JUST WHAT THE DOCTOR ORDERED?
WASHINGTON STATE’S REGULATORY BARRIERS TO CHRONIC PAIN TREATMENT

by
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As the number of Americans suffering from chronic pain continues to escalate – now surpassing the number of those suffering from diabetes, heart disease, and cancer combined – the use of prescription opioids for relieving pain has become prevalent as an effective and medically proven treatment for a variety of patient pain levels.

Unfortunately, Washington State recently enacted burdensome regulations on prescription opioids, redefining the patient-physician relationship such that physicians are often forced to choose between “providing access to pain medications for those who need them and managing the variety of risks posed by [opioid] analgesic drugs.” The regulations were intended to reduce prescription drug abuse, but in actuality, they place physicians in an unenviable treatment, and threaten the ability of medical providers to appropriately evaluate and prescribe personalized treatment for all patients.

New Rules Governing Washington State Pain Management. In March 2010, the state of Washington passed Engrossed Substitute House Bill (ESHB) 2876, which called for an overhaul of the state’s pain management rules. According to the legislative record, a key purpose of ESHB


3See generally E.S.H.B. 2876, 61st Leg., 2010 Reg. Sess. (WA 2010), available at

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2876 was to reverse the increasing trend of overdose deaths in Washington, which exceeded the national average.\(^4\) While a legislative response to the recognized public health concern of prescription drug abuse was understandable, the restrictions imposed under the adopted regulations are troublesome for patient advocacy groups fearful that future access to pain management treatment in Washington will be diminished, and for doctors, who are put in the dilemma of balancing regulatory law with patient well-being.\(^5\)

Two of the most unsettling changes under the new regulations are: (1) requirements for significantly greater physician monitoring of a patient’s prescription use and (2) a mandatory consultation with a “pain management specialist” for all chronic pain patients who are prescribed opioids above specified dosage levels.\(^6\) On their face, these might seem like laudable measures, but in effect they bar legitimate patients from receiving the drugs they need.

The modified patient monitoring program mandates that physicians not only establish “pain contracts,” in writing, to document a patient’s responsibility under personalized opioid treatment plans,\(^7\) but also to “determine [a] patient’s compliance with any medication treatment plan” during formal periodic reviews.\(^8\) While confusion commonly occurs during the implementation of any new or unfamiliar regulation, the Washington State Medical Quality Assurance Commission (“the Commission”) provided physicians with little more than generalized instructions for drafting patient treatment plans\(^9\) and conducting periodic reviews.\(^10\) This lack of specificity places medical providers in the position of crafting ad hoc treatment documents and evaluating patient conformity in a manner that may not fully comply with the Commission’s regulatory vision, thus exposing providers to the risk of potential sanctions by state licensing boards.\(^11\) The serious consequence of non-compliance has left many Washington State primary care providers hesitant to continue prescribing pain management medications.\(^12\)


\(^8\)Id. at § 246-919-857. In addition to determining a patient’s compliance, this treatment agreement also must include, “A written authorization from the [prescriber] may notify the proper authorities if he or she has reason to believe that the patient has engaged in illegal activity.” Id. at § 246-918-806.

\(^9\)Id. at § 246-919-856.

\(^10\)Id. at § 246-919-857.


\(^12\)See id.
A second and more controversial provision under the new pain management regulation requires a “mandatory consultation . . . with a pain management specialist” for any adult who is prescribed an opioid dosage “that meets or exceeds . . . one hundred twenty milligrams morphine equivalent dose per day.” This additional mandate for treating patients with pain will likely result in either an increase of physician reimbursement rates by third-party payers for the additional oversight care required, or a decrease in the availability of opioid pain management treatment due to the burdensome and resource-intensive requirements for delivering such care.

In the short time that has passed since the now-effective regulations were first announced, a number of Washington-based healthcare entities discontinued opioid treatment for relieving chronic pain. The exodus of physicians and medical practices from the “prescription opioids for pain” market will likely have its greatest impact on patients within society’s lowest socio-economic strata. Washington Department of Health officials, recognizing that opioid therapy will become increasingly difficult to obtain, proposed that chronic pain patients should explore alternative treatments for relieving pain, such as “physical therapy, yoga, massages or acupuncture.” Unfortunately (and ironically), a majority of these alternative medicine options are not covered under Washington’s Medicaid program because they are not clinically proven, rendering these “choices” financially unrealistic for many patients who suffer from chronic pain.

Additional Concerns with Washington’s Invasive and Selective Pain Regulations. The new pain management rules, which effectively deny treatment for those suffering from chronic pain, are strangely limited in scope. If Washington policy-makers were truly concerned with controlling abuse of opioids, one would expect the rules to cover all uses of the medication; yet the regulations govern opioid treatment only for “chronic noncancer pain,” with specific exclusions for patients receiving similar prescription opioids for treatment of cancer, palliative care, end-of-life care, and acute injury or surgery related pain. The selective imposition of barriers against only a chronic pain patient’s access to treatment, and in particular against those attempting to utilize appropriate and lawful medical channels for relieving pain, demonstrates a misunderstanding of the underlying issue: “drug abusers are the problem . . . not chronic-pain patients.”

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13 WASH. ADMIN. CODE § 246-919-860.
14 E.S.H.B. 2876, supra note 3 (According to ESHB 2876, which was passed and filed on March 26, 2010, the new regulations serve to replace the previous state pain management statutes, effective as of July 1, 2011).
16 See id.
17 Id.
18 Id.
19 “Chronic noncancer pain” is defined as “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.” WASH. ADMIN. CODE § 246-922-622(3).
20 WASH. ADMIN. CODE § 246-919-851.
21 Ostrom, supra note 7.
Balancing Patient-Physician Decisions with Public Safety. Washington’s recent overhaul of its pain medication rules represents a classic case of “good intention, bad delivery,” and healthcare leaders would be wise to pay close attention to the impact that such excessive government intervention has, particularly on those with chronic pain. In order to effectively diminish the nonmedical use of opioids, a commitment must be made at all levels within a prescription drug’s life cycle to ensure that from manufacturing to distribution, only individuals with authorization and medical orders are able to obtain these medications.

Due to the all-consuming nature of pain, the enactment of new government regulations that obstruct patients from receiving physician-prescribed pain treatment is likely to have negligible impact on the nonmedical and unmanaged use of pain-relieving opioids. Rather than creating new government regulations which harm chronic pain patients, states and federal agencies may find greater success by focusing on the enforcement of existing laws and holding accountable those who illegally distribute or abuse prescription drugs. Decisions regarding appropriate and otherwise lawful medical treatment, including the administration of opioid analgesics for chronic pain, are best left to individual physicians and their patients.

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