalignant pain who also have issues with addiction.

**Summary**

Managing patients with chronic nonmalignant pain who suffer from addiction presents the prescriber/provider with many challenges. Abuse, misuse, and diversion are on the rise and leading to increasing numbers of unintentional overdose, emergency room visits and other adverse health effects. Regulatory and governing bodies have sought to curb the problems of abuse and diversion by introducing rules which not only target patients who may be misusing medication, but also the providers who provide opioid medications for relief of chronic pain. Some providers are responding by refusing to accept chronic pain patients who require opioid therapy over an increased fear of regulatory punishment and concerns over the increased documentation and examination requirements. Patients are then faced with the difficulty of finding a provider who is willing to manage their pain. For those patients with chronic pain whose treatment is inadequate, there is the risk for neurophysiological changes, disability, depression and other adverse health-related effects. There is also the issue of too little education and training for providers in the areas of pain management and addiction, which are frequently cited barriers to effective treatment of chronic nonmalignant pain.

Providers can overcome common barriers to opioid pain management by (a) managing all patients with a universal precautions approach, (b) obtaining the education and training necessary to treat chronic pain and prescribe opioid medications appropriately, (c) becoming familiar with national guidelines and recommendations, (d) becoming well-versed in state laws, and (e) utilizing specialists as needed. The risks associated with opioid prescribing can be mitigated by appropriate initial screening, rational prescribing, regular supervision and on-going
monitoring for all patients, urine drug testing, treatment agreements and referrals to other mental health, addiction or healthcare specialists as needed.

Patients and providers alike benefit from a universal approach which emphasizes patient accountability, provider competence, and provides a well-structured and predictable framework for patients receiving pain management treatment with opioids. Universal precautions allow providers to offer equal access to care for all patients with chronic nonmalignant pain, regardless of addiction history or status, and to provide that care safely and effectively.
References


Retrieved 01/2012 from http://www.cdc.gov/nchs/data/hus/hus06.pdf


Appendix A

1) Webster’s Opioid Risk Tool (ORT):

**Purpose:** The Opioid Risk Tool (ORT) is designed to predict which pain patients may develop aberrant, drug-related behaviors based on known risk factors associated with abuse or addiction. The purpose is not to deny high-risk patients treatment, but to set a level of clinical monitoring appropriate to the risk level.

**Target Population:** Adults

**Evidence:**
- Provides excellent discrimination between high risk and low risk patients (Passik, et al, 2008).
- Exhibited a high degree of sensitivity and specificity for determining which individuals are at risk for opioid abuse (Webster & Webster, 2005).
- Patients categorized as high-risk on the ORT have an increased likelihood of future abusive drug-related behavior (Chou et al., 2009).

**Advantages:**
- Preferable to SOAPP in low-risk populations (Passik, et al, 2008)
- Brief, simple scoring tool that is validated in pain populations (Passik, et al, 2008).
- Validated for both male and female patients (Webster & Webster, 2005).

**Limitations**
- One question on the ORT is limited by the patient's knowledge of family history of substance abuse (Passik, et al, 2008).

**Test Features:**

**Length/time:** 5 items, less than 1 minute to administer and score

**Administered by:** Self-Report

**Intended Settings:** Primary care

Opioid Risk Tool (ORT) Copyright © Lynn R. Webster, MD. All rights reserved.
2) STOP PAIN SCALE

- Developed by a certified pain management specialist in private practice, the STOP PAIN SCALE is a tool used to screen patients for appropriateness of dose escalations.

- Dr. Jasper describes the purpose of his tool as being used to: achieve consistency in evaluating the adequacy of the patient's efforts to manage their own pain, and to help select additional approaches to reduce pain.

- The STOP PAIN SCALE is filled out by the provider.

- The STOP PAIN SCALE may be copied in its entirety for medical use and not for commercial gain.

@ Jasper and Beall 2011.
3) Screener and Opioid Assessment for Patients in Pain (SOAPP-R)

Purpose: The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) predicts possible opioid abuse in chronic pain patients.

Target population: Adults

Evidence:

- Provides excellent discrimination between high risk and low risk patients (Passik et al. 2008).
- High-risk score on the SOAPP-R correlates with an increased likelihood of drug abuse (Chou et al. 2009).
- Study suggests that the SOAPP-R is an improvement over the original version in screening risk potential for deviant medication-related behavior among chronic pain patients (Butler et al. 2008).

Advantages:

- SOAPP-R is cross validated (Butler et al. 2008)
- Developed specifically for pain patients (Butler 2008)
- Easily understood by patients, takes little time to administer and score, and taps information believed by experienced professionals to be important (Butler et al. 2008).
- Less susceptible to overt deception than original SOAP (Butler et al. 2008).

Limitations:

- Less sensitive and specific than original SOAP (Butler et al. 2008).

Test Features:

Length/time: 5 minutes to administer and score

Administered by: Self-report; Observation and toxicology report by health care professional

Intended settings: Primary care

@ Inflexxion, Inc. The SOAPP-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.
4) Current Opioid Misuse Measure (COMM)

**Purpose:** The Current Opioid Misuse Measure (COMM) tool helps clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future.

**Target population:** Adults

**Evidence:**

- The COMM demonstrates excellent internal consistency, sensitivity and test–retest reliability (Butler et al. 2007)
- Increased score on the COMM correlates with a higher likelihood of current opioid-related aberrant behavior (Chou et al. 2009).
- Recently published validation study found COMM score of $\geq 13$ had a sensitivity of 77% and a specificity of 77% for identifying patients with a prescription drug use disorder (PDD) using DSM-IV criteria (Meltzer et al. 2011).
- The COMM is a promising tool for identifying patients with concurrent aberrant prescription drug use problems who are receiving opioid pain medications (Meltzer et al. 2011).

**Advantages:**

- Useful in assessing adherence to an opioid treatment program and in reassessment
- Questionnaire is easy to understand and takes little effort to score

**Limitations:**

- Using a high cutoff COMM score may lead to retaining a larger percentage of false positives, which the authors of the tool acknowledge could be improved. However, they believe this may also be at the risk of missing more of those who actually do show aberrant behavior.

**Test features:**

**Length/time:** 17 items, less than 10 minutes to administer and score

**Administered by:** Self-report

**Intended settings:** Primary Care

@ Inflexxion, Inc. The COMM was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.
5) Pain Medicine Questionnaire (PMQ)

**Purpose:** The Pain Medication Questionnaire (PMQ) is an assessment tool for ongoing monitoring of aberrant behaviors. It helps clinicians to identify whether a long-term chronic pain patient is exhibiting aberrant behaviors associated with opioid medication misuse.

**Target population:** Adults

**Evidence:**
- Good reliability and validity (Dowling et al. 2007)
- Useful in measuring progress in pain patients already taking opioids (Passik et al. 2008).
- The PMQ has long-term utility in identifying patients who are likely to benefit from a pain management program (Holmes et al. 2006).
- High PMQ scores are associated with a history of substance abuse, psychosocial distress and poor functioning (Adams et al. 2004).

**Advantages:**
- Specific to chronic pain patients using opioid treatments
- Reliable for long-term across a patient’s pain management program

**Limitations:**
- Not validated in populations other than chronic pain patients

**Test features:**
- **Length/time:** 26 items, about 10 minutes to administer and score
- **Administered by:** Self-report.
- **Intended settings:** Primary care
6) DIRE tool

**Purpose:** The Diagnosis, Intractability, Risk, Efficacy (DIRE) tool assesses the risk of opioid abuse and suitability of candidates for long-term opioid therapy.

**Target population:** Adults

**Evidence:**

- Validated by six experts studying patient case vignettes (Passik et al. 2008).
- Showed sensitivity, efficacy, specificity and high internal consistency (Belgrade et al. 2006)

**Advantages:**

- Specifically designed for primary care use (Passik et al. 2008)
- Patient’s DIRE score correlates well with patient compliance and efficacy of long-term opioid therapy (Belgrade et al. 2006)

**Limitations:**

- Prospective validation needed (Passik et al. 2008)

**Test Features:**

**Length/time:** Prescreen, plus 7 items, less than 2 minutes to administer and score

**Administered by:** Patient interview

**Intended settings:** Primary care

**Available Formats:** Online, Print
7) Brief Pain Inventory (BPI)

**Purpose:** The Brief Pain Inventory (BPI) assesses the intensity of physical pain using a numerical rating scale (1 to 10) and percent pain relief. It measures both the intensity of pain and interference of pain in the patient's life and also queries the patient about pain relief, pain quality, and patient perception of the cause of pain.

**Target population:** Adults

**Evidence:**
- Demonstrated both reliability and validity across cultures and languages and is being adopted in many countries for clinical pain assessment (Cleeland & Ryan 1994)
- Responsive in detecting and reflecting improvement in pain over time (Tan et al. 2004)
- Reliable and valid scale scores for assessing pain intensity and interference in patients with chronic nonmalignant pain (Tan et al. 2004)

**Advantages:**
- Validated in at least 11 languages and widely used internationally (Radbruch et al. 1999)
- Although developed for assessing cancer pain the BPI has been validated in nonmalignant chronic pain patients (Tan et al. 2004)
- Brief, user-friendly and simple to administer

**Limitations:**
- As with other self-reports, it is subject to distortion by the respondent

**Test features:**
- **Length/time:** 32 items, about 15 minutes to administer and score
- **Administered by:** Patient Interview or Self-Report
- **Intended settings:** Primary Care

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8) Patient Health Questionnaire - PHQ-9 and GAD-7

**Purpose:** The Patient Health Questionnaire (PHQ), PHQ-9 and GAD-7 are designed to help the primary care provider recognize and diagnose common mental health disorders including depression and anxiety. The PHQ-9 and GAD-7 can be used to monitor patient status throughout treatment.

- Ideally patients should be screened at intake, and at least annually with treatment. All patients suspected of having a disorder need to be screened or re-screened.
- Diagnoses must be verified by the clinician and verified with other relevant information from the patient, his or her family or other sources.

**Target population:** Adults

**Evidence:**
- PHQ-9 has demonstrated validity and reliability in making criteria-based depression diagnoses as well as a reliable and valid measure of severity of depression (Kroenke, Spitzer & Williams, 2001)
- GAD-7 had good reliability, as well as criterion, construct, factorial, and procedural validity. A cut point was identified that optimized sensitivity (89%) and specificity (82%) (Spitzer, Kroenke, Williams, & Lowe, 2006)

**Advantages:**
- Both screening tools are brief, user-friendly and simple to administer

**Limitations:**
- As with similar tools, they may be subject to self-report bias

**Test features:**

**Length/time:** 16 questions combined, approximately 10 minutes for both tools

**Administered by:** Self-report

**Intended settings:** Primary Care

PHQ-9 and GAD-7 were developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues.
9) What’s your Snore Score?

**Purpose:** Evaluate patients for sleep apnea before initiating treatment with opioid medications for chronic pain. Untreated apnea along with narcotic pain medications could be a potentially life-threatening combination in some patients.

- According to the American Sleep Apnea Association, the Greek word "apnea" literally means "without breath." Sleep apnea is an involuntary cessation of breathing that occurs while the patient is asleep. There are three types of sleep apnea: obstructive, central, and mixed. Of the three, obstructive sleep apnea, often called OSA for short, is the most common. In most cases the sleeper is unaware of these breath stoppages because they don't trigger a full awakening.

- Left untreated, sleep apnea can have serious and life-shortening consequences: high blood pressure, heart disease, stroke, automobile accidents caused by falling asleep at the wheel, diabetes, depression, and other ailments.

**Test Features:**

- **Length/time:** 6 items, less than 5 minutes to complete
- **Administered by:** Self-report
- **Intended settings:** Primary care
Alternative strategies for managing pain must be explored. If alternative strategies for managing the pain are unsuccessful, long-term opioid therapy can be added. The goal is not merely to treat the symptoms of pain but to devise pain management strategies that deal effectively with all aspects of the patient's pain syndrome, including psychological, physical, social, and work-related factors. Documentation in the patient's medical record should include:

1. **History and medical examination.** A complete physical examination and comprehensive medical history should be part of the active treatment record, including but not limited to, a review of past pain treatment outcomes and any history of addiction risks to establish a diagnosis and treatment plan.

2. **Diagnosis and medical indication.** A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.

3. **Written treatment plan with recorded measurable objectives.** The plan should have clearly stated, measurable objectives, indication of further planned diagnostic evaluation, and alternative treatments.

4. **Informed consent.** Discussions of risks and benefits should be noted in some format in the patient's record.

5. **Periodic reviews and modifications indicated.** At these periodic reviews, the provider should reassess the treatment plan, the patient's clinical course, and outcome goals with particular attention paid to disease progression, side effects, and emergence of new conditions.

6. **Consultation.** The treating provider should be knowledgeable and competent in referring patients to the appropriate specialist if needed and noting in the patient's record the treating provider's interpretation of the consultation reports. Additionally, a new patient with evidence of at-risk patterns of opioid usage should be evaluated by a knowledgeable specialist.

7. **Records.** The provider should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications, and patient instructions.

8. **Assessment and monitoring.** Some patients with chronic pain not associated with cancer may be at risk of developing increasing opioid consumption without objective improvement in functional status. Subjective reports by the patient should be supported by objective observations. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, patient consumption of healthcare resources, positive answers to specific questions about the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient as observed by the physician. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a disease with behavior characterized by psychological
dependence and aberrant drug-related behaviors. Addicts compulsively use drugs for nonmedical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts merely because they are being treated with opioids. The physician is responsible for monitoring the dosage of the opioid. Monitoring includes ongoing assessment of patient compliance with drug prescriptions and related treatment plans. Communication between healthcare providers is essential. The patient should receive long-term analgesic medications from one physician and where possible one pharmacy. All providers should be particularly cautious with patients who have a history of alcoholism or other drug addiction when prescribing long-term opioids. Consultation with addiction specialists is recommended.

- **Patient Responsibilities**

  1. It is the patient's responsibility to candidly provide the treatment provider with a complete and accurate treatment history, including past medical records, past pain treatment, and alcohol and other drug addiction history.
  2. The patient should participate as fully as possible in all treatment decisions.
  3. The patient and family members, if available, should inform the prescriber of all drug side effects and concerns regarding prescription drugs.
  4. The patient should not use other psychoactive agents, including alcohol, naturopathic products, or over-the-counter drugs without agreement of the prescriber.
  5. The patient should always use the same name when receiving medical care to assure completeness of the medical record.
  6. The patient should demand respect and expect to be believed.
  7. The patient should keep an open mind and be willing to work with the treatment provider, including:
     a. Negotiate with the provider to arrive at an acceptable plan of treatment;
     b. Be open in trying alternative treatment strategies; and
     c. Follow the treatment provider's instructions precisely.
  8. The patient should, where possible, get all central nervous system medications from one provider. If this is not possible, the patient should inform each provider of all medications he or she is receiving.
  9. The patient should, where possible, have all prescriptions filled at a single pharmacy.
  10. The patient should not horde, share, or sell medications.
  11. The patient should be aware that providers may, by law, share information with other providers about the patient's care.

WAC 246 – Opioid Prescribing Reference for the Primary Care Provider

WAC 246-840-460 Pain Management Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

WAC 246-840-463 Exclusions. The rules adopted under WAC 246-840-460 through 246-840-493 do not apply to: the provision of palliative, hospice, or other end-of-life care; or the management of acute pain caused by an injury or surgical procedure.


1. Obtain, evaluate and document the patient’s health history including:

   Current and past treatments for pain, comorbidities and any substance abuse.
   Review any available prescription monitoring program, ED-based information exchanges and any information provided from a pharmacist.

2. Obtain and document a thorough physical including:

   Nature and intensity of the pain.
   Effect of pain on physical and psychological function.
   Medications including date, type, dosage, and quantity prescribed.
   Risk screening for potential comorbidities and risk factors addressing:
     - History of addiction, abuse or aberrant behavior regarding opioid use
     - Receipt of opioids from more than one prescribing practitioner or group
     - Repeated visits to ED seeking opioids
     - Psychiatric conditions, poorly controlled depression or anxiety
     - Regular concomitant use of benzodiazepines, alcohol, or other CNS medications
     - Evidence or risk of significant adverse events, including falls or fractures
     - History of sleep apnea or other respiratory risk factors
     - Possible or current pregnancy
     - History of allergies or intolerances

   Initial evaluation should include:
     - Any available diagnostic, therapeutic, and laboratory results
     - Any available consultations

3. The health record should include:

   Diagnosis, treatment plan and objectives.
   Documentation of the presence of one or more recognized indications for the use of pain medication.
   Documentation of any medication prescribed.
Results of periodic reviews.
Any written agreements for treatment between the patient and the provider.
The provider’s instructions to the patient.

4. WAC 246-840-470  Treatment Plan.

The treatment plan shall include at a minimum:

- Any change in pain relief, physical and psychosocial function.
- Additional diagnostic evaluations or other planned treatments.
- The indications for medication use shall be included on the prescription.
- Photo ID shall be required of the person picking up the RX in order to fill.
- Provider shall advise the patient that it is the patient’s responsibility to safeguard all medications and keep them in a secure location.

5. WAC 246-840-473  Informed Consent.

The provider shall discuss the risks and benefits of treatment options with the patient.

6. WAC 246-840-475  Written Agreement for Treatment.

If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing provider shall use a written agreement for treatment with the patient outlining patient responsibilities which shall include:

- The patient agrees to provide biological samples for urine/serum medical level screening when requested by the provider.
- To take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills.
- Reasons for which drug therapy may be discontinued (e.g. violation of agreement).
- All chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system.
- The patient’s agreement to not abuse alcohol or use other medically unauthorized substances.
- Written authorization for: The provider to release the agreement for treatment to local ED’s, urgent care facilities, and pharmacies, and for other practitioners to report violations of the agreement back to the provider.
Notifying the proper authorities if he or she has reason to believe the patient has engaged in illegal activity.

Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription.

Acknowledgment that it is the patient’s responsibility to safeguard all medications and keep them in a secure location.

Acknowledgment that if the patient violates the terms of the agreement, the violation and the provider’s response to the violation will be documented, as well as the rationale for changes in the treatment plan.

7. WAC 246-840-477 Periodic Review.

The provider 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, the periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving non-escalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

During the periodic review, the provider shall determine:

- Patient’s compliance with any medication treatment plan
- If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers
- If continuation or modification of medications for pain management treatment is necessary based on the provider’s evaluation of progress towards treatment objectives.

The provider 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 provider shall consider tapering, changing, or discontinuing treatment when:

- Function or pain does not improve after a trial period.
- There is evidence of significant adverse effects.
- Other treatment modalities are indicated.
- There is evidence of misuse, addiction, or diversion.

The provider should periodically review information from any available prescription monitoring program or ED-based information exchange.
The provider should periodically review any relevant information from a pharmacist provided to the provider.

8. WAC 246-840-480  Long-acting Opioids, Including Methadone.

Long-acting opioids, including methadone, should only be prescribed by a provider who is familiar with its risks and use, and is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. A provider prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.


See WAC for details.

10. WAC 246-840-485  Consultation Recommendations and Requirements.

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

The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED) (oral). In the event a provider prescribes a dosage amount that meets or exceeds the consultation threshold of 120mg MED daily, a consultation with a pain management specialist as described in WAC 246-840-493, 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.

The mandatory consultation shall consist of at least one of the following:

- An office visit with the patient and the pain management specialist.
- A telephone consultation between the pain management specialist and the provider.
- An electronic consultation between the pain management specialist and the provider.
An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the provider or a licensed health care practitioner designated by the provider or the pain management specialist.

The provider shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the provider, the provider shall maintain it as part of the patient record.

Consultations with pain management specialists can be contractually required by any person, company, insurance, hospital, etc.

11. WAC 246-840-487 Consultation Exemptions for Exigent and Special Circumstances.

A provider is not required to consult with a pain management specialist when he or she 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:

The patient is following a tapering schedule.

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.

The provider documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above 120mg (MED) per day without first obtaining a consultation.

The provider documents the patient’s pain and function is stable and the patient is on a non-escalating dosage of opioids.

12. WAC 246-840-490 Consultation Exemptions for the Advanced Registered Nurse Practitioner.

The ARNP/Physician is a pain management specialist under WAC 246-840-493.

The ARNP/Physician 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 2 of these hours dedicated to long-acting opioids, to include methadone.

The ARNP/Physician is a pain management practitioner working in a multi-disciplinary chronic pain treatment center, or a multi-disciplinary academic research facility.
The ARNP/Physician has a minimum 3 years of clinical experience in a chronic pain management setting, and at least 30% of his or her current practice is the direct provision of pain management care.


A pain management specialist shall meet one or more of the following qualifications:

If a physician or osteopathic physician:

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

Has a subspecialty certificate in pain medicine by an ABMS-approved board; or

Has a certification of added qualification in pain management by the AOA; or

A minimum of 3 years of clinical experience in a chronic pain management care setting; AND

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 Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past 2 years; AND At least 30% of the physician’s or osteopathic physician’s current practice is the direct provision of pain management care or is in a multi-disciplinary pain clinic.

If an Advanced Registered Nurse Practitioner (ARNP): A minimum of 3 years of clinical experience in a chronic pain management setting; Credentialed in pain management by a Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity; Successful completion of a minimum of at least 18 continuing education hours in pain management during the past 2 years; AND At least 30% of the ARNP’s current practice is the direct provision of pain management care or is in a multi-disciplinary pain clinic.