

Chapter 246-853 WAC OSTEOPATHIC PHYSICIANS AND SURGEONS

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WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-853-040 Renewal of licenses. [Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-040, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-040, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138-070, filed 11/23/88; Order PL 262, § 308-138-070, filed 1/13/77.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-853-221 How do advanced registered nurse practitioners qualify for prescriptive authority for Schedule II - IV drugs? [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-221, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-222 Criteria for joint practice arrangement. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-222, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-223 Endorsement of joint practice arrangements for ARNP licensure. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-223, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-224 Process for joint practice arrangement termination. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-224, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-225 Seventy-two-hour limit. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-225, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-226 Education for prescribing Schedule II - IV drugs. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-226, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-227 Jurisdiction. [Statutory Authority: RCW 18.57.005 and 18.57.280. WSR 01-16-008, § 246-853-227, filed 7/19/01, effective 8/19/01.] Repealed by WSR 06-05-050, filed 2/13/06, effective 3/16/06. Statutory Authority: RCW 18.57.005, 18.57.280.

246-853-240 Application for registration. [Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-240, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-240, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138-360, filed 11/23/88.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-853-260 USMLE examination application deadline. [Statutory Authority: RCW 18.57.005 and 18.130.050. WSR 94-15-068, § 246-853-260, filed 7/19/94, effective 8/19/94. Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-260, filed 4/25/91, effective 5/26/91.] Repealed by WSR 15-16-085, filed 7/31/15, effective 8/31/15. Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250.

246-853-270 Renewal expiration date. [Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-270, filed 4/25/91, effective 5/26/91.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-853-275 Change of mailing address and notice of official documents. [Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-853-275, filed 11/22/93, effective 12/23/93.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-853-510 Use of controlled substances for pain control. [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-853-510, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-062, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.

246-853-520 What specific guidance should an osteopathic physician follow? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-853-520, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-062, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.

246-853-530 What knowledge should an osteopathic physician who elects to treat chronic pain patients possess? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-853-530, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-062, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.

246-853-540 How will the board evaluate prescribing for pain? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-853-540, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-062, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.

246-853-663 Patient evaluation. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-663, filed 5/2/11, effective 7/1/11.] Repealed by

WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-664 Treatment plan. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-664, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-665 Informed consent. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-665, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-666 Written agreement for treatment. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-666, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-667 Periodic review. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-667, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-668 Long-acting opioids, including methadone. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-668, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-669 Episodic care. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-669, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-670 Consultation—Recommendations and requirements. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-670, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-671 Consultation—Exemptions for exigent and special circumstances. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-671, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-672 Consultation—Exemptions for the osteopathic physician. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-672, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-853-673 Pain management specialist. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-673, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

WAC 246-853-020 Osteopathic medicine and surgery examination.

(1) An applicant for licensure as an osteopathic physician must successfully pass:

(a) Parts I, II, and III of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) or Parts I, II, and III of the exam administered by the National Board of Osteopathic Medical Examiners (NBOME); or

(b) The Washington Osteopathic Principles and Practices (OP&P) Examination with a minimum score of seventy-five percent in each section; the Comprehensive Osteopathic Variable-Purpose Examination (COMVEX) administered by NBOME with a minimum passing score as established by NBOME; or other state administered OP&P exam approved by the board.

(2) In addition to the exams identified in subsection (1)(b) of this section, the applicant must also pass at least one of the following:

(a) The Federation of State Licensing Board (FLEX) Examination taken prior to June 1985 passed with a FLEX weighted average of a minimum seventy-five percent; or

(b) The FLEX I and FLEX II Examination with a minimum score of seventy-five on each component; or

(c) The United States Medical Licensing Examination (USMLE) Steps I, II, and III after December 1993 with a minimum score as established by the Federation of State Medical Boards and the National Board of Medical Examiners.

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250. WSR 15-16-085, § 246-853-020, filed 7/31/15, effective 8/31/15. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-853-020, filed 11/22/93, effective 12/23/93. Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-020, filed 4/25/91, effective 5/26/91. Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-020, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2), 18.57A.020 and 18.130.050(1). WSR 88-14-113 (Order 745), § 308-138-055, filed 7/6/88. Statutory Authority: RCW 18.57A.020, 18.57.005 and 18.130.050. WSR 88-09-030 (Order PM 723), § 308-138-055, filed 4/15/88. Statutory Authority: RCW 18.57.005. WSR 85-10-025 (Order PL 527), § 308-138-055, filed 4/24/85. Statutory Authority: 1979 c 117 § 3(3). WSR 79-12-068 (Order PL 321), § 308-138-055, filed 11/29/79.]

WAC 246-853-025 Special purpose examination. (1) The board of osteopathic medicine and surgery, upon review of an application for licensure pursuant to RCW 18.57.130 or reinstatement of an inactive license, may require an applicant to pass a special purpose examination, e.g., SPEX, and/or any other examination deemed appropriate. An applicant may be required to take an examination when the board 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 an interval of time.

(2) As a result of a determination in a disciplinary proceeding a licensee may be required to pass the SPEX examination.

(3) 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 board.

[Statutory Authority: RCW 18.57.005 and 18.130.050. WSR 94-15-068, § 246-853-025, filed 7/19/94, effective 8/19/94. Statutory Authority: RCW 18.57.005 and chapter 18.57 RCW. WSR 92-20-001 (Order 303B), § 246-853-025, filed 9/23/92, effective 10/24/92.]

WAC 246-853-030 Acceptable intern or residency programs. The board accepts the following training programs.

(1) Nationally approved one-year internship programs;

(2) The first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-030, filed 12/3/90, effective 1/31/91. Statutory Authority: 1979 c 117 § 3(3). WSR 79-12-068 (Order PL 321), § 308-138-065, filed 11/29/79.]

WAC 246-853-045 Inactive credential. A practitioner may obtain an inactive credential. Refer to the requirements of chapter 246-12 WAC, Part 4.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-045, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005 and chapter 18.57 RCW. WSR 92-20-001 (Order 303B), § 246-853-045, filed 9/23/92, effective 10/24/92.]

WAC 246-853-050 Ethical considerations. The following acts and practices are unethical and unprofessional conduct warranting appropriate disciplinary action:

(1) The division or "splitting" of fees with other professionals or nonprofessionals as prohibited by chapter 19.68 RCW. Specifically, a person authorized by this board shall not:

(a) Employ another to so solicit or obtain, or remunerate another for soliciting or obtaining, patient referrals.

(b) Directly or indirectly aid or abet an unlicensed person to practice acupuncture or medicine or to receive compensation therefrom.

(2) Use of testimonials, whether paid for or not, to solicit or encourage use of the licensee's services by members of the public.

(3) Making or publishing, or causing to be made or published, any advertisement, offer, statement or other form of representation, oral or written, which directly or by implication is false, misleading or deceptive.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-050, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57A.020. WSR 79-02-011 (Order 297), § 308-138-180, filed 1/11/79.]

WAC 246-853-060 Continuing professional education required.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-060, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005, 18.57A.020 and 18.57A.070. WSR 84-05-011 (Order PL 457), § 308-138-200, filed 2/7/84. Statutory Authority: 1979 c 117 § 3(4). WSR 79-12-066 (Order 324), § 308-138-200, filed 11/29/79.]

WAC 246-853-065 Mandatory one-time training in suicide assessment, treatment, and management. A licensed osteopathic physician, except for osteopathic physicians holding a post-graduate training limited license, must complete a board-approved one-time training that is at least six hours long in suicide assessment, treatment, and management. This training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or the first full continuing education reporting period after initial licensure, whichever is later.

(1) Until July 1, 2017, a board-approved training must be an empirically supported training in suicide assessment, including screening and referral, suicide treatment, and suicide management, and meet any other requirement in RCW 43.70.442.

(2) Beginning July 1, 2017, training accepted by the board must be on the department's model list developed in accordance with rules adopted by the department that establish minimum standards for train-

ing programs. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.

(3) A board-approved training must be at least six hours in length and may be provided in one or more sessions.

(4) The hours spent completing the training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education requirements.

[Statutory Authority: RCW 18.57.005, 18.130.050, and 43.70.442. WSR 17-12-100, § 246-853-065, filed 6/6/17, effective 7/7/17.]

WAC 246-853-070 Categories of creditable continuing professional education activities. The following are categories of creditable continuing medical education activities approved by the board. The credits must be earned in the thirty-six month period preceding application for renewal of licensure. One clock hour shall equal one credit hour for the purpose of satisfying the one hundred fifty hour continuing professional education requirement.

(1) Category 1 - A minimum of sixty credit hours of the total one hundred fifty hour requirements are mandatory under this general category.

(a) Category 1-A - Formal educational programs sponsored by nationally recognized osteopathic or medical institutions, organizations and their affiliates.

Examples of recognized sponsors include but are not limited to:
Accredited osteopathic or medical schools and hospitals.

Osteopathic or medical societies and specialty practice organizations.

Continuing medical education institutes.

Governmental health agencies and institutions.

Residencies, fellowships and preceptorships.

(b) Category 1-B - Preparation in publishable form of an original scientific paper (defined as one which reflects a search of the literature, appends a bibliography, and contains original data gathered by the author) and initial presentation before a postdoctoral audience qualified to critique the author's statements. Maximum allowable credit for the initial presentation will be ten credit hours per scientific paper. A copy of the paper in publishable form shall be submitted to the board. Publication of the above paper or another paper in a professional journal approved by the board may receive credits as approved by the board up to a maximum of fifteen credit hours per scientific paper.

(c) Category 1-C - Serving as a teacher, lecturer, preceptor or moderator-participant in any formal educational program. Such teaching would include classes in colleges of osteopathic medicine and medical colleges and lecturing to hospital interns, residents and staff. Total credits allowed under Category 1-C are forty-five per three-year period, with one hour's credit for each hour of actual instruction.

(A) Category 2-A - Home study - The board strongly believes that participation in formal professional education programs is essential in fulfilling a physician's total education needs. The board is also concerned that the content and educational quality of many unsolicited home study materials are not subject to impartial professional review and evaluation. It is the individual physician's responsibility to select home study materials that will be of actual benefit. For these reasons, the board has limited the number of credits which may be

granted for home study, and has adopted strict guidelines in granting these credits.

Reading - Credits may be granted for reading the Journal of the AOA, and other selected journals published by recognized osteopathic organizations. One-half credit per issue is granted for reading alone. An additional one-half credit per issue is granted if the quiz found in the AOA Journal is completed and returned to the division of continuing medical education. Credit for all other reading is limited to recognized scientific journals listed in *Index Medicus*. One-half credit per issue is granted for reading these recognized journals.

Listening - Credits may be granted for listening to programs distributed by the AOA audio-educational service. Other audio-tape programs sponsored by nationally recognized organizations and companies are eligible for credit. One-half credit per tape program may be granted. An additional one-half credit may be granted for each AOA audio-educational service program if the quiz card for the tape found in the AOA Journal is completed and returned.

Other home study courses - Subject-oriented and refresher home study courses and programs sponsored by recognized professional organizations are eligible for credit. The number of credit hours indicated by the sponsor will be accepted by the board.

A maximum of ninety credit hours per three-year period may be granted for all home study activities under Category 2-A.

(B) Category 2-B - Preparation and personal presentation of a scientific exhibit at a county, regional, state or national professional meeting. Total credits allowed under Category 2-B are thirty per three-year period, with ten credits granted for each new and different scientific exhibit. Appropriate documentation must be submitted with the request for credit.

(C) Category 2-C - All other programs and modalities of continuing professional education. Included under this category are informal educational activities such as observation at medical centers; programs dealing with experimental and investigative areas of medical practice, and programs conducted by nonrecognized sponsors.

Total credits allowed under Category 2-C are thirty hours per three-year period.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-070, filed 12/3/90, effective 1/31/91. Statutory Authority: 1979 c 117 § 3(4). WSR 79-12-066 (Order 324), § 308-138-210, filed 11/29/79.]

WAC 246-853-080 Continuing education. (1) Licensed osteopathic physicians and surgeons must complete one hundred fifty hours of continuing education every three years as required in chapter 246-12 WAC, Part 7.

(2) Certification of compliance with the requirement for continuing medical education of the American Osteopathic Association, or receipt of the AMA physicians recognitions award or a current certification of continuing medical education from medical practice academies shall be deemed sufficient to satisfy the requirements of these regulations.

(3) Original certification or recertification within the previous six years by a specialty board will be considered as evidence of equivalent compliance with these continuing professional education requirements.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-080, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-080, filed 12/3/90, effective 1/31/91. Statutory Authority: 1979 c 117 § 3(4). WSR 79-12-066 (Order 324), § 308-138-220, filed 11/29/79.]

WAC 246-853-085 Approved colleges and schools of osteopathic medicine and surgery. For the purposes of meeting the qualifications under RCW 18.57.020, the board approves those colleges or schools of osteopathic medicine accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation.

[Statutory Authority: RCW 18.57.005, 18.57.020 and chapter 18.57 RCW. WSR 07-08-070, § 246-853-085, filed 3/30/07, effective 4/30/07.]

WAC 246-853-090 Prior approval not required. (1) It will not be necessary for a physician to inquire into the prior approval of any continuing medical education. The board will accept any continuing professional education that reasonably falls within these regulations and relies upon each individual physician's integrity in complying with this requirement.

(2) Continuing professional education program sponsors need not apply for nor expect to receive prior board approval for continuing professional education programs. The continuing professional education category will depend solely upon the 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 board relies upon the integrity of program sponsors to present continuing professional education that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-090, filed 12/3/90, effective 1/31/91. Statutory Authority: 1979 c 117 § 3(4). WSR 79-12-066 (Order 324), § 308-138-230, filed 11/29/79.]

WAC 246-853-100 Prohibited publicity and advertising. An osteopathic physician shall not use or allow to be used any form of public communications or advertising connected with his or her profession or in his or her professional capacity as an osteopathic physician which:

- (1) Is false, fraudulent, deceptive or misleading;
- (2) Uses testimonials;
- (3) Guarantees any treatment or result;
- (4) Makes claims of professional superiority;
- (5) States or includes prices for professional services except as provided for in WAC 246-853-110;
- (6) Fails to identify the physician as an osteopathic physician as described in RCW 18.57.140;
- (7) Otherwise exceeds the limits of WAC 246-853-110.

[Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-100, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-100, filed 12/3/90, effective 1/31/91;

WSR 85-22-016 (Order PL 562), § 308-138-300, filed 10/30/85. Statutory Authority: 1979 c 117 § 3(5). WSR 79-12-064 (Order PL 322), § 308-138-300, filed 11/29/79.]

WAC 246-853-110 Permitted publicity and advertising. To facilitate the process of informed selection of a physician by potential patients, a physician may publish or advertise the following information, provided that the information disclosed by the physician in such publication or advertisement complies with all other ethical standards promulgated by the board;

(1) Name, including name of professional service corporation or clinic, and names of professional associates, addresses and telephone numbers;

(2) Date and place of birth;

(3) Date and fact of admission to practice in Washington and other states;

(4) Accredited schools attended with dates of graduation, degrees and other scholastic distinction;

(5) Teaching positions;

(6) Membership in osteopathic or medical fraternities, societies and associations;

(7) Membership in scientific, technical and professional associations and societies;

(8) Whether credit cards or other credit arrangements are accepted;

(9) Office and telephone answering service hours;

(10) Fee for an initial examination and/or consultation;

(11) Availability upon request of a written schedule of fees or range of fees for specific services;

(12) The range of fees for specified routine professional services, provided that the statement discloses that the specific fee within the range which will be charged will vary depending upon the particular matter to be handled for each patient, and the patient is entitled without obligation to an estimate of the fee within the range likely to be charged;

(13) Fixed fees for specified routine professional services, the description of which would not be misunderstood by or be deceptive to a prospective patient, provided that the statement discloses that the quoted fee will be available only to patients whose matters fall into the services described, and that the client is entitled without obligation to a specific estimate of the fee likely to be charged.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-110, filed 12/3/90, effective 1/31/91. Statutory Authority: 1979 c 117 § 3(5). WSR 79-12-064 (Order PL 322), § 308-138-310, filed 11/29/79.]

WAC 246-853-120 Malpractice suit reporting. Every osteopathic physician shall, within sixty days after settlement or judgment, notify the board of any and all malpractice settlements or judgments in excess of twenty thousand dollars as a result of a claim or action for damages alleged to have been caused by a physician's incompetency or negligence in the practice of osteopathic medicine. Every osteopathic physician shall also report the settlement or judgment of three or more claims or actions for damages during a year as the result of the

alleged physician's incompetence or negligence in the practice of osteopathic medicine regardless of the dollar amount of the settlement or judgment.

[Statutory Authority: RCW 18.57.005, WSR 90-24-055 (Order 100B), recodified as § 246-853-120, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57A.020, 18.57.005 and 18.130.050. WSR 88-09-030 (Order PM 723), § 308-138-320, filed 4/15/88. Statutory Authority: 1979 c 117 § 3(6). WSR 79-12-065 (Order 323), § 308-138-320, filed 11/29/79.]

WAC 246-853-130 General provisions for mandatory reporting rules. (1) "Unprofessional conduct" shall mean the conduct described in RCW 18.130.180.

(2) "Hospital" shall mean any health care institution licensed pursuant to chapter 70.41 RCW.

(3) "Nursing home" shall mean any health care institution regulated under chapter 18.51 RCW.

(4) "Board" shall mean the Washington state board of osteopathic medicine and surgery.

(5) "Physician" shall mean an osteopathic physician and surgeon licensed pursuant to chapter 18.57 RCW.

(6) "Physician's assistant" shall mean an osteopathic physician's assistant approved pursuant to chapter 18.57A RCW.

(7) "Mentally or physically impaired practitioner" shall mean an osteopathic physician and surgeon or osteopathic physician's assistant who has been determined by a court to be mentally incompetent or mentally ill or who is unable to practice medicine with reasonable skill and safety to patients by reason of any mental or physical condition.

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250. WSR 15-16-085, § 246-853-130, filed 7/31/15, effective 8/31/15. Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-130, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-130, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-321, filed 5/20/87.]

WAC 246-853-135 Temporary practice permit. A temporary permit to practice osteopathic medicine and surgery may be issued to an individual licensed in another state that has substantially equivalent licensing standards to those in Washington.

(1) The temporary permit may be issued upon receipt of:

(a) Documentation from the reciprocal state that the licensing standards used for issuing the license are substantially equivalent to the current Washington licensing standards;

(b) A completed application form on which the applicant indicates he or she wishes to receive a temporary permit and application and temporary permit fees;

(c) Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment;

(d) Verification from the federation of state medical board's disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency.

(2) A temporary practice permit grants the individual the full scope to practice osteopathic medicine and surgery.

(3) The temporary permit shall expire upon issuance of a license by the board or one hundred eighty days after issuance of the temporary permit, whichever occurs first. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(4) A temporary permit shall be issued only once to each applicant. An applicant who does not complete the application process shall not receive a subsequent temporary permit.

[Statutory Authority: RCW 18.57.005 and 18.130.075. WSR 10-03-071, § 246-853-135, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.57.005 and chapter 18.57 RCW. WSR 92-20-001 (Order 303B), § 246-853-135, filed 9/23/92, effective 10/24/92.]

WAC 246-853-140 Mandatory reporting. (1) All reports required by these regulations shall be submitted to the board as soon as possible, but no later than sixty days after a determination is made.

(2) A report should contain the following information if known:

(a) The name, address, and telephone number of the person making the report.

(b) The name, address, and telephone number of the physician or physician's assistant being reported.

(c) The case number of any patient whose treatment is a subject of the report.

(d) A brief description or summary of the facts which give rise to the issuance of the report, including dates of occurrences.

(e) If court action is involved, the name of the court in which the action is filed along with the date of filing and docket number.

(f) Any further information which would aid in the evaluation of the report.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-140, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-322, filed 5/20/87.]

WAC 246-853-150 Health care institutions. The chief administrator or executive officer of any hospital or nursing home shall report to the board when any physician's clinical privileges are terminated or are restricted based on a determination that a physician has committed an act or acts which may constitute unprofessional conduct or that a physician may be mentally or physically impaired. Said officer shall also report if a physician accepts voluntary termination or restriction of clinical privileges in lieu of formal action based upon unprofessional conduct or upon being mentally or physically impaired.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-150, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-323, filed 5/20/87.]

WAC 246-853-160 Medical associations or societies. The president or chief executive officer of any medical association or society within this state shall report to the board when a medical society hearing panel or committee determines that a physician or physician's assistant may have committed unprofessional conduct or that a physician or physician's assistant may not be able to practice medicine with reasonable skill and safety to patients as the result of any mental or physical condition and constitutes an apparent risk to the public health, safety, or welfare. The report required by this section shall be made without regard to whether the license holder appeals, accepts, or acts upon the termination made by the association or society. Notification of appeal shall be included.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-160, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-324, filed 5/20/87.]

WAC 246-853-170 Health care service contractors and disability insurance carriers. The executive officer of every health care service contractor and disability insurer regulated under chapters 48.20, 48.21, 48.21A, or 48.44 RCW, shall report to the board all final determinations that an osteopathic physician may have engaged in unprofessional conduct, or by reason of mental or physical impairment may be unable to practice the profession with reasonable skill and safety.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-170, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.130.270 [18.130.070]. WSR 88-01-104 (Order PM 698), § 308-138-325, filed 12/22/87.]

WAC 246-853-180 Courts. The board requests the assistance of all clerks of trial courts within the state to report all medical malpractice judgments and all convictions of osteopathic physicians and physician's assistants, other than minor traffic violations.

[Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-180, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-180, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-326, filed 5/20/87.]

WAC 246-853-190 State and federal agencies. The board requires the assistance of executive officers of any state and requests the assistance of executive officers of any federal program operating in the state of Washington, under which an osteopathic physician or physician's assistant is employed to provide patient care services, to report to the board whenever such an osteopathic physician or physician's assistant has demonstrated his/her incompetency or negligence in the practice of osteopathic medicine, or has otherwise committed unprofessional conduct, or is a mentally or physically impaired practitioner.

[Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-853-190, filed 11/22/93, effective 12/23/93; WSR 91-20-120 (Order 199B), § 246-853-190, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-190, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-327, filed 5/20/87.]

WAC 246-853-200 Professional review organizations. Unless prohibited by federal law, every professional review organization operating within the state of Washington shall report to the board any determinations that an osteopathic physician or osteopathic physician's assistant may have engaged in unprofessional conduct, or by reason of mental or physical impairment may be unable to practice the profession with reasonable skill and safety.

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-200, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.130.270 [18.130.070]. WSR 88-01-104 (Order PM 698), § 308-138-328, filed 12/22/87.]

WAC 246-853-210 Expired license. (1) If the license has expired for three years or less, the practitioner must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the license has expired for over three years, and the practitioner has been in active practice in another United States jurisdiction, the practitioner must:

(a) Submit verification of active practice from any other United States jurisdiction;

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

(3) If the license has expired for over three years, and the practitioner has not been in active practice in another United States jurisdiction, the practitioner:

(a) May be required to be reexamined as provided in RCW 18.57.080;

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

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-210, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-210, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-210, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005 and 18.130.070. WSR 87-11-062 (Order PM 651), § 308-138-330, filed 5/20/87. Statutory Authority: RCW 18.57.005 and 18.57A.020. WSR 82-17-005 (Order PL 402), § 308-138-330, filed 8/5/82.]

WAC 246-853-220 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 and/or for nontherapeutic cosmetic appearance.

(2) A physician shall complete and maintain patient medical records which accurately reflect the prescription, administering or dis-

pensing of any substance or drug described in this rule or any form of autotransfusion. Patient medical records shall 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 shall constitute grounds for disciplinary action under RCW 18.130.180(7). A violation of subsection (1) of this rule shall also constitute grounds for disciplinary action under RCW 18.130.180(6).

[Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-853-220, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2), 18.57A.020 and 18.130.050(1). WSR 88-21-081 (Order PM 780), § 308-138-340, filed 10/19/88; WSR 88-14-113 (Order 745), § 308-138-340, filed 7/6/88.]

WAC 246-853-230 AIDS education and training. Applicants must complete seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-230, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 91-20-120 (Order 199B), § 246-853-230, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-853-230, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138-350, filed 11/23/88.]

WAC 246-853-235 Retired active license. (1) To obtain a retired active license an osteopathic physician must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) An osteopathic physician with a retired active license may not receive compensation for health care services.

(3) An osteopathic physician with a retired active license may practice under the following conditions:

(a) In emergent circumstances calling for immediate action; or

(b) Intermittent circumstances on a part-time or full-time non-permanent basis.

(4) A retired active license expires each year on the license holder's birthday. Retired active credential renewal fees are accepted no sooner than ninety days prior to the expiration date.

(5) An osteopathic physician with a retired active license shall complete and report one hundred fifty hours of continuing medical education every three years.

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250. WSR 15-16-085, § 246-853-235, filed 7/31/15, effective 8/31/15.]

WAC 246-853-245 Reentry to practice requirements. An osteopathic physician who has not been in active practice for a period of at least five years in any jurisdiction in the United States must:

(1) Successfully pass a board approved competency evaluation;

(2) Successfully pass a board approved exam;

(3) Successfully complete a board approved retraining program arranged by the osteopathic physician; or

(4) Successfully complete a board approved reentry to practice or monitoring program.

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250. WSR 15-16-085, § 246-853-245, filed 7/31/15, effective 8/31/15.]

WAC 246-853-290 Intent. It is the intent of the legislature that the board of osteopathic medicine and surgery seek ways to identify and support the rehabilitation of osteopathic physicians and surgeons and osteopathic physician assistants where practice or competency may be impaired due to the abuse of drugs or alcohol. The legislature intends that these practitioners be treated so that they can return to or continue to practice osteopathic medicine and surgery in a way which safeguards the public. The legislature specifically intends that the board of osteopathic medicine and surgery establish an alternate program to the traditional administrative proceedings against osteopathic physicians and surgeons and osteopathic physician assistants.

In lieu of disciplinary action under RCW 18.130.160 and if the board of osteopathic medicine and surgery determines that the unprofessional conduct may be the result of substance abuse, the board may refer the registrant/licensee to a voluntary substance abuse monitoring program approved by the board.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-290, filed 4/25/91, effective 5/26/91.]

WAC 246-853-300 Definitions used relative to substance abuse monitoring. (1) "Approved substance abuse monitoring program" or "approved monitoring program" is a program the board has determined meets the requirements of the law and rules established by the board, according to the Washington Administrative Code, which enters into a contract with osteopathic practitioners who have substance abuse problems. The approved substance abuse monitoring program oversees compliance of the osteopathic practitioner's recovery activities as required by the board. Substance abuse monitoring programs may provide evaluation and/or treatment to participating osteopathic practitioners.

(2) "Impaired osteopathic practitioner" means an osteopathic physician and surgeon or an osteopathic physician assistant who is unable to practice osteopathic medicine and surgery with judgment, skill, competence, or safety due to chemical dependence, mental illness, the aging process, loss of motor skills, or any other mental or physical condition.

(3) "Contract" is a comprehensive, structured agreement between the recovering osteopathic practitioner and the approved monitoring program wherein the osteopathic practitioner consents to comply with the monitoring program and the required components for the osteopathic practitioner's recovery activity.

(4) "Approved treatment facility" is a facility approved by the bureau of alcohol and substance abuse, department of social and health services as specified in RCW 18.130.175.

(5) "Chemical dependence/substance abuse" means a chronic progressive illness which involves the use of alcohol and/or other drugs to a degree that it interferes in the functional life of the regis-

trant/licensee, as manifested by health, family, job (professional services), legal, financial, or emotional problems.

(6) "Drug" means a chemical substance alone or in combination, including alcohol.

(7) "Aftercare" means that period of time after intensive treatment that provides the osteopathic practitioner and the osteopathic practitioner's family with group, or individualized counseling sessions, discussions with other families, ongoing contact and participation in self-help groups, and ongoing continued support of treatment program staff.

(8) "Practitioner support group" is a group of osteopathic practitioners and/or other health care professionals meeting regularly to support the recovery of its members. The group provides a confidential setting with a trained and experienced facilitator in which participants may safely discuss drug diversion, licensure issues, return to work, and other professional issues related to recovery.

(9) "Twelve-step groups" are groups such as Alcoholics Anonymous, Narcotics Anonymous, and similar organizations.

(10) "Random drug screens" are laboratory tests to detect the presence of drugs of abuse in body fluids which are performed at irregular intervals not known in advance by the person to be tested. The collection of the body fluids must be observed by a treatment or health care professional or other board or monitoring program-approved observer.

(11) "Recovering" means that a chemically dependent osteopathic practitioner is in compliance with a treatment plan of rehabilitation in accordance with criteria established by an approved treatment facility and an approved substance abuse monitoring program.

(12) "Rehabilitation" means the process of restoring a chemically dependent osteopathic practitioner to a level of professional performance consistent with public health and safety.

(13) "Reinstatement" means the process whereby a recovering osteopathic practitioner is permitted to resume the practice of osteopathic medicine and surgery.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-300, filed 4/25/91, effective 5/26/91.]

WAC 246-853-310 Approval of substance abuse monitoring programs.

The board will approve the monitoring program(s) which will participate in the recovery of osteopathic practitioners. The board will enter into a contract with the approved substance abuse monitoring program(s) on an annual basis.

(1) An approved monitoring program may provide evaluations and/or treatment to the participating osteopathic practitioners.

(2) An approved monitoring program staff must have the qualifications and knowledge of both substance abuse and the practice of osteopathic medicine and surgery as defined in chapter 18.57 RCW to be able to evaluate:

(a) Drug screening laboratories;

(b) Laboratory results;

(c) Providers of substance abuse treatment, both individual and facilities;

(d) Osteopathic practitioner support groups;

(e) Osteopathic practitioners' work environment; and

(f) The ability of the osteopathic practitioners to practice with reasonable skill and safety.

(3) An approved monitoring program will enter into a contract with the osteopathic practitioner and the board to oversee the osteopathic practitioner's compliance with the requirement of the program.

(4) The program staff of the approved monitoring program will evaluate and recommend to the board, on an individual basis, whether an osteopathic practitioner will be prohibited from engaging in the practice of osteopathic medicine and surgery for a period of time and restrictions, if any, on the osteopathic practitioner's access to controlled substances in the work place.

(5) An approved monitoring program shall maintain records on participants.

(6) An approved monitoring program will be responsible for providing feedback to the osteopathic practitioner as to whether treatment progress is acceptable.

(7) An approved monitoring program shall report to the board any osteopathic practitioner who fails to comply with the requirements of the monitoring program.

(8) An approved monitoring program shall provide the board with a statistical report on the program, including progress of participants, at least annually, or more frequently as requested by the board.

(9) The board shall provide the approved monitoring program guidelines on treatment, monitoring, and/or limitations on the practice of osteopathic medicine and surgery for those participating in the program.

(10) An approved monitoring program shall provide for the board a complete financial breakdown of cost for each individual osteopathic practitioner participant by usage at an interval determined by the board in the annual contract.

(11) An approved monitoring program shall provide for the board a complete annual audited financial statement.

(12) An approved monitoring program shall enter into a written contract with the board and submit monthly billing statements supported by documentation.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-310, filed 4/25/91, effective 5/26/91.]

WAC 246-853-320 Participation in approved substance abuse monitoring program.

(1) The osteopathic practitioner who has been investigated by the board may accept board referral into the approved substance abuse monitoring program. This may occur as a result of disciplinary action.

(a) The osteopathic practitioner shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation is to be performed by a health care professional(s) with expertise in chemical dependency. The person(s) performing the evaluation shall not be the provider of the recommended treatment.

(b) The osteopathic practitioner shall enter into a contract with the board and the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to:

(i) The osteopathic practitioner will undergo intensive substance abuse treatment in an approved treatment facility.

(ii) The osteopathic practitioner shall agree to abstain from the use of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101. Said prescriber shall notify the monitoring program of all drugs prescribed within fourteen days of the date care was provided.

(iii) The osteopathic practitioner must complete the prescribed aftercare program of the intensive treatment facility. This may include individual and/or group psychotherapy.

(iv) The osteopathic practitioner must cause the treatment counselor(s) and authorized prescriber(s) to provide reports to the appropriate monitoring program at specified intervals. Reports shall include treatment prognosis, goals, drugs prescribed, etc.

(v) The osteopathic practitioner shall submit to random drug screening, with observed specimen collection, as specified by the approved monitoring program.

(vi) The osteopathic practitioner shall attend osteopathic practitioner support groups facilitated by health care professionals and/or twelve-step group meetings as specified by the contract.

(vii) The osteopathic practitioner shall comply with specified employment conditions and restrictions as defined by the contract.

(viii) The osteopathic practitioner shall sign a waiver allowing the approved monitoring program to release information to the board if the osteopathic practitioner does not comply with the requirements of the contract.

(c) The osteopathic practitioner is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment, random urine screens, and other personal expenses incurred in compliance with the contract.

(d) The osteopathic practitioner may be subject to disciplinary action under RCW 18.130.160 and 18.130.180 if the osteopathic practitioner does not consent to be referred to the approved monitoring program, does not comply with specified practice restrictions, or does not successfully complete the program.

(2) An osteopathic practitioner who is not being investigated by the board or subject to current disciplinary action, not currently being monitored by the board for substance abuse, may voluntarily participate in the approved substance abuse monitoring program without being referred by the board. Such voluntary participants shall not be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for their substance abuse, and shall not have their participation made known to the board if they continue to satisfactorily meet the requirements of the approved monitoring program:

(a) The osteopathic practitioner shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation will be performed by a health care professional with expertise in chemical dependency. The person(s) performing the evaluation shall not also be the provider of the recommended treatment.

(b) The osteopathic practitioner shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to:

(i) The osteopathic practitioner will undergo intensive substance abuse treatment in an approved treatment facility.

(ii) The osteopathic practitioner will agree to abstain from the use of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber, as defined in RCW

69.41.030 and 69.50.101. Said prescriber shall notify the monitoring program of all drugs prescribed within fourteen days of the date care was provided.

(iii) The osteopathic practitioner must complete the prescribed aftercare program of the intensive treatment facility. This may include individual and/or group psychotherapy.

(iv) The osteopathic practitioner must cause the treatment counselor(s) and authorized prescriber(s) to provide reports to the approved monitoring program at specified intervals. Reports shall include treatment prognosis, goals, drugs prescribed, etc.

(v) The osteopathic practitioner shall submit to random drug screening, with observed specimen collection, as specified by the approved monitoring program.

(vi) The osteopathic practitioner will attend practitioner support groups facilitated by a health care professional and/or twelve-step group meetings as specified by the individual's contract.

(vii) The osteopathic practitioner will comply with specified employment conditions and restrictions as defined by the contract.

(viii) The osteopathic practitioner shall sign a waiver allowing the approved monitoring program to release information to the board if the osteopathic practitioner does not comply with the requirements of the contract. The osteopathic practitioner may be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for noncompliance with the contract or if he/she does not successfully complete the program.

(c) The osteopathic practitioner is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment, random urine screens, and other personal expenses incurred in compliance with the contract.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-320, filed 4/25/91, effective 5/26/91.]

WAC 246-853-330 Confidentiality. (1) The treatment and pre-treatment records of license holders referred to or voluntarily participating in approved monitoring programs shall be confidential, shall be exempt from RCW 42.17.250 through 42.17.450 and shall not be subject to discovery by subpoena or admissible as evidence except for monitoring records reported to the disciplinary authority for cause as defined in WAC 246-853-320. Records held by the board under this section shall be exempt from RCW 42.17.250 through 42.17.450 and shall not be subject to discovery by subpoena except by the license holder.

(2) Notwithstanding subsection (1) of this section, board orders shall be subject to RCW 42.17.250 through 42.17.450.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-330, filed 4/25/91, effective 5/26/91.]

WAC 246-853-340 Examination appeal procedures. (1) Any candidate who takes and does not pass the osteopathic practices and principles examination, may request review of the results of the examination by the Washington state board of osteopathic medicine and surgery.

(a) The board will not modify examination results unless the candidate presents clear and convincing evidence of error in the examination content or procedure, or bias, prejudice, or discrimination in the examination process.

(b) The board will not consider any challenges to examination scores unless the total of the potentially revised score would result in issuance of a license.

(2) The procedure for requesting an informal review of examination results is as follows:

(a) The request must be in writing and must be received by the department within thirty days of the date on the letter of notification of examination results sent to the candidate.

(b) The following procedures apply to an appeal of the results of the written examination.

(i) In addition to the written request required in (a) of this subsection, the candidate must appear personally in the department office in Olympia for an examination review session. The candidate must contact the department to make an appointment for the examination review session.

(ii) The candidate's incorrect answers will be available during the review session. The candidate will be given a form to complete in defense of the examination answers. The candidate must specifically identify the challenged questions on the examination and must state the specific reason(s) why the candidate believes the results should be modified.

(iii) The candidate may not bring in any resource material for use while completing the informal review form.

(iv) The candidate will not be allowed to remove any notes or materials from the office upon completing the review session.

(c) The board will schedule a closed session meeting to review the examinations, score sheets, and forms completed by the candidate. The candidate will be notified in writing of the board's decision.

(i) The candidate will be identified only by candidate number for the purpose of this review.

(ii) Letters of referral or requests for special consideration will not be read or considered by the board.

(d) Any candidate not satisfied with the results of the informal examination review may request a formal hearing before the board to challenge the examination results.

(3) The procedures for requesting a formal hearing are as follows:

(a) The candidate must complete the informal review process before requesting a formal hearing.

(b) The request for formal hearing must be received by the department within twenty days of the date on the notice of the results of the board's informal review.

(c) The written request must specifically identify the challenged portion(s) of the examination and must state the specific reason(s) why the candidate believes the examination results should be modified.

(d) Candidates will receive at least twenty days notice of the time and place of the formal hearing.

(e) The hearing will be restricted to the specific portion(s) of the examination the candidate had identified in the request for formal hearing.

(f) The formal hearing will be conducted pursuant to the Administrative Procedure Act, chapter 34.05 RCW.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-340, filed 4/25/91, effective 5/26/91.]

WAC 246-853-350 Examination conduct. Any applicant who fails to follow written or oral instructions relative to the conduct of the examination, is observed talking or attempting to give or receive information, or use unauthorized materials during any portion of the examination will be terminated from the examination and not permitted to complete it.

[Statutory Authority: RCW 18.57.005 and 18.130.175. WSR 91-10-043 (Order 159B), § 246-853-350, filed 4/25/91, effective 5/26/91.]

WAC 246-853-400 Brief adjudicative proceedings—Denials based on failure to meet education, experience, or examination prerequisites for licensure. The board adopts RCW 34.05.482 and 34.05.485 through 34.05.494 for adjudicative proceedings requested by applicants, who are denied a license under chapters 18.57 and 18.57A RCW for failure to meet the education, experience, or examination prerequisites for licensure. The sole issue at the adjudicative proceeding shall be whether the applicant meets the education, experience, and examination prerequisites for the issuance of a license.

[Statutory Authority: RCW 18.57.005 and chapter 18.57 RCW. WSR 92-20-001 (Order 303B), § 246-853-400, filed 9/23/92, effective 10/24/92.]

WAC 246-853-500 Adjudicative proceedings. The board adopts the model procedural rules for adjudicative proceedings as adopted by the department of health and contained in chapter 246-11 WAC, including subsequent amendments.

[Statutory Authority: RCW 18.57.005 and 18.130.050. WSR 94-15-068, § 246-853-500, filed 7/19/94, effective 8/19/94.]

WAC 246-853-600 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 osteopathic 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 osteopathic physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Osteopathic physician" means a person licensed to practice osteopathic medicine and surgery under chapter 18.57 RCW.

(c) "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, guardians and proxies.

(2) An osteopathic physician shall not engage in sexual misconduct with a current patient or a key third party. An osteopathic physician engages in sexual misconduct when he or she engages in 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;
 - (g) Not allowing a patient the privacy to dress or undress;
 - (h) Encouraging the patient to masturbate in the presence of the osteopathic physician or masturbation by the osteopathic physician while the patient is present;
 - (i) Offering to provide practice-related services, such as medication, in exchange for sexual favors;
 - (j) Soliciting a date;
 - (k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the osteopathic physician.
- (3) 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.
- (4) An osteopathic 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 osteopathic 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 osteopathic physician's personal or sexual needs.
- (5) To determine whether a patient is a current patient or a former patient, the board 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;
 - (d) The length of time of the professional relationship;
 - (e) The extent to which the patient has confided personal or private information to the osteopathic physician;
 - (f) The nature of the patient's health problem;
 - (g) The degree of emotional dependence and vulnerability.
- (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 shall constitute grounds for disciplinary action.

[Statutory Authority: RCW 18.57.005, 18.130.050, 18.130.062, and Executive Order 06-03. WSR 17-01-164, § 246-853-600, filed 12/21/16, effective 1/21/17. Statutory Authority: RCW 18.57.005, 18.130.050 and chapters 18.57, 18.57A RCW. WSR 07-12-091, § 246-853-600, filed 6/6/07, effective 7/7/07.]

WAC 246-853-610 Abuse. (1) An osteopathic physician commits unprofessional conduct if the osteopathic physician abuses a patient or key third party. "Osteopathic physician," "patient" and "key third party" are defined in WAC 246-853-600. An osteopathic 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;

(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 18.57.005, 18.130.050 and chapters 18.57, 18.57A RCW. WSR 07-12-091, § 246-853-610, filed 6/6/07, effective 7/7/07.]

WAC 246-853-630 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this section, laser, light, radiofrequency, and plasma (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 prescriptive devices.

(2) Because an LLRP device is used to treat disease, injuries, deformities, and other physical conditions in human beings, the use of an LLRP device is the practice of osteopathic medicine under RCW 18.57.001. 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 those in subsection (1) of this section constitutes surgery and is outside the scope of this section.

OSTEOPATHIC PHYSICIAN RESPONSIBILITIES

(4) An osteopathic 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) An osteopathic physician must use an LLRP device in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, an osteopathic 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 osteopathic physician is ultimately responsible for the safety of the patient.

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

(9) The osteopathic 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 the following:

(a) A mechanism to identify complications and problematic 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 osteopathic physician supervising practices; and

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

OSTEOPATHIC PHYSICIAN DELEGATION OF LLRP TREATMENT

(10) An osteopathic physician who meets the requirements in subsections (1) through (9) of this section may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice allows the use of a prescriptive LLRP medical 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 osteopathic 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) An osteopathic 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 osteopathic physician authorized to use the LLRP 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 pursuant to 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 osteopathic physician concerning specific decisions made;

(e) The supervised professional has appropriate training including, but not limited to:

- (i) Application techniques of each LLRP device;
 - (ii) Cutaneous medicine;
 - (iii) Indications and contraindications for such procedures;
 - (iv) Preprocedural and postprocedural care;
 - (v) Potential complications; and
 - (vi) Infectious disease control involved with each treatment;
- (f) The delegating osteopathic 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 osteopathic 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;
- (h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating osteopathic physician provided there is a local back-up physician, licensed under chapter 18.57 or 18.71 RCW, 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. In case of an emergency the delegating osteopathic physician or a back-up physician shall be reachable by phone and able to see the patient within sixty minutes.
- (11) The use of, or the delegation of the use of, an LLRP device by an osteopathic physician assistant is covered by WAC 246-854-220.
- (12) This section only applies to the use of LLRP devices by osteopathic physicians and osteopathic physician assistants.

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.250. WSR 15-16-085, § 246-853-630, filed 7/31/15, effective 8/31/15. Statutory Authority: RCW 18.57.005, 18.57A.020, 18.130.050. WSR 08-20-125, § 246-853-630, filed 10/1/08, effective 11/1/08.]

WAC 246-853-640 Nonsurgical medical cosmetic procedures. (1)

The purpose of this rule is to set forth the duties and responsibilities of an osteopathic physician who delegates the injection of medications 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, disfiguration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of osteopathic medicine under RCW 18.57.001(4).

- (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 246-853-630 and 246-854-220;
 - (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. These definitions 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.

(b) "Osteopathic physician" means an individual licensed under chapter 18.57 RCW.

(c) "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.

OSTEOPATHIC PHYSICIAN RESPONSIBILITIES

(4) An osteopathic physician must be appropriately trained in a nonsurgical medical cosmetic procedure prior to performing the procedure or delegating the procedure. The osteopathic 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 board.

(5) Prior to authorizing a nonsurgical medical cosmetic procedure, an osteopathic 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 osteopathic physician is ultimately responsible for the safety of the patient.

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

(8) The osteopathic 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 practitioners 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) of this section and osteopathic physician supervising practices; and

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

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

(10) The osteopathic 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) An osteopathic 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 osteopathic 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 osteopathic 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 osteopathic 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 osteopathic physician concerning specific decisions made.

(e) The osteopathic 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 an osteopathic physician delegates the performance of a procedure that uses a medication or substance, whether or not approved by the federal Food and Drug Administration for the particular purpose for which it is used, the osteopathic physician must be on-site during the procedure.

(13) If the physician is unavailable to supervise a delegate as required by this section, the osteopathic 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 pursuant to the protocols, and must have comparable training as the primary supervising osteopathic physician.

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

[Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.050(4). WSR 11-08-024, § 246-853-640, filed 3/31/11, effective 5/1/11.]

WAC 246-853-650 Safe and effective analgesia and anesthesia administration in office-based settings. (1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The board of osteopathic medicine and surgery establishes the following rule for physicians licensed under chapter 18.57 RCW 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 rule unless the text clearly indicates otherwise:

(a) "Board" means the board of osteopathic medicine and surgery.

(b) "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 maintained.

(c) "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. 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.

(d) "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.

(e) "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.

(f) "Minimal sedation" or "analgesia" 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 or intramuscular medications, or both.

(g) "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 maintained.

(h) "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 loca-

tion 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.

(i) "Physician" means an osteopathic physician licensed under chapter 18.57 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 using general anesthesia. Facilities in which physicians perform procedures in which general anesthesia is a planned event are regulated by rules related to hospitals or hospital-associated surgical centers licensed under chapter 70.41 RCW, or ambulatory surgical facilities licensed under chapter 70.230 RCW.

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

(i) Is licensed both as a physician under chapter 18.57 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 his or her 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. Within three hundred sixty-five calendar days of the effective date of this rule, 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 one of the following:

(a) The Joint Commission (JC);

(b) The Accreditation Association for Ambulatory Health Care (AAAHC);

(c) The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF);

(d) The Centers for Medicare and Medicaid Services (CMS); or

(e) Planned Parenthood Federation of America or the National Abortion Federation, for facilities limited to office-based surgery for abortion or abortion-related services.

(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; or

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

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

(8) Resuscitative preparedness. At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group (e.g., advanced cardiac life support (ACLS), pediatric advanced life support (PALS) or advanced pediatric life support (APLS)) 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.

(9) Sedation, assessment and management.

(a) 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.

(b) 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" patients who enter a deeper level of sedation than intended.

(c) 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, the 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:

(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) Type of sedation or anesthesia used;
 - (ii) Drugs (name and dose) and time of administration;
 - (iii) Documentation at regular intervals of information obtained from 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 18.57.005 and 18.130.050. WSR 11-01-117, § 246-853-650, filed 12/17/10, effective 1/17/11.]

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-853-660 Intent and scope. WAC 246-853-660 through 246-853-790 govern the prescribing of opioids in the treatment of pain.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-660, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-660, filed 5/2/11, effective 7/1/11.]

WAC 246-853-661 Exclusions. WAC 246-853-660 through 246-853-790 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. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

[Statutory Authority: RCW RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-661, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-661, filed 5/2/11, effective 7/1/11.]

WAC 246-853-662 Definitions. The definitions in this section apply in WAC 246-853-660 through 246-853-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(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 considered to be 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 resulting from cancer in a patient who is less than two years postcompletion of curative anti-cancer treatment with current evidence of disease.

(5) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anti-cancer treatment with no current evidence of disease.

(6) "High-dose" means ninety milligrams MED, or more, per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

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

(9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(10) "Low-risk" means 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.

(11) "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.

(12) "Moderate-risk" means a category of patient at a 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 and ninety milligram morphine equivalent doses.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(14) "Multidisciplinary pain clinic" means a facility that provides comprehensive pain management and includes care provided by multiple available disciplines, practitioners, or treatment modalities.

(15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative" means care that improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "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.

(22) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(23) "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 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-662, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-853-662, filed 5/2/11, effective 7/1/11.]

WAC 246-853-675 Patient notification, secure storage, and disposal. (1) The osteopathic physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

- (a) The first issuance of a prescription for an opioid; and
- (b) The transition between phases of treatment, as follows:

- (i) Acute nonoperative pain or acute perioperative pain to subacute pain; and
 - (ii) Subacute pain to chronic pain.
- (3) Patient notification must include information regarding:
- (a) The safe and secure storage of opioid prescriptions; and
 - (b) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-675, filed 10/1/18, effective 11/1/18.]

WAC 246-853-680 Use of alternative modalities for pain treatment. The osteopathic physician shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-680, filed 10/1/18, effective 11/1/18.]

WAC 246-853-685 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic 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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-685, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

WAC 246-853-690 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic 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, including date, type, dosage and quantity prescribed.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-690, filed 10/1/18, effective 11/1/18.]

WAC 246-853-695 Treatment plan—Acute nonoperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

(3) If the osteopathic 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) A three-day supply or less will often be sufficient.

(b) More than a seven-day supply will rarely be needed.

(c) The osteopathic 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 osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall 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 includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function;

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician need to prescribe a long-acting opioid for acute pain, the osteopathic physician must document the reason in the patient record.

(7) An osteopathic physician shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-853-780.

(8) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic 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 246-853-705 and 246-853-710 shall apply.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-695, filed 10/1/18, effective 11/1/18.]

WAC 246-853-700 Treatment plan—Acute perioperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic 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. For more specific best practices, the osteopathic physician may refer to clinical practice guidelines.

(4) The osteopathic physician shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall 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 includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(6) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician must prescribe in accordance with WAC 246-853-775.

(7) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain,

the osteopathic physician shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-853-705 and 246-853-710 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-700, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-853-705 Patient evaluation and patient record. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

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

(c) Inquire about other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are 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 significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP and any concerns the osteopathic physician may have;

(d) All medications the patient is known to be prescribed or taking;

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

- (f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;
 - (g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;
 - (h) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;
 - (i) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable; and
 - (j) All other required components of the patient record, as established in statute or rule.
- (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 planned diagnostic evaluations or other treatments.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-705, filed 10/1/18, effective 11/1/18.]

WAC 246-853-710 Treatment plan—Subacute pain. (1) The osteopathic physician shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic 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. The osteopathic physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician shall prescribe in accordance with WAC 246-853-775.

(5) If the osteopathic physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic 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 in WAC 246-853-715 through 246-853-760 shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

WAC 246-853-715 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

- (i) The nature and intensity of the pain;
- (ii) The effect of pain on physical and psychosocial function;
- (iii) Current and past treatments for pain, including medications and their efficacy;
- (iv) Review of any significant comorbidities;
- (v) Any current or historical substance use disorder;
- (vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and
- (vii) Medication allergies.

(b) Evaluation. The patient evaluation prior to opioid prescribing must include:

- (i) Appropriate physical examination;
- (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
- (iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;
- (iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-853-790;
- (v) Any available diagnostic, therapeutic, and laboratory results;
- (vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The osteopathic physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk.

(vii) Any available consultations, particularly as related to the patient's pain;

(viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(ix) Treatment plan and objectives including:

- (A) Documentation of any medication prescribed;
- (B) Biologic specimen testing ordered; and
- (C) Any labs or imaging ordered;

(x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician; and

(xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-715, filed 10/1/18, effective 11/1/18.]

WAC 246-853-720 Treatment plan. (1) When the patient enters the chronic pain phase, the osteopathic physician shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include:

- (a) Any change in pain relief;
- (b) Any change in physical and psychosocial function; and
- (c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the osteopathic physician shall adjust drug therapy to the individual health needs of the patient.

(4) The osteopathic physician shall complete patient notification in accordance with the provisions of WAC 246-853-675.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-720, filed 10/1/18, effective 11/1/18.]

WAC 246-853-725 Written agreement for treatment. The osteopathic physician shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

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

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

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

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician to release the agreement for treatment to:

- (i) Local emergency departments;
- (ii) Urgent care facilities;
- (iii) Other practitioners caring for the patient who might prescribe pain medications; and
- (iv) Pharmacies.

(b) The osteopathic physician to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

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

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-853-660 through 246-853-790, refills are subject to the same limitations and requirements as initial prescriptions.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-725, filed 10/1/18, effective 11/1/18.]

WAC 246-853-730 Periodic review. (1) The osteopathic physician shall periodically review the course of treatment for chronic pain. The osteopathic physician shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-853-790 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 or aberrant behavior; and

(e) More frequently at the osteopathic physician's discretion.

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

- (a) The patient's compliance with any medication treatment plan;
- (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
- (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

- (a) History and physical exam related to the pain;
- (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-853-790 and subsection (1) of this section.

(4) The osteopathic physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-853-755.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-730, filed 10/1/18, effective 11/1/18.]

WAC 246-853-735 Consultation—Recommendations and requirements.

(1) The osteopathic physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment ob-

jectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-853-740 or 246-853-745, an osteopathic physician who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-853-750. 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 consultation between the pain management specialist and the osteopathic physician;

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

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

(3) The osteopathic physician shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician, the osteopathic physician shall maintain it as part of the patient record.

(4) The osteopathic physician shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-735, filed 10/1/18, effective 11/1/18.]

WAC 246-853-740 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician is not required to consult with a pain management specialist as defined in WAC 246-853-750 when the osteopathic physician has documented adherence to all standards of practice as defined in WAC 246-853-715 through 246-853-760, 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 expected return to their baseline dosage level or below;

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

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-740, filed 10/1/18, effective 11/1/18.]

WAC 246-853-745 Consultation—Exemptions for the osteopathic physician. An osteopathic physician is exempt from the consultation requirement in WAC 246-853-735 if one or more of the following qualifications are met:

(1) The osteopathic physician is a pain management specialist under WAC 246-853-750;

(2) The osteopathic physician has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

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

(4) The osteopathic physician has a minimum 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-745, filed 10/1/18, effective 11/1/18.]

WAC 246-853-750 Pain management specialist. (1) A pain management specialist shall meet one or more of the following qualifications:

(a) An osteopathic physician shall be board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology;

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

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

(d) Be credentialed in pain management by an entity approved by the board; or

(e) Have a minimum of three years of clinical experience in a chronic pain management care setting including:

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

(ii) At least thirty percent of the osteopathic physician's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

(2) An osteopathic physician assistant shall meet requirements in WAC 246-854-330.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-750, filed 10/1/18, effective 11/1/18.]

WAC 246-853-755 Tapering requirements. (1) The osteopathic physician shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests;

(b) The patient experiences a deterioration in function or pain;

(c) The patient is noncompliant with the written agreement;

(d) Other treatment modalities are indicated;

(e) There is evidence of misuse, abuse, substance use disorder, or diversion;

(f) The patient experiences a severe adverse event or overdose;

(g) There is unauthorized escalation or doses; or

(h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-755, filed 10/1/18, effective 11/1/18.]

WAC 246-853-760 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-853-735 and the tapering requirements of WAC 246-853-755 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams 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 demonstrated history in their record of compliance with treatment plans and written agreements as 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 dose in excess of one hundred twenty milligrams MED.

(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 246-853-735 and 246-853-755 shall apply.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-760, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-853-765 Special populations—Patients twenty-five years of age or under, pregnant patient, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-765, filed 10/1/18, effective 11/1/18.]

WAC 246-853-770 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician providing episodic care to a patient who the osteopathic physician knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-770, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-853-775 Coprescribing of opioids with certain medications. (1) The osteopathic physician must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-775, filed 10/1/18, effective 11/1/18.]

WAC 246-853-780 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-780, filed 10/1/18, effective 11/1/18.]

WAC 246-853-785 Coprescribing of naloxone. (1) The osteopathic physician shall confirm or provide a current prescription for naloxone when high dose opioids are prescribed.

(2) The osteopathic physician should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-785, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-853-790 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or of a benzodiazepine.

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

(5) In cases of technical or electrical failure, the osteopathic physician shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-853-790, filed 10/1/18, effective 11/1/18.]

WAC 246-853-990 Osteopathic fees and renewal cycle. (1) Licenses must be renewed every year 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 program dates.

(3) The following nonrefundable fees will be charged for osteopathic physicians:

Title of Fee	Fee
Original application	
Endorsement application	\$375.00
UW online access fee (HEAL-WA)	16.00
Active license renewal	
Renewal	375.00
Late renewal penalty	190.00
Expired license reissuance	250.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Inactive license renewal	
Renewal	310.00
Expired license reissuance	225.00
Late renewal penalty	155.00

Title of Fee	Fee
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Retired active license renewal	
Renewal	195.00
Late renewal penalty	100.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Endorsement/state exam application	500.00
Reexam	100.00
Verification of license	50.00
Limited license	
Application	285.00
Renewal	265.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Temporary permit application	70.00
Duplicate certificate	20.00

(4) The following nonrefundable fees will be charged for osteopathic physician assistants:

Title of Fee	Fee
Original application	
Application	\$220.00
UW online access fee (HEAL-WA)	16.00
Active license renewal	
Renewal	220.00
Late renewal penalty	110.00
Expired license reissuance	100.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Retired active license renewal	
Renewal	120.00
Late renewal penalty	60.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Verification of license	30.00
Interim permit	200.00
License after exam	100.00
Duplicate certificate	20.00

[Statutory Authority: 2016 c 42 and RCW 18.130.175, and 43.10.250. WSR 16-21-062, § 246-853-990, filed 10/14/16, effective 2/1/17. Statutory Authority: RCW 18.130.250, 43.70.250, and 18.130.186. WSR 15-07-004, § 246-853-990, filed 3/6/15, effective 4/6/15. Statutory Authority: RCW 43.70.250, 43.70.280, and 2013 c 129. WSR 13-21-069, § 246-853-990, filed 10/16/13, effective 1/1/14. Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-19-088, § 246-853-990, filed 9/18/12, effective 11/1/12. Statutory Authority: RCW 43.70.250, 43.70.110. WSR 11-14-038, § 246-853-990, filed 6/28/11, effective 8/15/11. Statutory

Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-853-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-853-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 43.70.250. WSR 99-24-063, § 246-853-990, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-853-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.250 and chapters 18.57, 18.57A, 18.22 and 18.59 RCW. WSR 94-22-055, § 246-853-990, filed 11/1/94, effective 1/1/95. Statutory Authority: RCW 43.70.250. WSR 92-14-054 (Order 281), § 246-853-990, filed 6/25/92, effective 7/26/92; WSR 91-21-034 (Order 200), § 246-853-990, filed 10/10/91, effective 11/10/91; WSR 91-13-002 (Order 173), § 246-853-990, filed 6/6/91, effective 7/7/91. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-853-990, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 43.70.250. WSR 90-04-094 (Order 029), § 308-138-080, filed 2/7/90, effective 3/10/90. Statutory Authority: RCW 43.24.086. WSR 87-10-028 (Order PM 650), § 308-138-080, filed 5/1/87. Statutory Authority: 1983 c 168 § 12. WSR 83-17-031 (Order PL 442), § 308-138-080, filed 8/10/83. Formerly WAC 308-138-060.]