

**WAC 246-919-905 Patient evaluation and patient record—Chronic pain.** When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician shall include in the patient's record:

- (1) An appropriate history including:
  - (a) The nature and intensity of the pain;
  - (b) The effect of pain on physical and psychosocial function;
  - (c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and
  - (d) Review of comorbidities with particular attention to psychiatric and substance use.
- (2) Appropriate physical examination.
- (3) Ancillary information and tools to include:
  - (a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;
  - (b) Any pertinent diagnostic, therapeutic, and laboratory results;
  - (c) Pertinent consultations; and
  - (d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.
- (4) Assessment. The physician must document medical decision making to include:
  - (a) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
  - (b) Consideration of the risks and benefits of chronic opioid treatment for the patient;
  - (c) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids; and
  - (d) Pertinent concerns discovered in the PMP.
- (5) Treatment plan as provided in WAC 246-919-910.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-905, filed 11/16/18, effective 1/1/19.]