

Chapter 246-919 WAC
WASHINGTON MEDICAL COMMISSION

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WAC

246-919-010 Definitions.
246-919-020 Commission address.
246-919-110 Commission meetings.

APPLICATIONS AND EXAMINATIONS

246-919-300 Application withdrawals.
246-919-320 Approved United States and Canadian medical schools.
246-919-330 Postgraduate medical training.
246-919-340 Additional requirements for international medical school graduates.
246-919-355 Examination accepted by the commission.
246-919-360 Examinations accepted for licensure.
246-919-365 FLEX examination standards.
246-919-370 Special purpose examination.
246-919-395 Substantially equivalent licensing standards—Temporary practice permit.
246-919-396 Background check—Temporary practice permit.
246-919-397 How to obtain a temporary practice permit—Military spouse.

RENEWAL AND CME REQUIREMENTS

246-919-421 Two year renewal cycle.
246-919-422 Transition from post-graduate limited license to full license.
246-919-430 Requirements for maintenance of licensure.
246-919-435 Training in suicide assessment, treatment, and management.
246-919-460 Categories of creditable continuing medical education activities.
246-919-470 Approval not required.
246-919-475 Expired license.
246-919-480 Retired active license.

ADJUDICATIVE PROCEDURES

246-919-520 Revocation of a physician's license.

OFFICE-BASED SURGERY RULES

246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings.
246-919-602 Administration of deep sedation and general anesthesia by physicians in dental offices.

STANDARDS FOR PROFESSIONAL CONDUCT

246-919-605 Use of laser, light, radiofrequency, and plasma devices as applied to the skin.
246-919-606 Nonsurgical medical cosmetic procedures.
246-919-610 Use of drugs or autotransfusion to enhance athletic ability.
246-919-620 Cooperation with investigation.
246-919-630 Sexual misconduct.
246-919-640 Abuse.

MANDATORY REPORTING

246-919-700 Mandatory reporting.

OPIOID PRESCRIBING—GENERAL PROVISIONS

246-919-850 Intent and scope.
246-919-851 Exclusions.
246-919-852 Definitions.
246-919-865 Patient notification, secure storage, and disposal.
246-919-870 Use of alternative modalities for pain treatment.
246-919-875 Continuing education requirements for opioid prescribing.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

246-919-880 Patient evaluation and patient record—Acute nonoperative pain.
246-919-885 Treatment plan—acute nonoperative pain.
246-919-890 Treatment plan—Acute perioperative pain.

OPIOID PRESCRIBING—SUBACUTE PAIN

246-919-895 Patient evaluation and patient record—Subacute pain.
246-919-900 Treatment plan—Subacute pain.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

246-919-905 Patient evaluation and patient record—Chronic pain.
246-919-910 Treatment plan—Chronic pain.
246-919-915 Written agreement for treatment—Chronic pain.
246-919-920 Periodic review—Chronic pain.
246-919-925 Long-acting opioids—Chronic pain.
246-919-930 Consultation—Recommendations and requirements—Chronic pain.
246-919-935 Consultation—Exemptions for exigent and special circumstances—Chronic pain.
246-919-940 Consultation—Exemptions for the physician—Chronic pain.
246-919-945 Pain management specialist—Chronic pain.
246-919-950 Tapering considerations—Chronic pain.

- 246-919-955 Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician.
- OPIOID PRESCRIBING—SPECIAL POPULATIONS
- 246-919-960 Special populations—Children or adolescent patients, pregnant patients, and aging populations.
- 246-919-965 Episodic care of chronic opioid patients.
- OPIOID PRESCRIBING—COPRESCRIBING
- 246-919-970 Coprescribing of opioids with certain medications.
- 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment.
- 246-919-980 Coprescribing of naloxone.
- OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM
- 246-919-985 Prescription monitoring program—Required registration, queries, and documentation.
- PHYSICIAN AND SURGEON FEES
- 246-919-990 Physician and surgeon fees and renewal cycle.
- DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER**
- 246-919-030 Current address. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-030, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.
- 246-919-100 Panel composition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-100, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-120 Appearance and practice before agency—Solicitation of business unethical. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-120, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-130 Appearance and practice before agency—Standards of ethical conduct. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-130, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-140 Appearance and practice before agency—Appearance by former member of attorney general's staff. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-140, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-150 Appearance and practice before agency—Former employee and board/commission member as witness. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-150, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-200 Petitions for rule making, amendment or repeal—Who may petition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-200, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.
- 246-919-210 Petitions for rule making, amendment or repeal—Requisites. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-210, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.
- 246-919-220 Petitions for rule making, amendment or repeal—Agency must consider. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-220, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.
- 246-919-230 Petitions for rule making, amendment or repeal—Notice of disposition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-230, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.
- 246-919-240 Declaratory rulings. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-240, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.
- 246-919-305 Refunds. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-305, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.
- 246-919-310 Credentialing of physicians and surgeons. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-310, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.
- 246-919-350 Examinations. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-350, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.
- 246-919-380 AIDS prevention and information education requirements. [Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-380, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-380, filed 1/17/96, effective 2/17/96.] Repealed by WSR 21-07-055, filed 3/12/21, effective 4/12/21. Statutory Authority: RCW 18.71.017 and 18.130.050.
- 246-919-390 Temporary permits—Recognized jurisdictions. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-390, filed 1/17/96, effective 2/17/96.] Repealed by

WSR 17-18-098, filed 9/6/17, effective 10/7/17. Statutory Authority: RCW 18.71.017 and 18.130.075.

246-919-400 Scope. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-400, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-919-410 License renewal. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-410, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-919-420 License renewal form. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-420, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-919-440 Certification of compliance. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-440, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-919-450 Categories of creditable continuing medical education activities. [Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-450, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-450, filed 1/17/96, effective 2/17/96.] Repealed by WSR 16-16-028, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080.

246-919-500 Brief adjudicative proceedings—Denials based on failure to meet education, experience, or examination prerequisites for licensure. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-500, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-09-118, filed 4/22/98, effective 5/23/98. Statutory Authority: RCW 18.71.017.

246-919-510 Adjudicative proceedings. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-510, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-09-118, filed 4/22/98, effective 5/23/98. Statutory Authority: RCW 18.71.017.

246-919-600 Prescriptions—Schedule II stimulant drugs. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-600, filed 1/17/96, effective 2/17/96.] Repealed by WSR 05-10-065, filed 5/2/05, effective 6/2/05. Statutory Authority: RCW 18.71.017.

246-919-615 Delegation of authority to initiate investigations. [Statutory Authority: RCW 18.71.017, 18.71A.020, 18.130.050(12), 18.130.080. WSR 07-03-150, § 246-919-615, filed 1/23/07, effective 2/23/07.] Repealed by WSR 10-20-138, filed 10/5/10, effective 11/5/10. Statutory Authority: RCW 18.130.050(1), 18.71.017.

246-919-710 Mandatory reporting requirement satisfied. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-710, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-720 Health care institutions. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-720, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-730 Medical associations or societies. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-730, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-740 Health care service contractors and disability insurance carriers. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-740, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-750 Courts. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-750, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-760 State and federal agencies. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-760, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-770 Professional standards review organizations. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-770, filed 1/17/96, effective 2/17/96.] Repealed by WSR 20-22-003, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.050.

246-919-800 Purpose. [Statutory Authority: RCW 18.71.017, 18.130.050(1) and (12) and 18.130.340. WSR 99-22-090, § 246-919-800, filed 11/2/99, effective 12/3/99.] Repealed by WSR 11-12-025, filed 5/24/11, effective 1/2/12. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020.

246-919-810 What specific guidance should a practitioner follow? [Statutory Authority: RCW 18.71.017, 18.130.050(1) and (12) and 18.130.340. WSR 99-22-090, § 246-919-810, filed 11/2/99, effective 12/3/99.] Repealed by WSR 11-12-025, filed 5/24/11, effective 1/2/12. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020.

246-919-820 What knowledge should a practitioner possess to treat pain patients? [Statutory Authority: RCW 18.71.017, 18.130.050(1) and (12) and 18.130.340. WSR 99-22-090, § 246-919-820, filed 11/2/99, effective 12/3/99.] Repealed by WSR 11-12-025, filed 5/24/11, effective 1/2/12. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020.

246-919-830 How will the commission evaluate prescribing for pain? [Statutory Authority: RCW 18.71.017, 18.130.050(1) and (12) and 18.130.340. WSR 99-22-090, § 246-919-830, filed 11/2/99, effective 12/3/99.] Repealed by WSR 11-12-025, filed 5/24/11, effective 1/2/12. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020.

246-919-840 How do advanced registered nurse practitioners qualify for prescriptive authority for Schedule II - IV drugs? [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-840, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-841 Criteria for joint practice arrangement. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-841, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-842 Endorsement of joint practice arrangements for ARNP licensure. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-842, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-843 Process for joint practice arrangement termination. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-843, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-844 Seventy-two-hour limit. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-844, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-845 Education for prescribing Schedule II - IV drugs. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-845, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-846 Jurisdiction. [Statutory Authority: RCW 18.71.017 and 18.71.370. WSR 01-16-010, § 246-919-846, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-02-089, filed 1/4/06, effective 2/4/06. Statutory Authority: RCW 18.71.017 and 18.71.050.

246-919-853 Patient evaluation. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-853, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-854 Treatment plan. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-854, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-855 Informed consent. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-855, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-856 Written agreement for treatment. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-856, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-857 Periodic review. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-857, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-858 Long-acting opioids, including methadone. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-858, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-859 Episodic care. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-859, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-860 Consultation—Recommendations and requirements. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-860, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-861 Consultation—Exemptions for exigent and special circumstances. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-861, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-862 Consultation—Exemptions for the physician. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-862, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

246-919-863 Pain management specialist. [Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-863, filed 5/24/11, effective 1/2/12.] Repealed by WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297.

WAC 246-919-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Applicant" is an individual who has completed the application form and has paid the application fee.
- (2) "Commission" means the Washington medical commission.
- (3) "Emergent" means a circumstance calling for immediate action.

(4) "Hospital" means any health care institution licensed under chapter 70.41 RCW.

(5) "Intermittent" means providing services on a part-time or full-time nonpermanent basis.

(6) "Physician" means a person licensed under chapter 18.71 RCW.

(7) "Unprofessional conduct" means the conduct described in RCW 18.130.180.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-010, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-010, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-010, filed 1/17/96, effective 2/17/96.]

WAC 246-919-020 Commission address. The commission's official mailing address is:

Washington Medical Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-020, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-020, filed 1/17/96, effective 2/17/96.]

WAC 246-919-110 Commission meetings. Regular commission meetings shall be held at least four times yearly. Additional regular or special meetings may be called at the discretion of the chair or by a quorum of the commission.

[Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-110, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-110, filed 1/17/96, effective 2/17/96.]

APPLICATIONS AND EXAMINATIONS

WAC 246-919-300 Application withdrawals. An application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license. Applications that are subject to investigation for unprofessional conduct or impaired practice may not be withdrawn.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-300, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-300, filed 1/17/96, effective 2/17/96.]

WAC 246-919-320 Approved United States and Canadian medical schools. For the purposes of RCW 18.71.055, the commission approves medical schools accredited by the Liaison Committee on Medical Education.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-320, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-320, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-320, filed 1/17/96, effective 2/17/96.]

WAC 246-919-330 Postgraduate medical training. (1) Postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties listed in the 2017-2018 ABMS Board Certification Report and new specialties or subspecialties approved by the commission.

(2) The commission approves only the following postgraduate clinical training courses:

(a) Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) at the time of residency.

(b) Programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC), or programs accredited by the RCPSC or CFPC at the time of residency.

(3) Postgraduate medical training includes, but is not limited to, internships, residencies and medical or surgical fellowships.

(4) A physician must complete two consecutive years of postgraduate medical training in no more than two programs. The physician must acquire this training after completion of a formal course of undergraduate medical instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-330, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71.050. WSR 05-07-024, § 246-919-330, filed 3/7/05, effective 4/7/05. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-087, § 246-919-330, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-330, filed 1/17/96, effective 2/17/96.]

WAC 246-919-340 Additional requirements for international medical school graduates. All graduates of medical schools outside the United States, Canada, or Puerto Rico must satisfy one of the following requirements:

(1) Held a full and unrestricted license to practice medicine in another state prior to 1958;

(2) Obtained a certificate with an indefinite status granted by the Educational Commission for Foreign Medical Graduates (ECFMG); or

(3) Successfully completed one year of supervised academic clinical training in the United States, commonly referred to as a Fifth Pathway program.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-340, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-086, § 246-919-340, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-340, filed 1/17/96, effective 2/17/96.]

WAC 246-919-355 Examination accepted by the commission. (1) The commission accepts the United States Medical Licensing Examination (USMLE) as the examination for licensure.

(2) The minimal passing scores for each component of any approved examination combination shall be a score of seventy-five as defined by the examining authority.

(3) Applicants must have passed all components of the USMLE within seven years after passing the first examination. The commission recognizes that an applicant with a combined degree may require an exception to the seven-year requirement. The commission will review exception requests on a case-by-case basis.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-355, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-355, filed 1/17/96, effective 2/17/96.]

WAC 246-919-360 Examinations accepted for licensure. (1) The commission may accept certain examinations as a basis for licensure. These examinations include USMLE, Federation Licensure Examination (FLEX), National Boards Examination (NBE), or those given by the other states, or territories of the United States. Those who have taken the Licentiate of the Medical Council of Canada (LMCC) and hold a valid LMCC certification obtained after 1969, may be granted a license without examination.

(2) Examination combination acceptable. Any applicant who has successfully completed Part I (NBE) or Step 1 (USMLE) plus Part II or Step 2 plus Part III or Step 3; or FLEX Component 1 plus Step 3; or Part I or Step 1, plus Part II or Step 2, plus FLEX Component 2 shall be deemed to have successfully completed a medical licensure examination as required by RCW 18.71.070. (For clarification, see Table 1.)

Table 1

Accepted Examinations taken in Sequence	Other Acceptable Combinations
NBME Part I <i>plus</i> NBME Part II <i>plus</i> NBME Part III	NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> NBME Part III or USMLE Step 3

Accepted Examinations taken in Sequence	Other Acceptable Combinations
FLEX Component 1 <i>plus</i> FLEX Component 2	FLEX Component 1 <i>plus</i> USMLE Step 3 or NBME Part I or USMLE Step 1 <i>plus</i> NBME Part II or USMLE Step 2 <i>plus</i> FLEX Component 2
USMLE Step 1 <i>plus</i> USMLE Step 2 <i>plus</i> USMLE Step 3	

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-360, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.050, 18.71.090, and [18.71.]095. WSR 06-18-042, § 246-919-360, filed 8/30/06, effective 9/30/06. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-360, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-360, filed 1/17/96, effective 2/17/96.]

WAC 246-919-365 FLEX examination standards. The commission will accept the Federation Licensing Examination (FLEX) weighted average of 75 reported from the Federation of State Medical Boards. All FLEX scores must be submitted directly from the Federation of State Medical Boards. FLEX scores reported by other states will not be accepted.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-365, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-365, filed 1/17/96, effective 2/17/96.]

WAC 246-919-370 Special purpose examination. (1) The commission may require an applicant to pass the Special Purpose Examination (SPEX) or any other examination deemed appropriate. An applicant may be required to take an examination when the commission has concerns with the applicant's ability to practice competently for reasons which may include, but are not limited to, the following:

- (a) Resolved or pending malpractice suits;
- (b) Pending action by another state licensing authority;
- (c) Actions pertaining to privileges at any institution; or
- (d) Not having practiced for the immediate two years prior to the application.

(2) The minimum passing score on the SPEX examination shall be seventy-five. The passing score for any other examination under this rule shall be determined by the commission.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-370, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-370, filed 1/17/96, effective 2/17/96.]

**WAC 246-919-395 Substantially equivalent licensing standards—
Temporary practice permit.** (1) An applicant who holds an unrestricted, active license in another state with licensing standards substantially equivalent to those in Washington may apply for a temporary practice permit authorizing the applicant to practice as a physician in Washington.

(2) The commission will issue the physician a temporary practice permit if the following requirements are met:

(a) The applicant submits a completed application for a physician and surgeon license on a form provided by the commission on which the applicant indicates that he or she wishes to receive a temporary practice permit;

(b) The applicant submits payment of the application fee and temporary practice permit fee under WAC 246-919-990;

(c) The commission receives the American Medical Association's physicians' data profile verifying states in which the applicant is or was licensed;

(d) The commission receives the practitioner profile from the Federation of State Medical Boards;

(e) The applicant requests and the commission receives written verification attesting that the applicant has a license in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment from all states which the applicant is or was licensed;

(f) The applicant is not subject to denial of a license or issuance of a conditional license under chapter 18.130 RCW; and

(g) The applicant is licensed in a state that has licensing standards substantially equivalent to Washington.

(3) The temporary practice permit allows the applicant to work in the state of Washington as a physician without restriction until the permit expires. The temporary practice permit is a license to practice medicine.

(4) The temporary practice permit shall expire upon the issuance of a license by the commission; initiation of an investigation by the commission of the applicant; or ninety days after the temporary practice permit is issued, whichever occurs first. The temporary permit will not be renewed, reissued, or extended.

(5) An applicant who receives a temporary practice permit and who does not complete the application process may not receive additional temporary practice permits even upon submission of a new application in the future.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-395, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.075. WSR 17-18-098, § 246-919-395, filed 9/6/17, effective 10/7/17. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-395, filed 1/17/96, effective 2/17/96.]

WAC 246-919-396 Background check—Temporary practice permit.

The commission conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

The commission will issue a temporary practice permit that is valid for six months. A one-time extension of six months will be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician during the time period specified on the permit. The temporary practice permit is a license to practice medicine.

(3) The commission issues a license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

(4) The temporary practice permit is no longer valid after the license is issued or action is taken on the application because of the background check.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-396, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-919-396, filed 2/9/10, effective 2/11/10.]

WAC 246-919-397 How to obtain a temporary practice permit—Military spouse. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for physicians.

(1) A temporary practice permit may be issued to an applicant who is a military spouse or state registered domestic partner of a military person and:

(a) Is moving to Washington as a result of the military person's transfer to Washington;

(b) Left employment in another state to accompany the military person to Washington;

(c) Holds an unrestricted, active license in another state that has substantially equivalent licensing standards for a physician to those in Washington; and

(d) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body of the other state or states.

(2) A temporary practice permit grants the individual the full scope of practice for the physician.

(3) A temporary practice permit expires when any one of the following occurs:

- (a) The license is granted;
 - (b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the temporary practice permit; or
 - (c) One hundred eighty days after the temporary practice permit is issued.
- (4) To receive a temporary practice permit, the applicant must:
- (a) Submit to the commission the necessary application, fee(s), fingerprint card if required, and documentation for the license;
 - (b) Attest on the application that the applicant left employment in another state to accompany the military person;
 - (c) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for physicians;
 - (d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards for physicians in Washington;
 - (e) Submit a copy of the military person's orders and a copy of:
 - (i) The military-issued identification card showing the military person's information and the applicant's relationship to the military person;
 - (ii) A marriage license; or
 - (iii) Documentation of a state registered domestic partnership.
 - (f) Submit a written request for a temporary practice permit.
- (5) For the purposes of this section:
- (a) "Military spouse" means the husband, wife, or registered domestic partner of a military person.
 - (b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-397, filed 10/21/20, effective 11/21/20.]

RENEWAL AND CME REQUIREMENTS

WAC 246-919-421 Two year renewal cycle. A licensed physician shall renew his or her license every two years in compliance with WAC 246-12-030. A licensed physician must also submit information about his or her current professional practice as required by RCW 18.71.080 (1) (b).

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-421, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-421, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-421, filed 11/16/99, effective 1/1/00.]

WAC 246-919-422 Transition from post-graduate limited license to full license. In order to obtain full license status, a physician with a post-graduate limited Washington license will pay the fee difference between the limited license application and the full license

application. This license will expire on their second birth date after issuance and every two years thereafter.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-422, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-422, filed 7/22/16, effective 8/22/16.]

WAC 246-919-430 Requirements for maintenance of licensure. A licensed physician must complete one of the following to satisfy maintenance of licensure requirements during renewal:

(1) Complete two hundred hours of continuing education every four years as required in chapter 246-12 WAC and as described in WAC 246-919-460. Participation in a residency program accredited by the Accreditation Council for Graduate Medical Education or in a fellowship program, accredited or not, may be credited fifty hours of Category I continuing medical education per year of training towards the two hundred hour requirement;

(2) Obtain a current Physician's Recognition Award from the American Medical Association in at least two of the four years preceding the renewal due date;

(3) Become certified by a member board of the American Board of Medical Specialties in the four years preceding the renewal due date;

(4) Meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-430, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-430, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-430, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-430, filed 1/17/96, effective 2/17/96.]

WAC 246-919-435 Training in suicide assessment, treatment, and management. (1) A licensed physician, other than a resident holding a limited license issued under RCW 18.71.095(3), must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.

(2) The training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education period after initial licensure, whichever occurs later, or during the first full continuing education reporting period after the exemption in subsection (6) of this section no longer applies. The commission accepts training completed between June 12, 2014, and January 1, 2016, that meets the requirements of RCW 43.70.442 as meeting the one-time training requirement.

(3) The training must be on the model list developed by the department of health under RCW 43.70.442. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.

(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

(5) The commission exempts any licensed physician from the training requirements of this section if the physician has only brief or limited patient contact, or no patient contact.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-435, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 43.70.442. WSR 17-07-043, § 246-919-435, filed 3/8/17, effective 4/8/17.]

WAC 246-919-460 Categories of creditable continuing medical education activities. (1) **Category I: Continuing medical education activities with accredited sponsorship.** The licensed physician may earn all two hundred credit hours in Category I. The commission will accept attendance at a continuing education program that is recognized as Category I credit and is offered by an organization or institution that meets the standards adopted by the Accreditation Council for Continuing Medical Education or its designated interstate accrediting agency, the Washington State Medical Association.

(2) **Category II: Continuing medical education activities with nonaccredited sponsorship.** A licensed physician may earn a maximum of eighty credit hours by attendance at continuing medical education programs that are not approved but which are in accordance with the provisions of Category I.

(3) **Category III: Teaching of physicians or other allied health professionals.** A licensed physician may earn a maximum of eighty credit hours for serving as an instructor of medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program if the hospital or institution has approved the instruction.

(4) **Category IV: Books, papers, publications, exhibits.** A licensed physician may earn:

(a) A maximum of eighty credit hours under Category IV, with specific subcategories listed below. Credit may be earned only during the forty-eight-month period following presentations or publications.

(b) Ten credit hours for a paper, exhibit, publication, or for each chapter of a book that is authored by the licensed physician and published. A paper must be published in a recognized medical journal. A licensed physician who presents a paper at a meeting or an exhibit must present to physicians or allied health professionals. Credit may be claimed only once for the scientific materials presented. Credit should be claimed as of the date materials were presented or published.

Medical editing will not be accepted in this or any other category for credit.

(5) **Category V: Self-directed activities.** A licensed physician may earn:

(a) A maximum of eighty credit hours under Category V.

(b) Self-assessment: Credit hours for completion of a multimedia medical education program.

(c) Self-instruction: Credit hours for the independent reading of scientific journals and books.

(d) Specialty board examination preparation: Credit hours for preparation for specialty board certification or recertification examinations.

(e) Quality care or utilization review: Credit hours for participation on a staff committee for quality of care or utilization review in a hospital or institution or government agency.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-460, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-460, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-460, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-460, filed 1/17/96, effective 2/17/96.]

WAC 246-919-470 Approval not required. (1) Except as required by law, the commission will not give prior approval for any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these rules and relies upon each individual physician's integrity to comply with this requirement.

(2) The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of creditable hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of program sponsors to present continuing medical education that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-470, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-470, filed 1/17/96, effective 2/17/96.]

WAC 246-919-475 Expired license. (1) If the license has been expired for three years or less, the physician must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the license has been expired for over three years, the physician must:

(a) Reapply for licensing under current requirements as stipulated in RCW 18.71.050 (1)(b) and WAC 246-919-330; and

(b) Meet the requirements of chapter 246-12 WAC, Part 2.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-475, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 01-03-115, § 246-919-475, filed 1/22/01, effective 2/22/01.]

WAC 246-919-480 Retired active license. (1) To obtain a retired active license a physician must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) A physician with a retired active license may not receive compensation for health care services;

(3) A physician with a retired active license may practice only in emergent or intermittent circumstances; and

(4) A physician with a retired active license must renew every two years and must report one hundred hours of continuing medical education at every renewal. The commission will accept a maximum of forty hours of continuing medical education in Categories II through V, as defined in WAC 246-919-460, during each renewal period. There is no limit to the number of hours that may be accepted in Category I.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-480, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-480, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-480, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-480, filed 1/17/96, effective 2/17/96.]

ADJUDICATIVE PROCEDURES

WAC 246-919-520 Revocation of a physician's license. A physician may request a review by the commission of its decision to revoke the physician's license under RCW 18.71.019:

(1) If the commission issues a final order revoking a physician's license following an adjudicative proceeding, the physician may request a review of the decision by a review panel of the commission.

(2) The physician shall file a written request with the commission within twenty days of the effective date of the final order. The physician may not request an extension of the twenty-day period to file a request for review.

(3) The physician's request for review of the final order does not change the effective date of the final order.

(4) A review panel shall review the final order. The review panel is composed of the members of the commission who did not:

(a) Review the initial investigation and make the decision to issue a statement of charges against the physician in this matter; or

(b) Hear the evidence at the adjudicative proceeding and issue the final order revoking the physician's license.

(5) Within seven days of receipt of the request for review of the final order, a scheduling order is issued setting a date for the review hearing, and a date for the filing of written argument by the parties. The review hearing must take place within sixty days of the physician's request for review of the final order.

(6) The review panel shall convene in person for the review hearing on the date set in the scheduling order. If a commission member is unavailable to meet on the scheduled date, a pro tempore member shall take that person's place on the review panel. At the review hearing, the review panel:

(a) Shall review the final order;

(b) Shall review written argument presented by the parties; and

(c) May hear oral argument by the parties.

(7) If the review panel determines that revocation of the physician's license is not the appropriate sanction, it shall issue an amended order setting the appropriate sanction(s) necessary to protect the public.

(8) If the review panel determines that revocation of the physician's license is appropriate, it shall issue an order confirming that decision.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-520, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.019. WSR 97-21-053, § 246-919-520, filed 10/13/97, effective 11/13/97.]

OFFICE-BASED SURGERY RULES

WAC 246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings. (1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The commission establishes the following rule for physicians licensed under this chapter who perform surgical procedures and use anesthesia, analgesia or sedation in office-based settings.

(2) Definitions. The following terms used in this subsection apply throughout this section unless the context clearly indicates otherwise:

(a) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(b) "General anesthesia" means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body, in which the patient is without protective reflexes and is unable to maintain an airway, and cardiovascular function may be impaired. Sedation that unintentionally progresses to the point at which the patient is without protective reflexes and is unable to maintain an airway is not considered general anesthesia.

(c) "Local infiltration" means the process of infusing a local anesthetic agent into the skin and other tissues to allow painless wound irrigation, exploration and repair, and other procedures, including procedures such as retrobulbar or periorbital ocular blocks only when performed by a board eligible or board certified ophthalmologist. It does not include procedures in which local anesthesia is injected into areas of the body other than skin or muscle where significant cardiovascular or respiratory complications may result.

(d) "Major conduction anesthesia" means the administration of a drug or combination of drugs to interrupt nerve impulses without loss of consciousness, such as epidural, caudal, or spinal anesthesia, lumbar or brachial plexus blocks, and intravenous regional anesthesia. Major conduction anesthesia does not include isolated blockade of small peripheral nerves, such as digital nerves.

(e) "Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral, intranasal, or intramuscular medications.

(f) "Moderate sedation" or "analgesia" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(g) "Office-based surgery" means any surgery or invasive medical procedure requiring analgesia or sedation, including, but not limited to, local infiltration for tumescent liposuction, performed in a location other than a hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(3) Exemptions. This rule does not apply to physicians when:

(a) Performing surgery and medical procedures that require only minimal sedation (anxiolysis), or infiltration of local anesthetic around peripheral nerves. Infiltration around peripheral nerves does not include infiltration of local anesthetic agents in an amount that exceeds the manufacturer's published recommendations.

(b) Performing surgery in a hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(c) Performing surgery utilizing or administering general anesthesia. Facilities in which physicians administer general anesthesia or perform procedures in which general anesthesia is a planned event are regulated by rules related to hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, an ambulatory surgical facility licensed under chapter 70.230 RCW, or a dental office under WAC 246-919-602.

(d) Administering deep sedation or general anesthesia to a patient in a dental office under WAC 246-919-602.

(e) Performing oral and maxillofacial surgery, and the physician:

(i) Is licensed both as a physician under chapter 18.71 RCW and as a dentist under chapter 18.32 RCW;

(ii) Complies with dental quality assurance commission regulations;

(iii) Holds a valid:

(A) Moderate sedation permit; or

(B) Moderate sedation with parenteral agents permit; or

(C) General anesthesia and deep sedation permit; and

(iv) Practices within the scope of their specialty.

(4) Application of rule.

This rule applies to physicians practicing independently or in a group setting who perform office-based surgery employing one or more of the following levels of sedation or anesthesia:

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia.

(5) Accreditation or certification.

(a) A physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the commission.

(b) The commission may approve an accrediting entity that demonstrates to the satisfaction of the commission that it has all of the following:

(i) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the commission;

(ii) Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;

(iii) Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and

(iv) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

(c) A physician may perform procedures under this rule in a facility that is not accredited or certified, provided that the facility has submitted an application for accreditation by a commission-approved accrediting entity, and that the facility is appropriately equipped and maintained to ensure patient safety such that the facility meets the accreditation standards. If the facility is not accredited or certified within one year of the physician's performance of the first procedure under this rule, the physician must cease performing procedures under this rule until the facility is accredited or certified.

(d) If a facility loses its accreditation or certification and is no longer accredited or certified by at least one commission-approved entity, the physician shall immediately cease performing procedures under this rule in that facility.

(6) Competency. When an anesthesiologist or certified registered nurse anesthetist is not present, the physician performing office-based surgery and using a form of sedation defined in subsection (4) of this section must be competent and qualified both to perform the operative procedure and to oversee the administration of intravenous sedation and analgesia.

(7) Qualifications for administration of sedation and analgesia may include:

(a) Completion of a continuing medical education course in conscious sedation;

(b) Relevant training in a residency training program; or

(c) Having privileges for conscious sedation granted by a hospital medical staff.

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility. Certification in advanced resuscitative techniques includes, but is not limited to, advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or advanced pediatric life support (APLS).

(9) Sedation assessment and management.

Sedation is a continuum. Depending on the patient's response to drugs, the drugs administered, and the dose and timing of drug administration, it is possible that a deeper level of sedation will be produced than initially intended.

(a) If an anesthesiologist or certified registered nurse anesthetist is not present, a physician intending to produce a given level of sedation should be able to "rescue" a patient who enters a deeper level of sedation than intended.

(b) If a patient enters into a deeper level of sedation than planned, the physician must return the patient to the lighter level of

sedation as quickly as possible, while closely monitoring the patient to ensure the airway is patent, the patient is breathing, and that oxygenation, heart rate and blood pressure are within acceptable values. A physician who returns a patient to a lighter level of sedation in accordance with this subsection (c) does not violate subsection (10) of this section.

(10) Separation of surgical and monitoring functions.

(a) The physician performing the surgical procedure must not administer the intravenous sedation, or monitor the patient.

(b) The licensed health care practitioner, designated by the physician to administer intravenous medications and monitor the patient who is under moderate sedation, may assist the operating physician with minor, interruptible tasks of short duration once the patient's level of sedation and vital signs have been stabilized, provided that adequate monitoring of the patient's condition is maintained. The licensed health care practitioner who administers intravenous medications and monitors a patient under deep sedation or analgesia must not perform or assist in the surgical procedure.

(11) Emergency care and transfer protocols. A physician performing office-based surgery must ensure that in the event of a complication or emergency:

(a) All office personnel are familiar with a written and documented plan to timely and safely transfer patients to an appropriate hospital.

(b) The plan must include arrangements for emergency medical services and appropriate escort of the patient to the hospital.

(12) Medical record. The physician performing office-based surgery must maintain a legible, complete, comprehensive, and accurate medical record for each patient.

(a) The medical record must include all of the following:

(i) Identity of the patient;

(ii) History and physical, diagnosis and plan;

(iii) Appropriate lab, X-ray or other diagnostic reports;

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

(vii) Documentation of which, if any, tissues and other specimens have been submitted for histopathologic diagnosis;

(viii) Provision for continuity of postoperative care; and

(ix) Documentation of the outcome and the follow-up plan.

(b) When moderate or deep sedation, or major conduction anesthesia is used, the patient medical record must include a separate anesthesia record that documents:

(i) The type of sedation or anesthesia used;

(ii) Name, dose, and time of administration of drugs;

(iii) Documentation at regular intervals of information obtained from the intraoperative and postoperative monitoring;

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

(vii) Estimated blood loss;

(viii) Duration of procedure; and

(ix) Any complication or unusual events related to the procedure or sedation/anesthesia.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-601, filed 10/21/20, effective 11/21/20. Statutory Authority:

RCW 18.71.017. WSR 17-18-032, § 246-919-601, filed 8/28/17, effective 9/28/17. Statutory Authority: RCW 18.71.017 and 18.130.050(4). WSR 10-16-109, § 246-919-601, filed 8/2/10, effective 9/2/10.]

WAC 246-919-602 Administration of deep sedation and general anesthesia by physicians in dental offices.

(1) Purpose. The purpose of this section is to govern the administration of deep sedation and general anesthesia by physicians in dental offices. The commission establishes these standards to promote effective perioperative communication and appropriately timed interventions, and mitigate adverse events and outcomes.

(2) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Administering physician" means an individual licensed under chapter 18.71 RCW who administers deep sedation or general anesthesia to a patient in a dental office.

(b) "Deep sedation" has the same meaning as in WAC 246-919-601.

(c) "Dental office" means any facility where dentistry is practiced, as defined in chapter 18.32 RCW, except a hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW.

(d) "General anesthesia" has the same meaning as in WAC 246-919-601.

(e) "Perioperative" includes the three phases of surgery: Preoperative, intraoperative, and postoperative.

(3) An administering physician is responsible for the perioperative anesthetic management and monitoring of a patient and must ensure patient care, recordkeeping, equipment, personnel, facilities, and other related matters are in accordance with acceptable and prevailing standards of care including, but not limited to, the following:

(a) Preoperative requirements. An administering physician shall ensure the patient has undergone a preoperative health evaluation and document review of the evaluation. The physician shall also conduct and document a risk assessment to determine whether a patient is an appropriate candidate for deep sedation or general anesthesia and discussion of the risks of deep sedation or general anesthesia with the patient. For a pediatric patient, this assessment must include:

(i) Whether the patient has specific risk factors that may warrant additional consultation before administration of deep sedation or general anesthesia, and how each patient meets criteria for deep sedation or general anesthesia in an outpatient environment. This must include a specific inquiry into whether the patient has signs and symptoms of sleep-disordered breathing or obstructive sleep apnea;

(ii) A discussion with a parent or guardian of a pediatric patient of the particular risks of deep sedation or general anesthesia for a patient who: (A) Is younger than six years old; (B) has special needs; (C) has airway abnormalities; or (D) has a chronic condition. This discussion must include reasoning why the pediatric patient can safely receive deep sedation or general anesthesia in an outpatient environment and any alternatives.

(b) Medical record. The anesthesia record must be complete, comprehensive, and accurate for each patient, including documentation at regular intervals of information from intraoperative and postoperative monitoring. The recordkeeping requirements under WAC 246-919-601 and 246-817-770 apply to an administering physician, including the elements of a separate anesthesia record. The anesthesia record must also

include temperature measurement and a heart rate and rhythm measured by electrocardiogram. For a pediatric patient, the administering physician shall ensure vital signs are postoperatively recorded at least at five-minute intervals until the patient begins to awaken, then recording intervals may be increased to ten to fifteen minutes.

(c) Equipment. An administering physician shall ensure the requirements for equipment and emergency medications under WAC 246-817-724 and 246-817-770 are met, regardless of any delineated responsibility for furnishing of the equipment or medications in a contract between the physician and dental office. Additionally, for a pediatric patient, an administering physician shall ensure there is a complete selection of equipment for clinical application to the pediatric patient. The physician shall also ensure equipment is available in the recovery area to meet the requirements in this section for monitoring during the recovery period. The physician shall ensure all equipment and medications are checked and maintained on a scheduled basis.

(d) Recovery and discharge requirements. An administering physician shall ensure that:

(i) A physician licensed under chapter 18.71 RCW capable of managing complications, providing cardiopulmonary resuscitation, and currently certified in advanced cardiac life support measures appropriate for the patient age group is immediately available for a patient recovering from anesthesia. For a pediatric patient, the physician shall also be trained and experienced in pediatric perioperative care;

(ii) At least one licensed health care practitioner experienced in postanesthetic recovery care and currently certified in advanced cardiac life support measures appropriate for the patient age group visually monitors the patient, at all times, until the patient has met the criteria for discharge from the facility. Consideration for prolonged observation must be given to a pediatric patient with an anatomic airway abnormality, such as significant obstructive sleep apnea. A practitioner may not monitor more than two patients simultaneously, and any such simultaneous monitoring must take place in a single recovery room. If a practitioner is qualified to administer deep sedation or general anesthesia, the practitioner may not simultaneously administer deep sedation or general anesthesia and perform recovery period monitoring functions. The practitioner shall provide: (A) Continuous respiratory monitoring via pulse oximetry and cardiovascular monitoring via electrocardiography during the recovery period; and (B) monitoring, at regular intervals, during the recovery period of the patient for color of mucosa, skin, or blood, oxygen saturation, blood pressure, and level of consciousness; and (C) measurement of temperature at least once during the recovery period. If a patient's condition or other factor for the patient's health or safety preclude the frequency of monitoring during the recovery period required by this section, the practitioner must document the reason why such a departure from these requirements is medically necessary;

(iii) Emergency equipment, supplies, medications, and services comply with the provisions of WAC 246-817-770 and are immediately available in all areas where anesthesia is used and for a patient recovering from anesthesia. Resuscitative equipment and medications must be age and size-appropriate, including for care of a pediatric patient, pediatric defibrillator paddles, and vasoactive resuscitative medications and a muscle relaxant such as dantrolene sodium, which must be immediately available in appropriate pediatric concentrations, as well as a written pediatric dose schedule for these medications.

The administering physician shall ensure that support personnel have knowledge of the emergency care inventory. All equipment and medications must be checked and maintained on a scheduled basis; and

(iv) Before discharge, the patient is awake, alert, and behaving appropriately for age and developmental status, normal patient vital signs, and if applicable, a capable parent or guardian present to assume care of the patient.

(e) Emergency care and transfer protocol. An administering physician shall monitor for, and be prepared to treat, complications involving compromise of the airway and depressed respiration, particularly with a pediatric patient. The physician shall ensure that in the event of a complication or emergency, his or her assistive personnel and all dental office clinical staff are well-versed in emergency recognition, rescue, and emergency protocols, and familiar with a written and documented plan to timely and safely transfer a patient to an appropriate hospital.

(4)(a) An administering physician shall submit to the commission a report of any patient death or serious perioperative complication, which is or may be the result of anesthesia administered by the physician.

(b) The physician shall notify the commission or the department of health, by telephone, email, or fax within seventy-two hours of discovery and shall submit a complete written report to the commission within thirty days of the incident. The written report must include the following:

(i) Name, age, and address of the patient;

(ii) Name of the dentist and other personnel present during the incident;

(iii) Address of the facility or office where the incident took place;

(iv) Description of the type of anesthetic being utilized at the time of the incident;

(v) Dosages, if any, of any other drugs administered to the patient;

(vi) A narrative description of the incident including approximate times and evolution of symptoms;

(vii) Additional information which the commission may require or request.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-602, filed 10/21/20, effective 11/21/20.]

STANDARDS FOR PROFESSIONAL CONDUCT

WAC 246-919-605 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this rule, laser, light, radiofrequency, and plasma devices (hereafter LLRP devices) are medical devices that:

(a) Use a laser, noncoherent light, intense pulsed light, radiofrequency, or plasma to topically penetrate skin and alter human tissue; and

(b) Are classified by the federal Food and Drug Administration as prescription devices.

(2) Because an LLRP device penetrates and alters human tissue, the use of an LLRP device is the practice of medicine under RCW

18.71.011. The use of an LLRP device can result in complications such as visual impairment, blindness, inflammation, burns, scarring, hypopigmentation and hyperpigmentation.

(3) Use of medical devices using any form of energy to penetrate or alter human tissue for a purpose other than the purpose set forth in subsection (1) of this section constitutes surgery and is outside the scope of this section.

PHYSICIAN RESPONSIBILITIES

(4) A physician must be appropriately trained in the physics, safety and techniques of using LLRP devices prior to using such a device, and must remain competent for as long as the device is used.

(5) A physician must use an LLRP device in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, a physician must take a history, perform an appropriate physical examination, make an appropriate diagnosis, recommend appropriate treatment, obtain the patient's informed consent (including informing the patient that a nonphysician may operate the device), provide instructions for emergency and follow-up care, and prepare an appropriate medical record.

(7) Regardless of who performs LLRP device treatment, the physician is ultimately responsible for the safety of the patient.

(8) Regardless of who performs LLRP device treatment, the physician is responsible for assuring that each treatment is documented in the patient's medical record.

(9) The physician must ensure that there is a quality assurance program for the facility at which LLRP device procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program shall include all of the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised professionals to written protocols;

(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (10)(d) of this section and physician supervising practices; and

(e) Ongoing training to maintain and improve the quality of treatment and performance of treating professionals.

PHYSICIAN DELEGATION OF LLRP TREATMENT

(10) A physician who meets the above requirements may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice allow the use of an LLRP device, provided all the following conditions are met:

(a) The treatment in no way involves surgery as that term is understood in the practice of medicine;

(b) Such delegated use falls within the supervised professional's lawful scope of practice;

(c) The LLRP device is not used on the globe of the eye;

(d) A physician has a written office protocol for the supervised professional to follow in using the LLRP device. A written office protocol must include at a minimum the following:

(i) The identity of the individual physician authorized to use the device and responsible for the delegation of the procedure;

(ii) A statement of the activities, decision criteria, and plan the supervised professional must follow when performing procedures delegated under this rule;

(iii) Selection criteria to screen patients for the appropriateness of treatments;

(iv) Identification of devices and settings to be used for patients who meet selection criteria;

(v) Methods by which the specified device is to be operated and maintained;

(vi) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made;

(e) The supervised professional has appropriate training in, at a minimum, application techniques of each LLRP device, cutaneous medicine, indications and contraindications for such procedures, preprocedural and postprocedural care, potential complications and infectious disease control involved with each treatment;

(f) The delegating physician ensures that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device;

(g) The delegating physician shall be on the immediate premises during the patient's initial treatment and be able to treat complications, provide consultation, or resolve problems, if indicated. The supervised professional may complete the initial treatment if the physician is called away to attend to an emergency; and

(h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating physician provided that there is a local back-up physician who satisfies the requirements of subsection (4) of this section. The local back-up physician must agree in writing to treat complications, provide consultation or resolve problems if medically indicated. The local back-up physician shall be reachable by phone and able to see the patient within sixty minutes. The delegating physician's absence from the site where the treatment occurs must be for brief and intermittent periods of time. The delegating physician's absence from the site where the treatment occurs cannot be an ongoing arrangement.

(11) The use of, or the delegation of the use of, an LLRP device by a physician assistant is covered by WAC 246-918-125.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-605, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(12). WSR 07-03-177, § 246-919-605, filed 1/24/07, effective 3/1/07.]

WAC 246-919-606 Nonsurgical medical cosmetic procedures. (1)

The purpose of this rule is to establish the duties and responsibilities of a physician who delegates the injection of medication or substances for cosmetic purposes or the use of prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, dis-

figuration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011(3).

(2) This rule does not apply to:

(a) Surgery;

(b) The use of prescription lasers, noncoherent light, intense pulsed light, radiofrequency, or plasma as applied to the skin; this is covered in WAC 246-919-605 and 246-918-125;

(c) The practice of a profession by a licensed health care professional under methods or means within the scope of practice permitted by such license;

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

(3) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Nonsurgical medical cosmetic procedure" means a procedure or treatment that involves the injection of a medication or substance for cosmetic purposes, or the use of a prescription device for cosmetic purposes. Laser, light, radiofrequency and plasma devices that are used to topically penetrate the skin are devices used for cosmetic purposes, but are excluded under subsection (2)(b) of this section, and are covered by WAC 246-919-605 and 246-918-125.

(b) "Prescription device" means a device that the federal Food and Drug Administration has designated as a prescription device, and can be sold only to persons with prescriptive authority in the state in which they reside.

PHYSICIAN RESPONSIBILITIES

(4) A physician must be fully and appropriately trained in a nonsurgical medical cosmetic procedure prior to performing the procedure or delegating the procedure. The physician must keep a record of his or her training in the office and available for review upon request by a patient or a representative of the commission.

(5) Prior to authorizing a nonsurgical medical cosmetic procedure, a physician must:

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent;

(f) Provide instructions for emergency and follow-up care; and

(g) Prepare an appropriate medical record.

(6) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is ultimately responsible for the safety of the patient.

(7) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is responsible for ensuring that each treatment is documented in the patient's medical record.

(8) The physician must ensure that there is a quality assurance program for the facility at which nonsurgical medical cosmetic procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program must include the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised health care professionals to written protocols;

(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (11)(d) of this section and physician supervising practices; and

(e) Ongoing training to maintain and improve the quality of treatment and performance of supervised health care professionals.

(9) A physician may not sell or give a prescription device to an individual who does not possess prescriptive authority in the state in which the individual resides or practices.

(10) The physician must ensure that all equipment used for procedures covered by this section is inspected, calibrated, and certified as safe according to the manufacturer's specifications.

PHYSICIAN DELEGATION

(11) A physician who meets the above requirements may delegate a nonsurgical medical cosmetic procedure to a properly trained physician assistant, registered nurse or licensed practical nurse, provided all the following conditions are met:

(a) The treatment in no way involves surgery as that term is understood in the practice of medicine;

(b) The physician delegates procedures that are within the delegate's lawful scope of practice;

(c) The delegate has appropriate training in, at a minimum:

(i) Techniques for each procedure;

(ii) Cutaneous medicine;

(iii) Indications and contraindications for each procedure;

(iv) Preprocedural and postprocedural care;

(v) Recognition and acute management of potential complications that may result from the procedure; and

(vi) Infectious disease control involved with each treatment.

(d) The physician has a written office protocol for the delegate to follow in performing the nonsurgical medical cosmetic procedure. A written office protocol must include, at a minimum, the following:

(i) The identity of the physician responsible for the delegation of the procedure;

(ii) Selection criteria to screen patients for the appropriateness of treatment;

(iii) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(iv) A statement of the activities, decision criteria, and plan the delegate shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(e) The physician ensures that the delegate performs each procedure in accordance with the written office protocol;

(f) Each patient signs a consent form prior to treatment that lists foreseeable side effects and complications, and the identity and license of the delegate or delegates who will perform the procedure; and

(g) Each delegate performing a procedure covered by this section must be readily identified by a name tag or similar means so that the patient understands the identity and license of the treating delegate.

(12) If a physician delegates the performance of a procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is

used, the physician must be on-site during the entire duration of the procedure.

(13) If a physician delegates the performance of a procedure that uses a medication or substance that is approved by the federal Food and Drug Administration for the particular purpose for which it is used, the physician need not be on-site during the procedure, but must be reachable by phone and able to respond within thirty minutes to treat complications.

(14) If the physician is unavailable to supervise a delegate as required by this section, the physician must make arrangements for an alternate physician to provide the necessary supervision. The alternate supervisor must be familiar with the protocols in use at the site, will be accountable for adequately supervising the treatment under the protocols, and must have comparable training as the primary supervising physician.

(15) A physician performing or delegating nonsurgical cosmetic procedures may not sponsor more than three physician assistants at any one time.

(16) A physician may not permit a delegate to further delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-606, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(4). WSR 10-11-001, § 246-919-606, filed 5/5/10, effective 6/5/10.]

WAC 246-919-610 Use of drugs or autotransfusion to enhance athletic ability. (1) A physician shall not prescribe, administer or dispense anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), other hormones, or any form of autotransfusion for the purpose of enhancing athletic ability.

(2) A physician shall complete and maintain patient medical records which accurately reflect the prescribing, administering or dispensing of any substance or drug described in this rule or any form of autotransfusion. Patient medical records must indicate the diagnosis and purpose for which the substance, drug, or autotransfusion is prescribed, administered or dispensed and any additional information upon which the diagnosis is based.

(3) A violation of any provision of this rule constitutes grounds for disciplinary action under RCW 18.130.180(7). A violation of subsection (1) of this section constitutes grounds for disciplinary action under RCW 18.130.180(6).

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-610, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-610, filed 1/17/96, effective 2/17/96.]

WAC 246-919-620 Cooperation with investigation. (1) A physician must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority under RCW 18.130.050(2).

(a) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the

physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the physician's attorney by letter as a reminder.

(b) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.

(c) If the physician fails to comply with the request within three business days after the receipt of the written reminder, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, those charges may be included in the statement of charges.

(d) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.

(2) A physician shall comply with a request from an investigator who is acting on behalf of the disciplining authority under RCW 18.130.050(2) for information, which may include, but is not limited to:

(a) Nonhealth care records or documents including, but not limited to:

- (i) An explanation of the matter under investigation;
- (ii) Curriculum vitae;
- (iii) Continuing medical education credits;
- (iv) Malpractice action summaries; or
- (v) Hospital affiliations.

(b) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the licensee's attorney by letter as a reminder.

(c) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.

(d) If the physician fails to comply with the request within three business days after the receipt of the written reminder, then a subpoena shall be served upon the physician to obtain the requested items.

(e) If the physician fails to comply with the subpoena, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, then those charges may be included in the statement of charges.

(f) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-620, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-620, filed 1/17/96, effective 2/17/96.]

WAC 246-919-630 Sexual misconduct. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, and guardians or proxies.

(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in any of the following behaviors with a patient or key third party:

- (a) Sexual intercourse or genital to genital contact;
- (b) Oral to genital contact;
- (c) Genital to anal contact or oral to anal contact;
- (d) Kissing in a romantic or sexual manner;
- (e) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment;
- (f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;
- (g) Not allowing a patient the privacy to dress or undress;
- (h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;
- (i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;
- (j) Soliciting a date; or
- (k) Communicating regarding the sexual history, preferences, or fantasies of the physician.

(3) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician:

- (a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or
- (b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

(4) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

(5) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

- (a) Documentation of formal termination;
- (b) Transfer of the patient's care to another health care provider;
- (c) The length of time that has passed since the last health care services to the patient;
- (d) The length of time of the professional relationship;

- (e) The extent to which the patient has confided personal or private information to the physician;
 - (f) The nature of the patient's health problem; and
 - (g) The degree of emotional dependence and vulnerability of the patient.
- (6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.
- (7) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.
- (8) A violation of any provision of this rule constitutes grounds for disciplinary action.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-630, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.062, and Executive Order 06-03. WSR 16-06-010, § 246-919-630, filed 2/18/16, effective 3/20/16. Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-630, filed 1/9/06, effective 2/9/06.]

WAC 246-919-640 Abuse. (1) A physician commits unprofessional conduct if the physician abuses a patient. A physician abuses a patient when he or she:

- (a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
- (b) Removes a patient's clothing or gown without consent;
- (c) Fails to treat an unconscious or deceased patient's body or property respectfully; or
- (d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-640, filed 1/9/06, effective 2/9/06.]

MANDATORY REPORTING

WAC 246-919-700 Mandatory reporting. The commission adopts the rules for mandatory reporting in chapter 246-16 WAC.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-700, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-700, filed 1/17/96, effective 2/17/96.]

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-919-850 Intent and scope. The rules in WAC 246-919-850 through 246-919-985 govern the prescribing of opioids in the treatment of pain.

The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain including acute, perioperative, subacute, and chronic pain. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate

prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist physicians in providing appropriate medical care for patients.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist physicians in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-850, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]

WAC 246-919-851 Exclusions. WAC 246-919-850 through 246-919-985 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;
- (3) The treatment of inpatient hospital patients who are patients who have been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural medications.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-851, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

WAC 246-919-852 Definitions. The following definitions apply to WAC 246-919-850 through 246-919-985 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates current misuse, diversion, unauthorized use of alcohol or other controlled substances, or multiple early refills (renewals).

(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. Acute pain is six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of urine, hair, or other biological samples for various drugs and metabolites.

(4) "Cancer-related pain" means pain that is an unpleasant, persistent, subjective sensory and emotional experience associated with actual or potential tissue injury or damage or described in such terms and is related to cancer or cancer treatment that interferes with usual functioning.

(5) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or which may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain is considered to be pain that persists for more than twelve weeks.

(6) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.

(7) "Designee" means a licensed health care practitioner authorized by a prescriber to request and receive prescription monitoring program (PMP) data on their behalf.

(8) "Episodic care" means noncontinuing medical or dental care provided by a physician other than the designated primary prescriber for a patient with chronic pain.

(9) "High dose" means a ninety milligram morphine equivalent dose (MED), or more, per day.

(10) "High-risk" is a category of patient at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or abuse, aberrant behavior, dose of opioids, or the use of any concurrent central nervous system depressant.

(11) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less.

(12) "Hospital" means any health care institution licensed pursuant to chapters 70.41 and 71.12 RCW, and RCW 72.23.020.

(13) "Low-risk" is a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy,

and dose of opioids of less than a fifty milligram morphine equivalent dose per day.

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

(15) "Moderate-risk" is a category of patient at moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history of substance use disorder or abuse, aberrant behavior, and dose of opioids between fifty to ninety milligram morphine equivalent doses per day.

(16) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose using the agency medical directors' group or other conversion table approved by the commission. MED is considered the same as morphine milligram equivalent or MME.

(17) "Multidisciplinary pain clinic" means a health care delivery facility staffed by physicians of different specialties and other non-physician health care providers who specialize in the diagnosis and management of patients with chronic pain.

(18) "Opioid" means a drug that is either an opiate that is derived from the opium poppy or opiate-like that is a semisynthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone when used to treat pain.

(19) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness.

(20) "Perioperative pain" means acute pain that occurs surrounding the performance of surgery.

(21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW. Other jurisdictions may refer to this as the prescription drug monitoring program or "PDMP."

(22) "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.

(23) "Refill" or "renewal" means a second or subsequent filling of a previously issued prescription.

(24) "Subacute pain" is considered to be a continuation of pain that is six- to twelve-weeks in duration.

(25) "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 is a normal physiological consequence 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-852, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

WAC 246-919-865 Patient notification, secure storage, and disposal. (1) The physician shall discuss with the patient the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic:

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

(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments, whenever reasonable, clinically appropriate, evidence-based alternatives exist;

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

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

(e) That the patient has the right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

(2) The requirements in subsection (1) of this section do not apply to the administration of an opioid including, but not limited to, the following situations as documented in the patient record:

(a) Emergent care;

(b) Where patient pain represents a significant health risk;

(c) Procedures involving the administration of anesthesia;

(d) When the patient is unable to grant or revoke consent; or

(e) MAT for substance use disorders.

(3) If the patient is under eighteen years old or is not competent, the discussion required by subsection (1) of this section must include the patient's parent, guardian, or the person identified in RCW 7.70.065, unless otherwise provided by law.

(4) The physician shall document completion of the requirements in subsection (1) of this section in the patient's health care record.

(5) The information in subsection (1) of this section must also be provided in writing. This requirement may be satisfied with a document provided by the department of health.

(6) To fulfill the requirements of subsection (1) of this section, a physician may designate any individual who holds a credential issued by a disciplining authority under RCW 18.130.040 to provide the information.

[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-919-865, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-865, filed 11/16/18, effective 1/1/19.]

WAC 246-919-870 Use of alternative modalities for pain treatment. The physician shall exercise their professional judgment in selecting appropriate treatment modalities for acute nonoperative, acute perioperative, subacute, or chronic pain including the use of multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-870, filed 11/16/18, effective 1/1/19.]

WAC 246-919-875 Continuing education requirements for opioid prescribing. (1) To prescribe an opioid in Washington state, a physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the physician'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.

(3) The hours spent completing training in prescribing of opioids count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-875, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

WAC 246-919-880 Patient evaluation and patient record—Acute nonoperative pain. Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the physician 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-880, filed 11/16/18, effective 1/1/19.]

WAC 246-919-885 Treatment plan—acute nonoperative pain. The physician shall comply with the requirements in this section when prescribing opioids for acute nonoperative pain.

(1) The physician should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-919-870.

(2) The physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-919-985.

(3) If the physician prescribes opioids for effective pain control, such prescription must not be in a 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. The physician 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 physician shall reevaluate the patient who does not follow the expected course of recovery, and 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 may include:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and
- (d) Additional indicated diagnostic evaluations.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(7) Long-acting or extended release opioids are not indicated for acute nonoperative pain.

(8) Medication assisted treatment medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-919-975.

(9) If the physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-919-895 and 246-919-900 shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-885, filed 11/16/18, effective 1/1/19.]

WAC 246-919-890 Treatment plan—Acute perioperative pain. The physician shall comply with the requirements in this section when prescribing opioids for perioperative pain.

(1) The physician should consider prescribing nonopioids as the first line of pain control in patients, unless not clinically appropriate, in accordance with the provisions of WAC 246-919-870.

(2) The physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-919-985.

(3) If the physician prescribes opioids for effective pain control, such prescription must not be in a 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. The physician 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.

(4) The physician shall reevaluate a patient who does not follow the expected course of recovery and 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 may include:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(7) Long-acting or extended release opioids are not indicated for acute perioperative pain.

(8) Medication assisted treatment medications must not be discontinued when treating acute perioperative pain except as consistent with the provisions of WAC 246-919-975.

(9) If the physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the physician 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 246-919-895 and 246-919-900 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-890, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-919-895 Patient evaluation and patient record—Subacute pain. The physician shall comply with the requirements in this section when prescribing opioids for subacute pain.

(1) Prior to issuing an opioid prescription for subacute pain, the physician shall assess the rationale for continuing opioid therapy as follows:

(a) Conduct an appropriate history and physical examination;

(b) Reevaluate the nature and intensity of the pain;

(c) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-919-985;

(d) Screen the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(e) Obtain a biological specimen test if the patient's functional status is deteriorating or if pain is escalating; and

(f) Screen or refer the patient for further consultation for psychosocial factors if the patient's functional status is deteriorating or if pain is escalating.

(2) The physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following is 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 or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode;

(c) Pertinent concerns discovered in the PMP;

(d) An appropriate pain treatment plan including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

- (e) The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;
 - (f) Results of psychosocial screening or consultation;
 - (g) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies; and
 - (h) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable.
- (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 indicated diagnostic evaluations or other treatments.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-895, filed 11/16/18, effective 1/1/19.]

WAC 246-919-900 Treatment plan—Subacute pain. The physician, having recognized the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase shall develop an opioid treatment plan.

(1) If tapering has not begun prior to the six- to twelve-week subacute phase, the physician shall reevaluate the patient. Based on effect on function or pain control, the physician shall consider whether opioids will be continued, tapered, or discontinued.

(2) If the physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain that is severe enough to require opioids. During the subacute phase the physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.

(3) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-919-970, such prescribing must be in accordance with WAC 246-919-970.

(4) If the physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the physician 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 246-919-905 through 246-919-955, shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-900, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

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.]

WAC 246-919-910 Treatment plan—Chronic pain. The physician, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop an opioid treatment plan as follows:

- (1) Treatment plan and objectives including:
 - (a) Documentation of any medication prescribed;
 - (b) Biologic specimen testing ordered;
 - (c) Any labs, diagnostic evaluations, referrals, or imaging ordered;
 - (d) Other planned treatments; and
 - (e) Written agreement for treatment as provided in WAC 246-919-915.
- (2) The physician shall complete patient notification in accordance with the provisions of WAC 246-919-865 or provide this information in the written agreement.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-910, filed 11/16/18, effective 1/1/19.]

WAC 246-919-915 Written agreement for treatment—Chronic pain. The physician shall use a written agreement that outlines the pa-

tient's responsibilities for opioid therapy. This written agreement for treatment must include the following provisions:

(1) The patient's agreement to provide samples for biological specimen testing when requested by the physician;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;

(3) Reasons for which opioid therapy may be discontinued;

(4) The requirement that all opioid prescriptions for chronic pain are provided by a single prescriber or a single clinic, except as provided in WAC 246-919-965 for episodic care;

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

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

(7) A violation of the agreement may result in a tapering or discontinuation of the prescription; and

(8) The patient's responsibility to safeguard all medications and keep them in a secure location.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-915, filed 11/16/18, effective 1/1/19.]

WAC 246-919-920 Periodic review—Chronic pain. (1) The physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-919-985, must be 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 physician's discretion.

(2) During the periodic review, the physician shall determine:

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

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-919-985 and subsection (1) of this section.

(4) If the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-920, filed 11/16/18, effective 1/1/19.]

WAC 246-919-925 Long-acting opioids—Chronic pain. Long-acting opioids should only be prescribed by a physician who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The physician prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-925, filed 11/16/18, effective 1/1/19.]

WAC 246-919-930 Consultation—Recommendations and requirements—Chronic pain. (1) The physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED per day, a consultation with a pain management specialist as described in WAC 246-919-945 is required, unless the consultation is exempted under WAC 246-919-935 or 246-919-940.

(3) The mandatory consultation must consist of at least one of the following:

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

(b) A telephone, electronic, or in-person consultation between the pain management specialist and the physician;

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

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

(4) A physician shall document each consultation with the pain management specialist.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-930, filed 11/16/18, effective 1/1/19.]

WAC 246-919-935 Consultation—Exemptions for exigent and special circumstances—Chronic pain. A physician is not required to consult with a pain management specialist as defined in WAC 246-919-945 when the physician has documented adherence to all standards of practice as defined in WAC 246-919-905 through 246-919-925, and when one or more of the following conditions are met:

(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 an expected return to their baseline dosage level or below;

(3) The physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or

(4) The physician documents the patient's pain and function are stable and the patient is on a nonescalating dosage of opioids.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-935, filed 11/16/18, effective 1/1/19.]

WAC 246-919-940 Consultation—Exemptions for the physician—Chronic pain. The physician is exempt from the consultation requirement in WAC 246-919-930 if one or more of the following qualifications is met:

(1) The physician is a pain management specialist under WAC 246-919-945;

(2) The physician has successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders;

(3) The physician is a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or

(4) The physician has a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-940, filed 11/16/18, effective 1/1/19.]

WAC 246-919-945 Pain management specialist—Chronic pain. A pain management specialist shall meet one or more of the following qualifications:

(1) If an allopathic physician or osteopathic physician:

(a) Is 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, neurology, rheumatology, or anesthesiology;

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

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

(d) Is credentialed in pain management by an entity approved by the commission for an allopathic physician or the Washington state board of osteopathic medicine and surgery for an osteopathic physician;

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

(i) Has successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for an allopathic physician or three years for an osteopathic physician; and

(ii) Has at least thirty percent of the allopathic 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 an allopathic physician assistant, in accordance with WAC 246-918-895.

(3) If an osteopathic physician assistant, in accordance with WAC 246-854-330.

(4) If a dentist, in accordance with WAC 246-817-965.

(5) If a podiatric physician, in accordance with WAC 246-922-750.

(6) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-945, filed 11/16/18, effective 1/1/19.]

WAC 246-919-950 Tapering considerations—Chronic pain. The physician shall consider tapering 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) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-950, filed 11/16/18, effective 1/1/19.]

WAC 246-919-955 Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician.

(1) When a patient receiving chronic opioid pain medications changes to a new physician, it is normally appropriate for the new physician to initially maintain the patient's current opioid doses. Over time, the physician may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A physician's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-919-930 if:

(a) The patient was previously being treated with a dosage of opioids in excess of a 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 history of compliance with treatment plans and written agreements 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 presenting opioid dose.

(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 246-919-930 shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-955, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-919-960 Special populations—Children or adolescent patients, pregnant patients, and aging populations. (1) Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician 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. The physician shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment for opioids, such as methadone or buprenorphine, must not be discontinued during pregnancy without consultation with a MAT prescribing practitioner.

(3) Aging populations. As people age, their sensitivities to and metabolizing of opioids may change. The physician 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.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-960, filed 11/16/18, effective 1/1/19.]

WAC 246-919-965 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the physician or their designee, shall review the PMP and document their review and any concerns.

(2) A physician providing episodic care to a patient who the physician knows is being treated with opioids for chronic pain should provide additional analgesics, including opioids when appropriate, to adequately treat acute pain. If opioids are provided, the physician shall limit the use of opioids to the minimum amount necessary to control the acute pain until the patient can receive care from the practitioner who is managing the patient's chronic pain.

(3) The episodic care physician shall coordinate care with the patient's chronic pain treatment practitioner, if possible.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-965, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-919-970 Coprescribing of opioids with certain medications. (1) The physician shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Nonbenzodiazepine hypnotics.

(2) If, because of a prior prescription by another provider, a prescription written by a physician results in a combination of opioids and medications described in subsection (1) of this section, the physician issuing the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-970, filed 11/16/18, effective 1/1/19.]

WAC 246-919-975 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the physician providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.

(2) The physician providing acute nonoperative pain or acute perioperative pain treatment shall not discontinue MAT medications without documentation of the reason for doing so, nor shall the use of these medications be used to deny necessary operative intervention.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-975, filed 11/16/18, effective 1/1/19.]

WAC 246-919-980 Coprescribing of naloxone. The opioid prescribing physician shall confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-980, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-919-985 Prescription monitoring program—Required registration, queries, and documentation. (1) The physician shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe Schedule II-V medications in Washington state.

(2) The physician is permitted to delegate performance of a required PMP query to an authorized designee.

(3) At a minimum, the physician shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-919-970 at the following times:

(a) Upon the first refill or renewal of an opioid prescription for acute nonoperative pain or acute perioperative pain;

(b) The time of transition from acute to subacute pain; and

(c) The time of transition from subacute to chronic pain.

(4) For chronic pain management, the physician 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; and

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

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

(6) The physician shall ensure a PMP query is performed when providing episodic care to a patient who the physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-919-965.

(7) If the physician is using an electronic medical record (EMR) that integrates access to the PMP into the workflow of the EMR, the physician shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-919-970.

(8) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the EMR cannot be accessed by the physician or their designee due to a temporary technological or electrical failure.

(9) Pertinent concerns discovered in the PMP shall be documented in the patient record.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-919-985, filed 11/16/18, effective 1/1/19.]

PHYSICIAN AND SURGEON FEES

WAC 246-919-990 Physician and surgeon fees and renewal cycle.

(1) Licenses must be renewed every two years on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2, except postgraduate training limited licenses.

(2) Postgraduate training limited licenses must be renewed every year to correspond to the program's date.

(3) A retired active physician who resides and practices in Washington and obtains or renews a retired active license is exempt from all licensing fees except for the impaired physician program surcharge authorized by RCW 18.71.310.

(4) The applicants and licensees must pay the following nonrefundable fees:

Title of Fee	Fee
Original application	

Title of Fee	Fee
Application	\$425.00
UW HEAL-WA surcharge*	16.00
Washington physician health program surcharge*	50.00
Active license renewal	
Two-year renewal	824.00
UW HEAL-WA surcharge*	32.00
Washington physician health program surcharge*	100.00
Late renewal penalty	300.00
Expired license reissuance	262.50
Retired active license renewal (resides and practices in-state per RCW 18.71.080 and 18.130.250)	
Two-year renewal (only includes Washington physician health program surcharge)**	100.00
Retired active license renewal (does not meet in-state exemption)	
Two-year renewal	200.00
UW HEAL-WA surcharge*	32.00
Washington physician health program surcharge*	100.00
Late renewal penalty	100.00
Verification of license	50.00
Duplicate license	15.00
Temporary permit	50.00
Transitioning from postgraduate training limited license	
Application fee	100.00
UW HEAL-WA surcharge*	16.00
Washington physician health program surcharge*	50.00
Postgraduate limited license: RCW 18.71.095 (One-year cycle)	
Original application	
Application	325.00
UW HEAL-WA surcharge*	16.00
Washington physician health program surcharge*	50.00
Limited license renewal (One-year cycle)	
Renewal	325.00
UW HEAL-WA surcharge*	16.00
Washington physician health program surcharge*	50.00
Limited duplicate license	15.00

* The Washington physician health program surcharge (RCW 18.71.310(2)) is assessed at \$50.00 per year, and the University of Washington (UW) HEAL-WA web portal access fee (RCW 43.70.110) is assessed at \$16.00 per year.

[Statutory Authority: RCW 43.70.250 and 43.70.280. WSR 19-21-052, § 246-919-990, filed 10/10/19, effective 2/1/20. Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-19-088, § 246-919-990, filed 9/18/12, effective 11/1/12. Statutory Authority: RCW 43.70.250, 43.70.280, 18.31.310, 18.71A.020, 18.71.080, and 43.70.110. WSR 09-16-120, § 246-919-990, filed 8/4/09, effective 8/15/09. Statutory Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-919-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250. WSR 06-11-167, § 246-919-990, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-919-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 18.71.017, 18.71A.020 and 43.70.280. WSR 02-05-009, § 246-919-990, filed 2/8/02, effective 3/11/02. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-990, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 43.70.250. WSR 97-15-100, § 246-919-990, filed 7/21/97, effective 8/21/97. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-990, filed 1/17/96, effective 2/17/96.]