

WAC 246-341-1015 Opioid treatment programs (OTP)—Clinical record content and documentation requirements. An agency providing opioid treatment program services must maintain an individual's clinical record. The clinical record must contain:

(1) Documentation that the agency made a good faith effort to review if the individual is enrolled in any other opioid treatment program and take appropriate action;

(2) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanction;

(3) Documentation that the individual service plan was reviewed quarterly and semi-annually after two years of continuous treatment;

(4) Documentation when an individual refuses to provide a drug testing specimen sample. The refusal is considered a positive drug screen specimen;

(5) Documentation in progress notes of timely interventions used to therapeutically address the disclosure of illicit drug use, a positive drug test, or possible diversion of opioid medication, as evidenced by the absence of opioids or related metabolites in drug toxicology test results;

(6) Documentation of all medical services including:

(a) Results of physical examination;

(b) Medical and family history;

(c) Nursing notes;

(d) Laboratory reports including results of regular toxicology screens, a problem list, and list of medications updated as clinically indicated; and

(e) Progress notes including documentation of all medications and dosages, if available.

[Statutory Authority: RCW 71.24.037, 71.05.560, 71.34.380, 18.205.160, 71.24.037 and chapters 71.05, 71.24, and 71.34 RCW. WSR 21-12-042, § 246-341-1015, filed 5/25/21, effective 7/1/21. Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-1015, filed 4/16/19, effective 5/17/19.]