Chapter 246-817 WAC
DENTAL QUALITY ASSURANCE COMMISSION

(Formerly chapters 246-816 and 246-818 WAC)

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WAC

ADMINISTRATION OF ANESTHETIC AGENTS FOR DENTAL PROCEDURES

SUBSTANCE ABUSE MONITORING PROGRAMS

OPIOID PRESCRIBING

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FEES

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-817-130 Licensure without examination for dentists—Eligibility. [Statutory Authority: RCW 18.32.0365 and 18.32.215. WSR 08-23-017, § 246-817-130, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-130, filed 10/10/95, effective 11/10/95.] Repealed by WSR 16-16-039, filed 7/26/16, effective 8/26/16. Statutory Authority: RCW 18.32.0365 and 18.32.215.

246-817-140 Licensure without examination for dentists—Licensing examination standards. [Statutory Authority: RCW 18.32.0365 and 18.32.215. WSR 08-23-017, § 246-817-140, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-140, filed 10/10/95, effective 11/10/95.] Repealed by WSR 16-16-039, filed 7/26/16, effective 8/26/16. Statutory Authority: RCW 18.32.0365 and 18.32.215.

246-817-155 Dental resident license to full dental license—Conditions. [Statutory Authority: RCW 18.32.0365 and 18.32.040. WSR 08-23-018, § 246-817-155, filed 11/6/08, effective 12/7/08.] Repealed by WSR 18-01-106, filed 12/19/17, effective 1/19/18. Statutory Authority: RCW 18.32.002, 18.32.0365, and 18.32.040.

246-817-170 Applications—Permits—Renewals for the administration of conscious sedation with multiple oral or parenteral agents or general anesthesia (including deep sedation). [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-170, filed 10/10/95, effective 11/10/95.] Repealed by WSR 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-175 Conscious sedation with parenteral or multiple oral agents—Education and training requirements—Application. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-175, filed 10/10/95, effective 11/10/95.] Repealed by WSR 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-180 General anesthesia (including deep sedation)—Education and training requirements. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-180, filed 10/10/95, effective 11/10/95.] Repealed by WSR 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-201 Application for licensure—AIDS education requirements. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-201, filed 10/10/95, effective 11/10/95.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-817-340 Recording requirements for all prescription drugs. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-340, filed 10/10/95, effective 11/10/95.] Repealed by WSR 16-19-078, filed 9/20/16, effective 10/21/16. Statutory Authority: RCW 18.32.0365 and 18.32.655.

246-817-360 Prescribing, dispensing or distributing drugs. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-360, filed 10/10/95, effective 11/10/95.] Repealed by WSR 15-12-091, filed 6/2/15, effective 7/3/15. Statutory Authority: RCW 18.32.0365.

246-817-620 Use of barriers and sterilization techniques. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-620, filed 10/10/95, effective 11/10/95.] Repealed by WSR 21-01-214, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.002 and 18.32.0365.

246-817-630 Management of single use items. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-630, filed 10/10/95, effective 11/10/95.] Repealed by WSR 21-01-214, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.002 and 18.32.0365.

246-817-750 Conscious sedation with an oral agent. [Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-750, filed 10/10/95, effective 11/10/95.] Repealed by WSR 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-910 Definitions. [Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-910, filed 5/2/11, effective 7/1/11.] Repealed by WSR 19-02-043, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297.

246-817-925 Informed consent. [Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-925, filed 5/2/11, effective 7/1/11.] Repealed by WSR 19-02-043, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297.

246-817-940 Long-acting opioids, including methadone. [Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-940, filed 5/2/11, effective 7/1/11.] Repealed by WSR 19-02-043, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297.

246-817-945 Episodic care. [Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-945, filed 5/2/11, effective 7/1/11.] Repealed by WSR 19-02-043, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297.

DENTISTS

WAC 246-817-001 Purpose. The purpose of these rules is to further clarify and define chapter 18.32 RCW, Dentistry.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-001, filed 10/10/95, effective 11/10/95.]

WAC 246-817-010 Definitions. The following general terms are defined within the context used in this chapter.

"Clinics" are locations situated away from the School of Dentistry on the University of Washington campus, as recommended by the dean in writing and approved by the DQAC.

"CITA" means Council of Interstate Testing Agencies, a regional dental testing agency that provides clinical dental testing services.

"CRDTS" means Central Regional Dental Testing Services, a regional testing agency that provides clinical dental testing services.

"Department" means the department of health.

"DQAC" means the dental quality assurance commission as established by RCW 18.32.0351.

"Facility" is defined as the building housing the School of Dentistry on the University of Washington campus, and other buildings, designated by the dean of the dental school and approved by the DQAC.

"NERB" means the Northeast Regional Board, a regional testing agency that provides clinical dental testing services.

"Secretary" means the secretary of the department of health or the secretary's designee.

"SRTA" means the Southern Regional Testing Agency, a regional testing agency that provides clinical dental testing services.

"WREB" means the Western Regional Examining Board, a national testing agency that provides clinical dental testing services.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-010, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.0365 and 18.32.040. WSR 08-23-019, § 246-817-010, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-010, filed 10/10/95, effective 11/10/95.]

WAC 246-817-015 Adjudicative proceedings—Procedural rules for the dental quality assurance commission. The DQAC 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 18.32.035. WSR 95-21-041, § 246-817-015, filed 10/10/95, effective 11/10/95.]

LICENSURE—APPLICATION AND ELIGIBILITY REQUIREMENTS

WAC 246-817-101 Dental licenses—Types authorized. The DQAC is granted the authority to issue the following types of dental licenses or permits:

(1) Licensure by examination standard. (RCW 18.32.040)

(2) Licensure without examination—Licensed in another state. (RCW 18.32.215)

(3) Faculty licensure. (RCW 18.32.195)

(4) Dental resident licensure. (RCW 18.32.195)

(5) Conscious sedation permits. (RCW 18.32.640)

(6) Anesthesia permits. (RCW 18.32.640)

(7) Temporary practice permits. (RCW 18.130.075)

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-101, filed 10/10/95, effective 11/10/95.]

WAC 246-817-110 Dental licensure—Initial eligibility and application requirements. To be eligible for Washington state dental licensure, the applicant must provide:

(1) A completed application and fee. The applicant must submit a signed application and required fee as defined in WAC 246-817-990;

(2) Proof of graduation from a dental school approved by the DQAC:

(a) DQAC recognizes only those applicants who are students or graduates of dental schools in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation of the American Dental Association. The applicant must have received, or will receive, a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree from that school;

(b) Other dental schools which apply for DQAC approval and which meet these adopted standards to the DQAC's satisfaction may be approved, but it is the responsibility of a school to apply for approval and of a student to ascertain whether or not a school has been approved;

(3) Proof of successful completion of the Integrated National Board Dental Examination, Parts I and II of the National Board Dental Examination, or the Canadian National Dental Examining Board Examination. An original scorecard or a certified copy of the scorecard shall be accepted. Exception: Dentists who obtained initial licensure in a state prior to that state's requirement for successful completion of the national boards, may be licensed in Washington, provided that the applicant provide proof that their original state of licensure did not require passage of the national boards at the time they were initially licensed. Applicants need to meet all other requirements for licensure;

(4) Proof of graduation from an approved dental school. The only acceptable proof is an official, posted transcript sent directly from such school, or in the case of recent graduates, a verified list of graduating students submitted directly from the dean of the dental school. Graduates of nonaccredited dental schools must also meet the requirements outlined in WAC 246-817-160;

(5) A complete listing of professional education and experience including college or university (predental), and a complete chronology of practice history from the date of dental school graduation to present, whether or not engaged in activities related to dentistry;

(6) Proof of malpractice insurance if available, including dates of coverage and any claims history;

(7) Written certification of any licenses held, submitted directly from another licensing entity, and including license number, issue date, expiration date and whether applicant has been the subject of final or pending disciplinary action;

(8) Proof of successful completion of:

(a) An approved practical/clinical examination under WAC 246-817-120; or

(b) A qualifying residency program under RCW 18.32.040 (3)(c);

(9) Proof of successful completion of an approved written jurisprudence examination;

(10) A recent 2" x 2" photograph, signed, dated, and attached to the application;

(11) Authorization for background inquiries to other sources may be conducted as determined by the DQAC including, but not limited to, the national practitioner data bank and drug enforcement agency. Applicants are responsible for any fees incurred in obtaining verification of requirements;

(12) Any other information for each license type as determined by the DQAC.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-110, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.002, 18.32.0365, and 18.32.040. WSR 19-15-094, § 246-817-110, filed 7/22/19, effective 8/22/19; WSR 18-01-106, § 246-817-110, filed 12/19/17, effective 1/19/18. Statutory Authority: RCW 18.32.0365 and 18.32.100 as amended by 2015 c 72. WSR 16-05-083, § 246-817-110, filed 2/16/16, effective 3/18/16. Statutory Authority: RCW 18.32.0365 and 18.32.040. WSR 08-23-019, § 246-817-110, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-817-110, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-110, filed 10/10/95, effective 11/10/95.]

WAC 246-817-120 Examination content. (1) An applicant seeking dentist licensure in Washington by examination, must successfully pass a written and practical examination approved by the Dental Quality Assurance Commission (commission).

The examination will consist of:

(a) A written examination. The Integrated National Board Dental Examination, Parts I and II of the National Board Dental Examination, or the Canadian National Dental Examining Board examination will be accepted, except as provided in subsection (4) of this section.

(b) A practical examination containing at least the following sections:

(i) Restorative;

(ii) Endodontic;

(iii) Periodontal;

(iv) Prosthodontic; and

(v) Comprehensive treatment planning or diagnostic skills.

(2)(a) The commission accepts the following practical examinations provided the testing agency offers at least the sections listed in subsection (1)(b) of this section:

(i) The Western Regional Examining Board's (WREB) clinical examination;

(ii) The Central Regional Dental Testing Services (CRDTS) clinical examination;

(iii) The Commission on Dental Competency Assessments (CDCA) formally known as Northeast Regional Board (NERB) clinical examination;

(iv) The Southern Regional Testing Agency (SRTA) clinical examination;

(v) The Council of Interstate Testing Agency's (CITA) clinical examination;

(vi) U.S. state or territory with an individual state board clinical examination;

(vii) The Joint Commission on National Dental Examinations dental licensure objective structured clinical examination (DLOSCE); or

(b) The commission will accept the complete National Dental Examining Board (NDEB) of Canada clinical examination as meeting its standards if the applicant is a graduate of an approved dental school defined in WAC 246-817-110 (2)(a).

(3) The applicant must pass all practical examination sections listed in subsection (1)(b) of this section with the following:

(a) The same testing agency; or

(b) A maximum of two testing agencies listed in subsection (2)(a) of this section administering all the practical examination sections in coordination with each other.

(4) The commission will only accept results of approved practical examinations taken within the preceding five years from the date of an application for licensure.

(5) The commission may, at its discretion, give or require an examination in any other subject under subsection (1)(a) and (b) of this section, whether in written or practical form or both written and practical.

[Statutory Authority: RCW 18.32.002, 18.32.0365 and 18.32.040. WSR 21-09-011, § 246-817-120, filed 4/8/21, effective 5/9/21; WSR 19-15-094, § 246-817-120, filed 7/22/19, effective 8/22/19; WSR 17-22-035, § 246-817-120, filed 10/24/17, effective 11/24/17. Statutory Authority: RCW 18.32.0365 and 18.32.040. WSR 16-14-067, § 246-817-120, filed 6/30/16, effective 7/31/16; WSR 08-23-019, § 246-817-120, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-120, filed 10/10/95, effective 11/10/95.]

WAC 246-817-135 Dental licensure without examination—Eligibility and application requirements. For individuals holding a dentist credential in another U.S. state or territory, to be eligible for Washington state dental license without examination, the applicant must provide:

(1) A completed application on forms provided by the secretary;

(2) Applicable fees under WAC 246-817-990;

(3) A verification by a U.S. state or territory board of dentistry (or equivalent authority) of an active credential to practice dentistry, without restrictions, and whether the applicant has been the subject of final or pending disciplinary action;

(4) Proof of graduation from an approved dental school under WAC 246-817-110 (2)(a):

(a) The only acceptable proof is an official, posted transcript sent directly from such school;

(b) Graduates of nonapproved dental schools must meet the requirements under RCW 18.32.215 (1)(b).

(5) Proof that the applicant is currently engaged in the practice of dentistry:

(a) Dentists serving in the United States federal services as described in RCW 18.32.030(2) must provide documentation from their commanding officer regarding length of service, duties and responsibilities, and any adverse actions or restrictions;

(b) Dentists employed by a dental school approved under WAC 246-817-110 (2)(a) must provide documentation from the dean or appropriate administrator of the institution regarding the length and terms

of employment, duties and responsibilities, and any adverse actions or restrictions;

(c) Dentists in a dental residency program must provide documentation from the director or appropriate administrator of the residency program regarding length of residency, duties and responsibilities, and any adverse actions or restrictions; or

(d) Dentists practicing dentistry for a minimum of twenty hours per week for the four consecutive years preceding application, in another U.S. state or territory must provide:

(i) Address of practice location(s);

(ii) Length of time at the location(s);

(iii) A letter from all malpractice insurance carrier(s) defining years when insured and any claims history;

(iv) Federal or state tax numbers; and

(v) DEA numbers if any.

(6) Proof of successful completion of a commission approved written jurisprudence examination;

(7) A recent 2" x 2" photograph, signed, dated, and attached to the application; and

(8) Authorization for background inquiries to other sources may include, but are not limited to, the national practitioner data bank and drug enforcement agency.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-135, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.0365 and 18.32.215. WSR 16-16-039, § 246-817-135, filed 7/26/16, effective 8/26/16; WSR 08-23-017, § 246-817-135, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-135, filed 10/10/95, effective 11/10/95.]

WAC 246-817-150 Licenses—Persons licensed or qualified out-of-state who are faculty at school of dentistry—Conditions. (1) The department shall provide an application for faculty licensure upon receipt of a written request from the dean of the school of dentistry of any institution of higher education in Washington state accredited by the commission on dental accreditation.

(2) Applicants for faculty licensure shall submit a signed application, including applicable fees, and other documentation as required by the DQAC.

(3) The dean of the school of dentistry of any higher education in Washington state accredited by the commission on dental accreditation, or their designee, shall notify the department of health of any changes in employment status of any person holding a faculty license.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.195, and 2023 c 89. WSR 24-08-057, § 246-817-150, filed 3/29/24, effective 4/29/24. Statutory Authority: RCW 18.32.0365 and 18.32.100 as amended by 2015 c 72. WSR 16-05-083, § 246-817-150, filed 2/16/16, effective 3/18/16. Statutory Authority: RCW 18.32.0365 and 18.32.195. WSR 11-11-073, § 246-817-150, filed 5/17/11, effective 6/17/11. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-817-150, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-150, filed 10/10/95, effective 11/10/95.]

WAC 246-817-160 Graduates of nonaccredited schools. (1) An applicant for Washington state dental licensure, who is a graduate of a dental school or college not accredited by the Commission on Dental Accreditation shall provide to the Dental Quality Assurance Commission (commission):

(a) Materials listed in WAC 246-817-110 (1), (3), (5) through (8), and (10) through (13);

(b) Official school transcript or diploma with dental degree listed transcribed to English if necessary;

(c) Evidence of successful completion of at least two additional predoctoral or postdoctoral academic years of dental education.

(i) Additional predoctoral or postdoctoral dental education completed prior to July 1, 2018, must be obtained at a dental school in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation.

(ii) Additional predoctoral or postdoctoral dental education completed after July 1, 2018, must be obtained in a dental program in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation and include clinical training; and

(d) An applicant for Washington state dental licensure must provide proof of successful completion of:

(i) An approved practical/clinical examination under WAC 246-817-120; or

(ii) A qualifying residency program under RCW 18.32.040 (3)(c).

(2) Upon completion of the requirements in subsection (1)(a) through (c) of this section, an applicant may be eligible to take the practical examination as approved in WAC 246-817-120 (2) through (4).

(a) The commission may issue examination approval up to six months before an applicant has completed the two additional predoctoral or postdoctoral academic years of dental education.

(b) An applicant must provide a letter from the school where the two additional predoctoral or postdoctoral academic years is being obtained indicating expected date of education completion.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 18.32.040. WSR 18-01-106, § 246-817-160, filed 12/19/17, effective 1/19/18. Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 16-17-104, § 246-817-160, filed 8/19/16, effective 9/19/16. Statutory Authority: RCW 18.32.0365, 18.32.002, 18.32.040, and 18.32.222. WSR 14-20-064, § 246-817-160, filed 9/26/14, effective 10/27/14. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-160, filed 10/10/95, effective 11/10/95.]

WAC 246-817-185 Temporary practice permits—Eligibility. Fingerprint-based national background checks may cause a delay in credentialing. Individuals who satisfy all other licensing requirements and qualifications may receive a temporary practice permit while the national background check is completed.

(1) A temporary practice permit, as defined in RCW 18.130.075, shall be issued at the written request of an applicant for dentists, expanded function dental auxiliaries, dental anesthesia assistants, and dental assistants. The applicant must be credentialed in another state, with credentialing standards substantially equivalent to Washington.

(2) The conditions of WAC 246-817-160 must be met for applicants who are graduates of dental schools or colleges not accredited by the American Dental Association Commission on Dental Accreditation.

[Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-185, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.130.064, 18.130.075, and 18.32.0365. WSR 10-07-026, § 246-817-185, filed 3/8/10, effective 4/8/10. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-185, filed 10/10/95, effective 11/10/95.]

WAC 246-817-186 Temporary practice permits—Issuance and duration. (1) Unless there is a basis for denial of the credential or for issuance of a conditional credential, the applicant shall be issued a temporary practice permit when DQAC receives:

(a) A completed application form, all other documentation required to complete the credential application, completed fingerprint card, and fees for the credential;

(b) A written request for a temporary practice permit;

(c) Written verification of all credentials, whether active or not, attesting that the applicant has a credential in good standing and is not the subject of any disciplinary action for unprofessional conduct or impairment; and

(d) Results of disciplinary national practitioner data bank reports.

(2) The temporary practice permit shall expire when one of the following occurs:

(a) A full, unrestricted credential is granted;

(b) A notice of decision is mailed;

(c) One hundred eighty days after the temporary practice permit is issued.

(3) A temporary practice permit shall not be renewed, reissued or extended.

(4) A temporary practice permit grants the individual the full scope of practice for the profession.

[Statutory Authority: RCW 18.130.064, 18.130.075, and 18.32.0365. WSR 10-07-026, § 246-817-186, filed 3/8/10, effective 4/8/10. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-186, filed 10/10/95, effective 11/10/95.]

WAC 246-817-187 Temporary practice permit—Military spouse eligibility and issuance. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for the profession. This section applies to dentists licensed in chapter 18.32 RCW, expanded function dental auxiliaries licensed and dental assistants registered in chapter 18.260 RCW, and dental anesthesia assistants certified in chapter 18.350 RCW.

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

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

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

(c) Holds an unrestricted, active credential in another state that has substantially equivalent credentialing standards for the same profession to those in Washington; and

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

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

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

(a) The credential is granted;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the temporary practice permit; or

(c) One hundred eighty days after the temporary practice permit is issued.

(4) To receive a temporary practice permit, the applicant must:

(a) Submit the necessary application, fee(s), fingerprint card if required, and documentation for the credential;

(b) Attest on the application that the applicant left employment in another state to accompany the military person;

(c) Meet all requirements and qualifications for the credential that are specific to the training, education, and practice standards for the profession;

(d) Provide verification of having an active unrestricted credential in the same profession from another state that has substantially equivalent credentialing standards for the profession in Washington;

(e) Submit a copy of the military person's orders and a copy of:

(i) The military-issued identification card showing the military person's information and the applicant's relationship to the military person;

(ii) A marriage license; or

(iii) A state registered domestic partnership; and

(f) Submit a written request for a temporary practice permit.

(5) For the purposes of this section:

(a) "Military person" means a person serving in the United States armed forces, the United States public health service commissioned corps, or the merchant marine of the United States.

(b) "Military spouse" means the husband, wife, or registered domestic partner of a military person.

[Statutory Authority: RCW 18.32.0365, 18.340.020, and chapter 18.340 RCW. WSR 15-11-005, § 246-817-187, filed 5/7/15, effective 6/7/15.]

WAC 246-817-190 Dental assistant registration. To be eligible for registration as a dental assistant you must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-99005; and

(3) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-190, filed 12/23/20, effective

1/23/21. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-190, filed 6/19/08, effective 7/1/08.]

WAC 246-817-195 Licensure requirements for expanded function dental auxiliaries (EFDAs). To be eligible for licensure as an EFDA in Washington an applicant must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-99005;

(3) Provide evidence of:

(a) Completion of a dental assisting education program accredited by the Commission on Dental Accreditation (CODA); or

(b) Obtain the Dental Assisting National Board (DANB) certified dental assistant credential, earned through pathway II, which includes:

(i) A minimum of three thousand five hundred hours of experience as a dental assistant within a continuous twenty-four through forty-eight month period;

(ii) Employer-verified knowledge in areas as specified by DANB;

(iii) Passage of DANB certified dental assistant examination; and

(iv) An additional dental assisting review course, which may be provided online, in person or through self-study; or

(c) A Washington limited license to practice dental hygiene; or

(d) A Washington full dental hygiene license and completion of a course in taking final impressions affiliated with or provided by a CODA accredited dental assisting program, dental hygiene school or dental school.

(4) Except for applicants qualified under subsection (3)(d) of this section, provide evidence of completing an EFDA education program approved by the commission where training includes:

(a) In a didactic, clinical and laboratory model to the clinically competent level required for close supervision:

(i) In placing and finishing composite restorations on a typodont and on clinical patients; and

(ii) In placing and finishing amalgam restorations on a typodont and on clinical patients; and

(iii) In taking final impressions on a typodont; and

(b) In a didactic, clinical and laboratory model to the clinically competent level required for general supervision:

(i) In performing coronal polish, fluoride treatment, and sealants on a typodont and on clinical patients; and

(ii) In providing patient oral health instructions; and

(iii) In placing, exposing, processing, and mounting dental radiographs; and

(c) The basic curriculum shall require didactic, laboratory, and clinical competency for the following:

(i) Tooth morphology and anatomy;

(ii) Health and safety (current knowledge in dental materials, infection control, ergonomics, mercury safety, handling);

(iii) Placement and completion of an acceptable quality reproduction of restored tooth surfaces—Laboratory and clinic only;

(iv) Radiographs (covered in path II)—Laboratory and clinic only;

(v) Ethics and professional knowledge of law as it pertains to dentistry, dental hygiene, dental assisting, and EFDA;

(vi) Current practices in infection control;
(vii) Health history alerts;
(viii) Final impression;
(ix) Matrix and wedge;
(x) Rubber dam;
(xi) Acid etch and bonding;
(xii) Occlusion and bite registration;
(xiii) Temporary restorations;
(xiv) Dental emergencies;
(xv) Risk management and charting;
(xvi) Intra-oral anatomy;
(xvii) Pharmacology; and
(xviii) Bases, cements, liners and sealers.

(5) Except for applicants qualified under subsection (3)(d) of this section, attain a passing score on:

(a) A written restorations examination approved by the commission; and

(b) A clinical restorations examination approved by the commission.

(6) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-195, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-195, filed 6/19/08, effective 7/1/08.]

WAC 246-817-200 Licensure without examination for expanded function dental auxiliary (EFDA). To be eligible for a license as an EFDA without examination you must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-990;

(3) Provide evidence of:

(a) A current license in another state with substantially equivalent licensing standards as determined by the commission; or

(b) A Washington full dental hygiene license and completion of a course in taking final impressions affiliated with or provided by a CODA accredited dental assisting program, dental hygiene school or dental school; and

(4) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-200, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-200, filed 6/19/08, effective 7/1/08.]

WAC 246-817-205 Dental anesthesia assistant certification requirements. An applicant for certification as a dental anesthesia assistant must submit to the department:

(1) A completed application on forms provided by the secretary;

(2) Applicable fees as defined in WAC 246-817-99005;

(3) Evidence of:

(a) Completion of a commission approved dental anesthesia assistant education and training. Approved education and training includes:

(i) Completion of the "Dental Anesthesia Assistant National Certification Examination (DAANCE)" or predecessor program, provided by the American Association of Oral and Maxillofacial Surgeons (AAOMS); or

(ii) Completion of the "Oral and Maxillofacial Surgery Assistants Course" course provided by the California Association of Oral and Maxillofacial Surgeons (CALAOMS); or

(iii) Completion of substantially equivalent education and training approved by the commission.

(b) Completion of training in intravenous access or phlebotomy. Training must include:

(i) Eight hours of didactic training that must include:

(A) Intravenous access;

(B) Anatomy;

(C) Technique;

(D) Risks and complications; and

(ii) Hands on experience starting and maintaining intravenous lines with at least ten successful intravenous starts on a human or simulator/manikin; or

(iii) Completion of substantially equivalent education and training approved by the commission;

(c) A current and valid certification for health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS);

(d) A valid Washington state general anesthesia permit of the oral and maxillofacial surgeon or dental anesthesiologist where the dental anesthesia assistant will be performing his or her services; and

(4) Any other information determined by the commission.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-205, filed 12/23/20, effective 1/23/21. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-205, filed 7/23/13, effective 8/23/13.]

WAC 246-817-210 Expired credential. (1) If the credential has expired for three years or less, the practitioner must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the credential has expired for over three years, the practitioner must:

(a) Comply with the current statutory conditions;

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

[Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-210, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-817-210, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-210, filed 10/10/95, effective 11/10/95.]

WAC 246-817-220 Inactive license. (1) A dentist may obtain an inactive license by meeting the requirements of WAC 246-12-090 and RCW 18.32.185.

(2) An inactive license must be renewed every year on or before the practitioner's birthday according to WAC 246-12-100 and 246-817-990.

(3) If a license is inactive for three years or less, to return to active status a dentist must meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(4) If a license is inactive for more than three years, and the dentist has been actively practicing in another United States jurisdiction, to return to active status the dentist must:

(a) Provide certification of an active dentist license, submitted directly from another licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(b) Provide verification of active practice in another United States jurisdiction within the last three years; and

(c) Meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(5) If a license is inactive for more than three years, and the dentist has not been actively practicing in another United States jurisdiction, to return to active status the dentist must provide:

(a) A written request to change licensure status;

(b) The applicable fees according to WAC 246-817-990;

(c) Proof of successful completion of:

(i) An approved practical/practice examination under WAC 246-817-120; or

(ii) A qualifying residency program under RCW 18.32.040 (3)(c);

(d) Written certification of all dental or health care licenses held, submitted directly from the licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(e) Written declaration that continuing education and competency requirements for the two most recent years have been met according to WAC 246-817-440;

(f) Proof of successful completion of an approved written jurisprudence examination within the past year; and

(g) Proof of malpractice insurance if available, including dates of coverage and any claims history.

[Statutory Authority: RCW 18.32.002, 18.32.0365, and 2020 c 76 § 22(11). WSR 21-01-215, § 246-817-220, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.002, 18.32.0365, and 18.32.040. WSR 18-01-106, § 246-817-220, filed 12/19/17, effective 1/19/18. Statutory Authority: RCW 18.32.185 and 18.32.0365. WSR 11-07-052, § 246-817-220, filed 3/17/11, effective 4/17/11.]

WAC 246-817-230 Dentist retired active status. (1) To obtain a retired active status license, a licensed dentist must comply with WAC 246-12-120, 246-12-130, and 246-12-140, excluding WAC 246-12-120 (2)(c) and (d).

(2) A licensed dentist with a retired active status license may practice under the following conditions:

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

(b) In intermittent circumstances on a nonpermanent basis.

(3) A licensed dentist with a retired active license may not receive compensation for dental services.

(4) A licensed dentist with a retired active status license must renew every year on or before the practitioner's birthday according to

WAC 246-12-130 and 246-817-990 and must complete 63 hours of continuing education as required in WAC 246-817-440 every three years.

[Statutory Authority: RCW 18.32.0365, 18.32.0357, 18.130.250, and 18.32.002. WSR 22-02-023, § 246-817-230, filed 12/28/21, effective 1/28/22. Statutory Authority: RCW 18.32.065 and 18.130.250. WSR 15-12-092, § 246-817-230, filed 6/2/15, effective 7/3/15.]

GENERAL PRACTICE REQUIREMENTS AND PROHIBITIONS

WAC 246-817-301 Display of licenses. The license of any dentist, dental hygienist or other individual licensed pursuant to the laws of Washington to engage in any activity being performed in the premises under the supervision or control of a licensed dentist shall be displayed in a place visible to individuals receiving services in the premises, and readily available for inspection by any designee of the DQAC.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-301, filed 10/10/95, effective 11/10/95.]

WAC 246-817-304 Definitions. The following definitions apply to WAC 246-817-304 through 246-817-315 unless the context requires otherwise:

(1) **"Clinical record"** is the portion of the record that contains information regarding the patient exam, diagnosis, treatment discussion, treatment performed, patient progress, progress notes, referrals, studies, tests, imaging of any type and any other information related to the diagnosis or treatment of the patient.

(2) **"Financial record"** is the portion of the record that contains information regarding the financial aspects of a patient's treatment including, but not limited to, billing, treatment plan costs, payment agreements, payments, insurance information or payment discussions held with a patient, insurance company or person responsible for account payments.

(3) **"Notation"** is a condensed or summarized written record/note.

(4) **"Patient record"** is the entire record of the patient maintained by a practitioner that includes all information related to the patient.

[Statutory Authority: RCW 18.32.0365, 18.32.655, and 18.32.002. WSR 16-07-084, § 246-817-304, filed 3/17/16, effective 4/17/16.]

WAC 246-817-305 Patient record content. (1) A licensed dentist who treats patients shall maintain legible, complete, and accurate patient records.

(2) The patient record must contain the clinical records and the financial records.

(3) The clinical record must include at least the following information:

(a) For each clinical record entry note, the signature, initials, or electronic verification of the individual making the entry note;

(b) For each clinical record entry note, identify who provided treatment if treatment was provided;

(c) The date of each patient record entry, document, radiograph or model;

(d) The physical examination findings documented by subjective complaints, objective findings, an assessment or diagnosis of the patient's condition, and plan;

(e) A treatment plan based on the assessment or diagnosis of the patient's condition;

(f) Up-to-date dental and medical history that may affect dental treatment;

(g) Any diagnostic aid used including, but not limited to, images, radiographs, and test results. Retention of molds or study models is at the discretion of the practitioner, except for molds or study models for orthodontia or full mouth reconstruction which shall be retained as listed in WAC 246-817-310;

(h) A complete description of all treatment/procedures administered at each visit;

(i) An accurate record of any medication(s) administered, prescribed or dispensed including:

(i) The date prescribed or the date dispensed;

(ii) The name of the patient prescribed or dispensed to;

(iii) The name of the medication; and

(iv) The dosage and amount of the medication prescribed or dispensed, including refills.

(j) Referrals and any communication to and from any health care provider;

(k) Notation of communication to or from the patient or patient's parent or guardian, including:

(i) Notation of the informed consent discussion. This is a discussion of potential risk(s) and benefit(s) of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;

(ii) Notation of posttreatment instructions or reference to an instruction pamphlet given to the patient;

(iii) Notation regarding patient complaints or concerns associated with treatment, this includes complaints or concerns obtained in person, by phone call, email, mail, or text; and

(iv) Termination of doctor-patient relationship; and

(l) A copy of each laboratory referral retained for three years as required in RCW 18.32.655.

(4) Clinical record entries must not be erased or deleted from the record.

(a) Mistaken handwritten entries must be corrected with a single line drawn through the incorrect information. New or corrected information must be initialed and dated.

(b) If the record is an electronic record then a record audit trail must be maintained with the record that includes a time and date history of deletions, edits and/or corrections to electronically signed records.

[Statutory Authority: RCW 18.32.0365, 18.32.655, and 18.32.002. WSR 16-07-084, § 246-817-305, filed 3/17/16, effective 4/17/16.]

WAC 246-817-310 Patient record retention and accessibility requirements. (1) A licensed dentist shall keep readily accessible pa-

tient records for at least six years from the date of the last treatment.

(2) A licensed dentist shall respond to a written request from a patient to examine or copy a patient's record within fifteen working days after receipt. A licensed dentist shall comply with chapter 70.02 RCW for all patient record requests.

(3) A licensed dentist shall comply with chapter 70.02 RCW and the Health Insurance Portability and Accountability Act, 45 C.F.R. destruction and privacy regulations.

[Statutory Authority: RCW 18.32.0365, 18.32.655, and 18.32.002. WSR 16-07-084, § 246-817-310, filed 3/17/16, effective 4/17/16. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-310, filed 10/10/95, effective 11/10/95.]

WAC 246-817-315 Business records accessibility. If requested as part of an investigation authorized by the secretary, a licensed dentist who operates a dental practice in the state of Washington shall provide to the secretary:

(1) Documentation that the licensed dentist is:

(a) The owner, purchaser, or lessee of the dental equipment;

(b) The owner, purchaser, or lessee of the office the dentist occupies; and

(c) Associated with other persons in the practice of dentistry, whether or not the associate is licensed to practice dentistry.

(2) All contracts or agreements governing the dental practice business relationships with co-owners, partners, and associates.

[Statutory Authority: RCW 18.32.0365, 18.32.655, and 18.32.002. WSR 16-07-084, § 246-817-315, filed 3/17/16, effective 4/17/16.]

WAC 246-817-320 Report of patient injury or mortality. All licensees engaged in the practice of dentistry shall submit a complete report of any patient mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of said patient during, or as a direct result of dental procedures or anesthesia related thereto. This report shall be submitted to the DQAC within thirty days of the occurrence.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-320, filed 10/10/95, effective 11/10/95.]

WAC 246-817-330 Prescriptions. Every dentist who operates a dental office in the state of Washington must write a valid prescription to the dental laboratory or dental technician with whom he/she intends to place an order for the making, repairing, altering or supplying of artificial restorations, substitutes or appliances to be worn in the human mouth. A separate prescription must be submitted to the dental laboratory or dental technician for each patient's requirements. To be valid, such prescriptions must be written in duplicate and contain the date, the name and address of the dental laboratory or the dental technician, the name and address of the patient, description of the basic work to be done, the signature of the dentist serving the patient for whom the work is being done and the dentist's li-

cense certificate number. The original prescription shall be referred to the dental laboratory or the dental technician and the carbon copy shall be retained for three years, by the dentist, in an orderly, accessible file and shall be readily available for inspection by the secretary or his/her authorized representative.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-330, filed 10/10/95, effective 11/10/95.]

WAC 246-817-350 Recording requirement for scheduled drugs. When Schedule II, III, IV or V drugs as described in chapter 69.50 RCW are stocked by the dental office for dispensing to patients, an inventory control record must be kept in such a manner to identify disposition of such medicines. Such records shall be available for inspection by the secretary or his/her authorized representative.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-350, filed 10/10/95, effective 11/10/95.]

WAC 246-817-370 Nondiscrimination. It shall be unprofessional conduct for any dentist to discriminate or to permit any employee or any person under the supervision and control of the dentist to discriminate against any person, in the practice of dentistry, on the basis of race, color, creed or national origin, or to violate any of the provisions of any state or federal antidiscrimination law.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-370, filed 10/10/95, effective 11/10/95.]

WAC 246-817-380 Patient abandonment. The attending dentist, without reasonable cause, shall not neglect, ignore, abandon, or refuse to complete the current procedure for a patient. If the dentist chooses to withdraw responsibility for a patient of record, the dentist shall:

(1) Advise the patient that termination of treatment is contemplated and that another dentist should be sought to complete the current procedure and for future care; and

(2) Advise the patient that the dentist shall remain reasonably available under the circumstances for up to fifteen days from the date of such notice to render emergency care related to that current procedure.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-380, filed 10/10/95, effective 11/10/95.]

WAC 246-817-390 Representation of care, fees, and records. Dentists shall not represent the care being rendered to their patients or the fees being charged for providing such care in a false or misleading manner, nor alter patient records, such as but not limited to, misrepresenting dates of service or treatment codes.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-390, filed 10/10/95, effective 11/10/95.]

WAC 246-817-400 Disclosure of provider services. A dentist who is personally present, operating as a dentist or personally overseeing the operations being performed in a dental office, over fifty percent of the time that such office is being operated, shall identify himself/herself in any representation to the public associated with such office or practice and shall provide readily visible signs designating his/her name at such respective office entrances or office buildings. Any representation that omits such a listing of dentists is misleading, deceptive, or improper conduct. Dentists who are present or overseeing operations under this rule less than fifty percent of the time shall identify themselves to patients prior to services being initiated or rendered in any fashion. Every office shall have readily available a list of the names of dentists who are involved in such office less than fifty percent of the time.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-400, filed 10/10/95, effective 11/10/95.]

WAC 246-817-410 Disclosure of membership affiliation. It shall be misleading, deceptive or improper conduct for any dentist to represent that he/she is a member of any dental association, society, organization, or any component thereof where such membership in fact does not exist.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-410, filed 10/10/95, effective 11/10/95.]

WAC 246-817-420 Specialty representation. In order to protect the public from inherently misleading claims of specialty expertise by dentists who are not adequately trained and experienced, a licensed dentist must comply with the requirements in this section to avoid deception of the public with accurate advertising and representation.

(1) A licensed dentist has the legal authority to practice in all areas of dentistry as defined in RCW 18.32.020 and also the authority to confine their practice in areas within the scope of their education, training, and experience and in accordance with chapters 18.32 RCW and 246-817 WAC.

(2) A licensed dentist may advertise or represent themselves as a specialist if the dentist meets the standards listed in subsection (4) of this section.

(3) A licensed dentist who does not meet the standards listed in subsection (4) of this section is considered a general dentist. A general dentist is permitted to render specialty services but shall not advertise or represent themselves as a specialist in the areas listed in subsection (4) of this section.

(4) A licensed dentist must comply with one of the following requirements before advertising or representing themselves as a specialist in Washington:

(a) Successfully complete a Commission on Dental Accreditation postdoctoral education program at least two years in length, and is recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards in one of the following specialty areas:

(i) Dental anesthesiology;

(ii) Dental public health;

(iii) Endodontics;
(iv) Oral and maxillofacial pathology;
(v) Oral and maxillofacial radiology;
(vi) Oral and maxillofacial surgery;
(vii) Oral medicine;
(viii) Orofacial pain;
(ix) Orthodontics and dentofacial orthopedics;
(x) Pediatric dentistry;
(xi) Periodontics; or
(xii) Prosthodontics.

(b) Successfully complete a Commission on Dental Accreditation advanced educational program or program of any other accreditors recognized by the United States Department of Education which is at least two years in length in a special interest area of dentistry not listed in (a) of this subsection.

(5) It is misleading, deceptive, or unprofessional conduct for a licensed dentist to advertise or represent themselves by adopting or using any title to the public as a dental specialist, expert, board certified, or diplomate practicing in an area when they have not successfully completed the requirements specified for the dental specialty listed in subsection (4) of this section.

(a) Effective July 1, 2022, a licensed dentist in a group practice that includes two or more dentists must be identified as a general dentist or a specialist as listed in subsection (4) of this section.

(b) A licensed dentist in a group practice who meets the standards listed in subsection (4) of this section shall include the area of their specialty.

(c) Qualifications of any licensed dentist must be made available to the public upon request.

[Statutory Authority: RCW 18.32.0365, 18.32.665 and 18.32.002. WSR 21-12-107, § 246-817-420, filed 6/2/21, effective 7/3/21. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-420, filed 10/10/95, effective 11/10/95.]

WAC 246-817-430 A rule applicable to dental technicians. To be exempt from the law prohibiting the practice of dentistry, dental technicians must comply with the provisions of RCW 18.32.030(6). The form of the required prescription is defined in WAC 246-817-330.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-430, filed 10/10/95, effective 11/10/95.]

WAC 246-817-440 Dentist continuing education requirements. The goal of continuing education is to encourage the lifetime professional development of the licensed dentist, and to enhance the clinical and overall skills needed to protect the health and safety of all patients.

(1) A licensed dentist shall complete a minimum of 63 hours of continuing education every three years.

(a) The three-year continuing education reporting period for a dentist licensed in Washington before 2019 begins January 1, 2019, and verification of completion of continuing education hours will be due on the dentist's annual license renewal date in 2022, and every three

years thereafter. The three-year continuing education reporting period for a dentist initially licensed in Washington in 2019 or later begins upon date of licensure.

(b) A licensed dentist shall attest to the completion of 63 hours of continuing education every three years as a part of their license renewal requirement.

(c) The dental quality assurance commission (commission) may randomly audit up to 25 percent of licensed dentists every three years for compliance after the license is renewed as allowed by WAC 246-12-170 through 246-12-240.

(d) A licensed dentist shall comply with the requirements of WAC 246-12-170 through 246-12-240.

(e) The commission will not authorize or approve specific continuing education courses.

(2) A licensed dentist shall complete the commission approved dental jurisprudence examination once every three years. One hour of continuing education will be granted toward the 63-hour requirement.

(3) A licensed dentist must complete a minimum of two hours of commission approved health equity training every three years. Two hours of continuing education will be granted towards the 63-hour requirement. An approved program providing health equity continuing education training must meet the requirements listed in WAC 246-12-830. For purposes of this rule, health equity has the same meaning as defined in WAC 246-12-810.

(4) Continuing education must contribute to the professional knowledge and development of the licensed dentist or enhance services provided to patients. Continuing education must be completed in one or more of the following subject categories:

(a) Education courses relating to the practice of dentistry;

(b) Emergency management, advanced cardiac life support (ACLS), and pediatric advanced life support (PALS);

(c) Health care provider basic life support (BLS). BLS certification is required in WAC 246-817-720. One hour of continuing education for each BLS certification course will be granted. A licensed dentist may not count more than three hours every three years in this category;

(d) Infection control, federal/state safety standards, and radiation protection;

(e) Pharmacology, prescribing practices, and pain management;

(f) Ethics;

(g) Patient care related education including risk management, methods of health delivery, multicultural, and suicide prevention education;

(h) Washington state dentistry law;

(i) Practice management and billing practices. A licensed dentist may not count more than 21 hours every three years in this category.

(5) Continuing education in subject categories identified in subsection (4) of this section may be completed using any of the following activities or methods:

(a) Attendance at local, state, national, or international continuing education courses, live interactive webinars, dental study clubs, postdoctoral education, and dental residencies;

(b) Self-study by various means, relevant to dentistry, without an instructor physically present.

(i) Self-study can be continuing education provided online or through the mail provided by a continuing education provider. Thirty

minutes will count for every one hour completed for this activity, except for live or recorded interactive webinars;

(ii) Self-study can be reading a book that contributes to the professional knowledge and development of the licensed dentist, or enhance services provided to patients. A two-page synopsis of what was learned written by the licensed dentist is required. Two hours of continuing education for each book and synopsis will be granted. A licensed dentist may not count more than six hours every three years for this activity.

(c) Teaching, presenting, or lecturing in a course, only if the presentation or lecture is created or authored by the dentist claiming the continuing education hours. A licensed dentist may not count more than 21 hours every three years in this activity;

(d) Direct clinical supervision of dental students and dental residents. A licensed dentist may not count more than 21 hours every three years in this activity;

(e) Publishing a paper in a peer review journal. A licensed dentist may count 15 hours the year the paper is published and may not count more than a total of 30 hours every three years in this activity. A copy of the publication is required;

(f) Reading and critically evaluating any hypothesis-driven scientific journal article on a topic that has relevance to dentistry and is published in a peer-reviewed journal devoted to dentistry, medicine, or useful to dentistry. A licensed dentist may not count more than 21 hours every three years.

(i) Before completing this activity, the licensed dentist must complete at least four hours of education in evidence-based dentistry or medicine that includes journal article evaluation. The four-hour education may count toward the required 63-hour requirement. The four-hour education is a one-time requirement. A licensed dentist may not count more than four hours every three years.

(ii) A licensed dentist may count one hour for each article that the dentist completes a "Critical Evaluation of a Journal Article" questionnaire. The questionnaire may be obtained from the commission. The completed questionnaire is required;

(g) Volunteer dental patient care. A licensed dentist may not count more than 21 hours every three years; and

(h) The commission will accept a current certification or recertification from any specialty board approved and recognized by the American Dental Association (ADA), the American Board of Dental Specialties (ABDS), or other specialty board certification or recertification approved by the commission as 62 hours of continuing education. The commission will also accept the award of Fellow of the Academy of General Dentistry, Master of the Academy of General Dentistry, or the Lifelong Learning and Service Recognition Award as 62 hours of continuing education. The certification, recertification, or award must be obtained in the three-year reporting period.

(6) Proof of continuing education is a certificate of completion, letter, or other documentation verifying or confirming attendance or completion of continuing education hours. Documentation must be from the organization that provided the activity, except in subsection (5)(b)(ii), (e), and (f)(ii) of this section, and must contain at least the following:

(a) Date of attendance or completion;

(b) Hours earned; and

(c) Course title or subject.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.180, 18.350.030, 18.130.040, and 43.70.613. WSR 24-02-056, § 246-817-440, filed 12/28/23, effective 1/28/24; WSR 24-01-100, § 246-817-440, filed 12/18/23, effective 1/18/24. Statutory Authority: RCW 18.32.0357, 18.32.0365, and 18.32.180. WSR 22-02-022, § 246-817-440, filed 12/28/21, effective 1/28/22. Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 18-12-116, § 246-817-440, filed 6/6/18, effective 1/1/19. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-440, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 06-07-036, § 246-817-440, filed 3/8/06, effective 4/8/06. Statutory Authority: RCW 18.32.0365. WSR 01-16-007, § 246-817-440, filed 7/19/01, effective 8/19/01.]

Reviser's note: The permanent filing 24-02-056 contained no amendments to this section.

WAC 246-817-441 Dentist suicide prevention education. Effective August 1, 2020, a licensed dentist must complete a commission-approved one-time training that is at least three hours in length for suicide assessment that includes screening, referral, and imminent harm via lethal means elements.

(1) This training must be completed by the end of the first full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later.

(2) Training accepted by the commission must be on the department's model list as authorized in chapter 246-12 WAC, Part 14.

(3) A licensed dentist who has successfully completed the suicide assessment, treatment, and management curriculum in RCW 43.70.447, by the school of dentistry at the University of Washington prior to licensure is exempt from the training requirement in this section.

(4) Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of subsection (2) or (3) of this section, is accepted as meeting the one-time training requirement of this section.

(5) The hours spent completing the training in suicide assessment under this section count toward meeting applicable continuing education requirements for dentist license renewal.

[Statutory Authority: RCW 18.32.002, 18.32.0365 and 43.70.442. WSR 18-12-112, § 246-817-441, filed 6/6/18, effective 7/7/18.]

WAC 246-817-445 Dental anesthesia assistant continuing education requirements. (1) To renew a certification a certified dental anesthesia assistant must complete a minimum of 14 hours of continuing education every three years and follow the requirements of WAC 246-12-170 through 246-12-240.

(2) A certified dental anesthesia assistant must complete a minimum of two hours of approved health equity training every three years. Two hours of continuing education will be granted towards the 14-hour requirement. An approved program providing health equity continuing education training must meet the requirements listed in WAC 246-12-830. For purposes of this rule, health equity has the same meaning as defined in WAC 246-12-810.

(3) Continuing education must involve direct application of dental anesthesia assistant knowledge and skills in one or more of the following categories:

(a) General anesthesia;

(b) Moderate sedation;

(c) Physical evaluation;

(d) Medical emergencies;

(e) Health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS);

(f) Monitoring and use of monitoring equipment;

(g) Pharmacology of drugs; and agents used in sedation and anesthesia.

(4) Continuing education is defined as any of the following activities:

(a) Attendance at local, state, national, or international continuing education courses;

(b) Health care provider basic life support (BLS), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS), or emergency related classes;

(c) Self-study through the use of multimedia devices or the study of books, research materials, or other publications.

(i) Multimedia devices. The required documentation for this activity is a letter or other documentation from the organization. A maximum of two hours is allowed per reporting period.

(ii) Books, research materials, or other publications. The required documentation for this activity is a two-page synopsis of what was learned written by the credential holder. A maximum of two hours is allowed per reporting period.

(d) Distance learning. Distance learning includes, but is not limited to, correspondence course, webinar, print, audio/video broadcasting, audio/video teleconferencing, computer aided instruction, e-learning/on-line-learning, or computer broadcasting/webcasting. A maximum of four hours of distance learning is allowed per reporting period.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.180, 18.350.030, 18.130.040, and 43.70.613. WSR 24-02-056, § 246-817-445, filed 12/28/23, effective 1/28/24; WSR 24-01-100, § 246-817-445, filed 12/18/23, effective 1/18/24. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-445, filed 7/23/13, effective 8/23/13.]

Reviser's note: The permanent filing 24-02-056 contained no amendments to this section.

SEXUAL MISCONDUCT

WAC 246-817-450 Definitions. The definitions in this section apply throughout this section and WAC 246-817-460 unless the context requires otherwise.

(1) "Health care provider" means an individual applying for a credential or credentialed specifically as defined in chapters 18.32, 18.260, and 18.350 RCW.

(2) "Health care information" means any information, whether oral or recorded in any form or medium that identifies or can readily be associated with the identity of, and relates to the health care of, a patient.

(3) "Key party" means a person legally authorized to make health care decisions for the patient.

(4) "Legitimate health care purpose" means activities for examination, diagnosis, treatment, and personal care of patients, including palliative care, as consistent with community standards of practice for the dental profession. The activity must be within the scope of practice of the health care provider.

(5) "Patient" means an individual who receives health care services from a health care provider. 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 health care provider and the person. The fact that a person is not receiving treatment or professional services is not the sole determining factor.

[Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-450, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.32.0365 and 18.130.050 (1) and (12). WSR 08-01-137, § 246-817-450, filed 12/19/07, effective 1/19/08.]

WAC 246-817-460 Sexual misconduct. (1) A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes, but is not limited to:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the health care provider's scope of practice;

(c) Rubbing against a patient or key party for sexual gratification;

(d) Kissing;

(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;

(f) Examination of or touching genitals without using gloves;

(g) Not allowing a patient privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient or key party;

(j) Removing patient's clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;

(k) Encouraging masturbation or other sex act in the presence of the health care provider;

(l) Masturbation or other sex act by the health care provider in the presence of the patient or key party;

(m) Soliciting a date with a patient or key party;

(n) Discussing the sexual history, preferences or fantasies of the health care provider;

(o) Any behavior, gestures, or expressions that can reasonably be interpreted as seductive or sexual;

(p) Sexually demeaning behavior including any verbal or physical contact which can reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient or key party;

(q) Photographing or filming the body or any body part or pose of a patient or key party, other than for legitimate health care purposes; or for the educational or marketing purposes with the consent of the patient; and

(r) Showing a patient or key party sexually explicit photographs, other than for legitimate health care purposes.

(2) 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.

(3) A health care provider shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient or key party for the purpose of engaging in sexual misconduct;

(c) Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

(4) A health care provider shall not engage in the activities listed in subsection (1) of this section with a former patient or key party if the health care provider:

(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 health care provider's personal or sexual needs.

(5) When evaluating whether a health care provider has engaged or has attempted to engage in sexual misconduct, the commission will consider factors including, but not limited to:

(a) Documentation of a formal termination;

(b) Transfer of care to another health care provider;

(c) Duration of the health care provider-patient relationship;

(d) Amount of time that has passed since the last dental health care services to the patient;

(e) Communication between the health care provider and the patient between the last dental health care services rendered and commencement of the personal relationship;

(f) Extent to which the patient's personal or private information was shared with the health care provider;

(g) Nature of the patient's health condition during and since the professional relationship; and

(h) The patient's emotional dependence and vulnerability.

(6) Patient or key party initiation or consent does not excuse or negate the health care provider's responsibility.

(7) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to the dental profession; or

(c) Providing dental services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient.

[Statutory Authority: RCW 18.32.0365, 18.130.050, 18.130.062 and Executive Order 06-03. WSR 15-16-118, § 246-817-460, filed 8/4/15, effective 9/4/15. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-460, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.32.0365 and 18.130.050 (1) and (12). WSR 08-01-137, § 246-817-460, filed 12/19/07, effective 1/19/08.]

DELEGATIONS OF DUTIES TO PERSONS NOT LICENSED AS DENTISTS

WAC 246-817-501 Purpose. The purpose of WAC 246-817-501 through 246-817-570 is to establish guidelines on delegation of duties to persons who are not licensed to practice dentistry. The dental laws of Washington state authorized the delegation of certain duties to non-dentist personnel and prohibit the delegation of certain other duties. By statute, the duties that may be delegated to a person not licensed to practice dentistry may be performed only under the supervision of a licensed dentist. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with, among other considerations, the nature of the procedure and the qualifications of the person to whom the duty is delegated. The dentist is ultimately responsible for the services performed in his/her office and this responsibility cannot be delegated. In order to protect the health and well-being of the people of this state, the DQAC finds it necessary to adopt the following definitions and regulations.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-501, filed 10/10/95, effective 11/10/95.]

WAC 246-817-510 Definitions. The definitions in this section apply throughout WAC 246-817-501 through 246-817-570 unless the context clearly requires otherwise.

(1) **"Close supervision"** means that a supervising dentist whose patient is being treated has personally diagnosed the condition to be treated and has personally authorized the procedures to be performed. The supervising dentist is continuously on-site and physically present in the treatment facility while the procedures are performed by the assistive personnel and capable of responding immediately in the event of an emergency. Close supervision does not require a supervising dentist to be physically present in the operatory.

(2) **"Coronal polishing"** means a procedure limited to the removal of plaque and stain from exposed tooth surfaces, using an appropriate instrument and polishing agent.

This procedure is not intended or interpreted to be an oral prophylaxis as defined in subsection (8) of this section a procedure specifically reserved to be performed by a licensed dentist or dental hygienist. Coronal polishing may, however, be a portion of the oral prophylaxis procedure.

(3) **"Debridement at the periodontal surgical site"** means curettage or root planing after reflection of a flap by the supervising dentist. This does not include cutting of osseous tissues.

(4) **"Elevating soft tissues"** means part of a surgical procedure involving the use of the periosteal elevator to raise flaps of soft tissues. Elevating soft tissue is not a separate and distinct procedure in and of itself.

(5) **"General supervision"** means that a supervising dentist has examined and diagnosed the patient and provided subsequent instructions to be performed by the assistive personnel, but does not require that the dentist be physically present in the treatment facility.

(6) **"Incising"** means part of the surgical procedure of which the end result is removal of oral tissue. Incising, or the making of an incision, is not a separate and distinct procedure in and of itself.

(7) **"Luxation"** means an integral part of the surgical procedure of which the end result is extraction of a tooth. It is the dislocation or displacement of a tooth or of the temporomandibular articulation.

(8) **"Oral prophylaxis"** means the preventive dental procedure of scaling and polishing which includes complete removal of calculus, soft deposits, plaque, stains and the smoothing of unattached tooth surfaces. The objective of this treatment is to create an environment in which hard and soft tissues can be maintained in good health by the patient.

(9) **"Periodontal soft tissue curettage"** means the closed removal of tissue lining the periodontal pocket, not involving the reflection of a flap.

(10) **"Root planing"** means the process of instrumentation by which the unattached surfaces of the root are made smooth by the removal of calculus or deposits.

(11) **"Supportive services"** means services that are related to clinical functions in direct relationship to treating a patient.

(12) **"Suturing"** is defined as the readaption of soft tissue by use of stitches as a phase of an oral surgery procedure.

(13) **"Treatment facility"** means a dental office or connecting suite of offices, dental clinic, room or area with equipment to provide dental treatment, or the immediately adjacent rooms or areas. A treatment facility does not extend to any other area of a building in which the treatment facility is located.

(14) **"Volunteer dental assistant"** means an individual who, without compensation, provides the supportive services under WAC 246-817-520 in a charitable dental clinic.

[Statutory Authority: RCW 18.260.040, 18.260.070, and 2015 c 120. WSR 17-05-056, § 246-817-510, filed 2/10/17, effective 3/13/17. Statutory Authority: RCW 18.32.0365, 18.260.110, and 18.260.120. WSR 09-15-075, § 246-817-510, filed 7/13/09, effective 8/13/09. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-510, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-510, filed 10/10/95, effective 11/10/95.]

WAC 246-817-520 Supportive services that may be performed by registered dental assistants. (1) A supervising dentist may delegate the supportive services in subsection (4) of this section under the dentist's close supervision, provided the registered dental assistant has demonstrated skills necessary to perform each task competently.

(2) Delegation of supportive services not in subsection (4) of this section may be subject to disciplinary action.

(3) In addition to supportive services in subsection (4) of this section, registered dental assistants may perform nonclinical tasks.

(4) Supportive services allowed under close supervision:

(a) Oral inspection, with no diagnosis.

(b) Take and record blood pressure and vital signs.

(c) Place, expose, and process radiographs.

(d) Take intra-oral and extra-oral photographs.

(e) Perform coronal polish. A licensed dentist shall determine the teeth are free of calculus or other extraneous material prior to dismissing the patient.

(f) Give fluoride treatments.

(g) Give patient education in oral hygiene.

(h) Give preoperative and postoperative instructions.

(i) Deliver an oral sedative drug to patient.

(j) Assist in the administration of inhalation minimal sedation (nitrous oxide) analgesia, including starting and stopping the flow as directed by the supervising dentist.

(k) Place topical anesthetics.

(l) Place and remove the rubber dam.

(m) Apply tooth separators as for placement for Class III gold foil.

(n) Apply sealants.

(o) Place a matrix and wedge for a direct restorative material after the dentist has prepared the cavity.

(p) Place cavity liners and bases.

(q) Perform acid etch and apply bonding agents.

(r) Polish restorations but may not intra-orally adjust or finish permanent restorations.

(s) Sterilize equipment and disinfect operatories.

(t) Place retraction cord.

(u) Hold in place and remove impression materials after the dentist has placed them.

(v) Take impressions, bite registrations, or digital scans of the teeth and jaws for:

(i) Diagnostic and opposing models;

(ii) Fixed and removable orthodontic appliances, occlusal guards, bleaching trays, and fluoride trays; and

(iii) Temporary indirect restorations such as temporary crowns.

(w) Take digital scans of prepared teeth for fabrication of permanent indirect restorations.

(x) Take a facebow transfer for mounting study casts.

(y) Fabricate and deliver bleaching and fluoride trays.

(z) Fabricate, cement, and remove temporary crowns or temporary bridges.

(aa) Remove the excess cement after the dentist has placed a permanent or temporary inlay, crown, bridge or appliance, or around orthodontic bands.

(bb) Place a temporary filling (as zinc oxide-eugenol (ZOE)) after diagnosis and examination by the dentist.

(cc) Pack and medicate extraction areas.

(dd) Place periodontal packs.

(ee) Remove periodontal packs or sutures.

(ff) Select denture shade and mold.

(gg) Place and remove orthodontic separators.

(hh) Select and fit orthodontic bands, try in fixed or removable orthodontic appliances prior to the dentist cementing or checking the appliance.

(ii) Prepare teeth for the bonding of orthodontic appliances.
(jj) Bond attachments for clear removable orthodontic aligners.
(kk) Remove and replace archwires and orthodontic wires.
(ll) Fit and adjust headgear.
(mm) Remove fixed orthodontic appliances, orthodontic cement, and orthodontic bonded resin material.

[Statutory Authority: RCW 18.260.040, 18.260.070, and 2015 c 120. WSR 17-05-056, § 246-817-520, filed 2/10/17, effective 3/13/17. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-520, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-520, filed 10/10/95, effective 11/10/95.]

WAC 246-817-525 Supportive services that may be performed by licensed expanded function dental auxiliaries (EFDAs). (1) A supervising dentist may delegate the supportive services in subsection (5) of this section under the dentist's close supervision, provided the EFDA has demonstrated skills necessary to perform each task competently.
(2) A dentist may delegate the supportive services in subsection (6) of this section under the dentist's general supervision, provided the EFDA has demonstrated skills necessary to perform each task.
(3) Delegation of supportive services not in subsection (5) or (6) of this section may be subject to disciplinary action.
(4) In addition to supportive services in subsections (5) and (6) of this section, licensed EFDAs may perform nonclinical tasks.
(5) Supportive services allowed under close supervision:
(a) Supportive services under WAC 246-817-520(4), except for supportive services in subsection (6) of this section.
(b) Place, carve, finish, and polish direct restorations.
(c) Take preliminary and final impressions and bite registrations, to include computer assisted design and computer assisted manufacture applications.
(6) Supportive services allowed under general supervision are:
(a) Perform coronal polishing.
(b) Give fluoride treatments.
(c) Apply sealants.
(d) Place, expose, and process radiographs.
(e) Give patient oral health instructions.

[Statutory Authority: RCW 18.260.040, 18.260.070, and 2015 c 120. WSR 17-05-056, § 246-817-525, filed 2/10/17, effective 3/13/17. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-525, filed 6/19/08, effective 7/1/08.]

WAC 246-817-530 An act that may be performed by unlicensed persons outside the treatment facility. Unlicensed persons may select shade for crowns or fixed prostheses with the use of a technique which does not contact the oral cavity to avoid contamination with blood or saliva. The procedure shall be performed pursuant to the written instructions and order of a licensed dentist.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-530, filed 10/10/95, effective 11/10/95.]

WAC 246-817-540 Acts that may not be performed by registered dental assistants. This list is not all inclusive. Delegation of procedures not in subsections (1) through (22) of this section should not be assumed to be allowed. Supportive services approved for delegation to registered dental assistants are under WAC 246-817-520. A dentist may not allow registered dental assistants who are in his or her employ or are acting under his or her supervision or direction to perform any of the following procedures:

(1) Any removal of or addition to the hard or soft natural tissue of the oral cavity.

(2) Any placing of permanent restorations in natural teeth.

(3) Any diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure.

(4) Any administration of general or local anesthetic, including intravenous sedation.

(5) Any oral prophylaxis, except coronal polishing as a part of oral prophylaxis as defined under WAC 246-817-510 and 246-817-520 (4)(e).

(6) Any scaling procedure.

(7) The taking of any impressions of the teeth or jaws, or the relationships of the teeth or jaws, for the purpose of fabricating any intra-oral restoration, appliances, or prosthesis, other than impressions allowed as a delegated task under WAC 246-817-520.

(8) Intra-orally adjust and finish permanent restorations.

(9) Cement or recement any permanent restoration or stainless steel crown.

(10) Incise gingiva or other soft tissue.

(11) Elevate soft tissue flap.

(12) Luxate teeth.

(13) Curette to sever epithelial attachment.

(14) Suture.

(15) Establish occlusal vertical dimension for dentures.

(16) Try-in of dentures set in wax.

(17) Insertion and post-insertion adjustments of dentures.

(18) Endodontic treatment - Open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

(19) Use of any light or electronic device for invasive procedures.

(20) Intra-oral air abrasion or mechanical etching devices.

(21) Place direct pulp caps.

(22) Fit and adjust occlusal guards.

[Statutory Authority: RCW 18.260.040, 18.260.070, and 2015 c 120. WSR 17-05-056, § 246-817-540, filed 2/10/17, effective 3/13/17. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-540, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-540, filed 10/10/95, effective 11/10/95.]

WAC 246-817-545 Acts that may not be performed by licensed expanded function dental auxiliaries (EFDAs). This list is not all inclusive. Delegation of procedures not in subsections (1) through (20) of this section should not be assumed to be allowed. Supportive services approved for delegation to licensed expanded function dental auxiliaries are under WAC 246-817-525. A dentist may not allow EFDAs who

are in his or her employ or are acting under his or her supervision or direction to perform any of the following procedures:

(1) Any removal of or addition to the hard or soft natural tissue of the oral cavity except for placing and carving direct restorations.

(2) Any diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure.

(3) Any administration of general or local anesthetic, including intravenous sedation.

(4) Any oral prophylaxis, except coronal polishing as a part of oral prophylaxis as defined under WAC 246-817-510 and 246-817-520 (4)(e).

(5) Any scaling procedure.

(6) Intra-orally adjust and finish permanent inlays, crowns, and bridges.

(7) Cement or recement any permanent restoration or stainless steel crown.

(8) Incise gingiva or other soft tissue.

(9) Elevate soft tissue flap.

(10) Luxate teeth.

(11) Curette to sever epithelial attachment.

(12) Suture.

(13) Establish occlusal vertical dimension for dentures.

(14) Try-in of dentures set in wax.

(15) Insertion and postinsertion adjustments of dentures.

(16) Endodontic treatment - Open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

(17) Use of any light or electronic device for invasive procedures.

(18) Intra-oral air abrasion or mechanical etching devices.

(19) Place direct pulp caps.

(20) Fit and adjust occlusal guards.

[Statutory Authority: RCW 18.260.040, 18.260.070, and 2015 c 120. WSR 17-05-056, § 246-817-545, filed 2/10/17, effective 3/13/17. Statutory Authority: RCW 18.260.120 and 18.32.0365. WSR 08-14-010, § 246-817-545, filed 6/19/08, effective 7/1/08.]

WAC 246-817-550 Acts that may be performed by licensed dental hygienists under general supervision. A dentist may allow a dental hygienist licensed under chapter 18.29 RCW to perform the following acts under the dentist's general supervision:

(1) Head and neck examination.

(2) Oral inspection and measuring of periodontal pockets, with no diagnosis.

(3) Record health histories.

(4) Take and record blood pressure and vital signs.

(5) Take intraoral and extraoral radiographs.

(6) Take intraoral and extraoral photographs.

(7) Patient education in oral hygiene.

(8) Give preoperative and postoperative instructions.

(9) Oral prophylaxis and removal of deposits and stains from the surfaces of the teeth.

(10) Give fluoride treatments.

(11) Apply topical anesthetic agents.

(12) Deliver oral antibiotic prophylaxis as prescribed by a dentist.

(13) Place and remove the rubber dam.

(14) Apply topical preventive or prophylactic agents.

(15) Administer local anesthetic agents and adjunctive procedures if all conditions in (a) through (d) of this subsection are met. Adjunctive procedures include local anesthetic reversal agents and buffered anesthetic.

(a) The patient is at least eighteen years of age;

(b) The patient has been examined by the delegating dentist within the previous twelve months;

(c) There has been no change in the patient's medical history since the last examination. If there has been a change in the patient's medical history within that time, the dental hygienist must consult with the dentist before administering local anesthetics;

(d) The delegating dentist who performed the examination has approved the patient for the administration of local anesthetics by a dental hygienist under general supervision and documented this approval in the patient's record;

(e) If any of the conditions in (a) through (d) of this subsection are not met, then close supervision is required.

(16) Perform subgingival and supragingival scaling.

(17) Perform root planing.

(18) Apply sealants.

(19) Polish and smooth restorations.

(20) Sterilize equipment and disinfect operatories.

(21) Place retraction cord.

(22) Take impressions, bite registration, or digital scans of the teeth and jaws for:

(a) Diagnostic and opposing models;

(b) Fixed and removable orthodontic appliances, occlusal guards, bleaching trays, and fluoride trays; and

(c) Temporary indirect restorations such as temporary crowns.

(23) Take a facebow transfer for mounting study casts.

(24) Fabricate and deliver bleaching and fluoride trays.

(25) Fabricate, cement, and remove temporary crowns or temporary bridges.

(26) Place a temporary filling such as zinc oxide-eugenol or ZOE after diagnosis and examination by the dentist.

(27) Remove excess cement after the dentist has placed a permanent or temporary inlay, crown, bridge or appliance, or around orthodontic bands.

(28) Pack and medicate extraction areas.

(29) Place periodontal packs.

(30) Remove periodontal packs or sutures.

(31) Select denture shade and mold.

(32) Place and remove orthodontic separators.

(33) Select and fit orthodontic bands, try in fixed or removable orthodontic appliances prior to the dentist cementing or checking the appliance.

[Statutory Authority: RCW 18.32.0365 and 18.29.050. WSR 19-18-095, § 246-817-550, filed 9/4/19, effective 10/5/19; WSR 17-01-045, § 246-817-550, filed 12/13/16, effective 1/13/17. Statutory Authority: RCW 18.32.0365, 18.29.050 and 18.32.002. WSR 14-12-057, § 246-817-550, filed 5/30/14, effective 6/30/14. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-550, filed 10/10/95, effective 11/10/95.]

WAC 246-817-560 Acts that may be performed by licensed dental hygienists under close supervision. In addition to the acts allowed in WAC 246-817-520 and 246-817-550, a dentist may allow a dental hygienist licensed under chapter 18.29 RCW to perform the following acts under the dentist's close supervision:

(1) Perform soft-tissue curettage.

(2) Administer local anesthetic agents and adjunctive procedures.

(a) General supervision is allowed if all conditions in WAC 246-817-550 (6)(a) through (d) are met.

(b) Adjunctive procedures include local anesthetic reversal agents and buffered anesthetic.

(3) Place restorations into the cavity prepared by the dentist, and thereafter could carve, contour, and adjust contacts and occlusion of the restoration.

(4) Administer nitrous oxide analgesia.

(5) Place antimicrobials.

[Statutory Authority: RCW 18.32.0365 and 18.29.050. WSR 17-01-045, § 246-817-560, filed 12/13/16, effective 1/13/17. Statutory Authority: RCW 18.32.0365. WSR 06-14-018, § 246-817-560, filed 6/23/06, effective 7/24/06. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-560, filed 10/10/95, effective 11/10/95.]

WAC 246-817-570 Acts that may not be performed by dental hygienists. No dentist shall allow a dental hygienist duly licensed under the provisions of chapter 18.29 RCW who is in his/her employ or is acting under his/her supervision or direction to perform any of the following procedures:

(1) Any surgical removal of tissue of the oral cavity, except for soft-tissue curettage, as defined in WAC 246-817-510.

(2) Any prescription of drugs or medications requiring the written order or prescription of a licensed dentist or physician.

(3) Any diagnosis for treatment or treatment planning.

(4) The taking of any impression of the teeth or jaw, or the relationship of the teeth or jaw, for the purpose of fabricating any intra-oral restoration, appliances, or prosthesis. Not prohibited are the taking of impressions solely for diagnostic and opposing models or taking wax bites solely for study casts.

(5) Intra-orally adjust occlusal of inlays, crowns, and bridges.

(6) Intra-orally finish margins of inlays, crowns, and bridges.

(7) Cement or recement, permanently, any cast restorations or stainless steel crowns.

(8) Incise gingiva or other soft tissue.

(9) Elevate soft tissue flap.

(10) Luxate teeth.

(11) Curette to sever epithelial attachment.

(12) Suture.

(13) Establish occlusal vertical dimension for dentures.

(14) Try-in of dentures set in wax.

(15) Insertion and post-insertion adjustments of dentures.

(16) Endodontic treatment—Open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

[Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-570, filed 10/10/95, effective 11/10/95.]

WAC 246-817-580 Novel coronavirus disease 2019 screening. (1) A supervising dentist may delegate the administration of a test for screening of novel coronavirus disease 2019 to a registered dental assistant and licensed expanded function dental auxiliary under the dentist's close supervision, provided the registered dental assistant and licensed expanded function dental auxiliary have demonstrated skills necessary to perform the task competently.

(2) A supervising dentist may delegate the administration of a test for screening of novel coronavirus disease 2019 to a licensed dental hygienist under the dentist's general supervision, provided the licensed dental hygienist has demonstrated skills necessary to perform the task competently.

[Statutory Authority: RCW 18.260.040, 18.260.070, 18.29.050, 18.32.0365 and 18.32.002. WSR 21-15-114, § 246-817-580, filed 7/21/21, effective 8/28/21.]

WAC 246-817-581 Novel coronavirus disease 2019 vaccination. (1) A supervising dentist may delegate the administration of a vaccination of novel coronavirus disease 2019 to a licensed dental hygienist under the dentist's close supervision, provided the licensed dental hygienist has demonstrated skills necessary to perform the task competently.

(2) For the purpose of administering vaccination for the novel coronavirus disease 2019, a dentist's approval of the vaccination protocol and screening meets the dentist's requirement to diagnose the condition to be treated and personal authorization of the procedure as required by close supervision under WAC 246-817-510(1).

[Statutory Authority: RCW 18.29.050, 18.32.0365 and 18.32.002. WSR 22-02-005, § 246-817-581, filed 12/22/21, effective 1/22/22.]

INFECTION CONTROL

WAC 246-817-601 Purpose. The purpose of WAC 246-817-601 through 246-817-660 is to establish requirements for infection control where dentistry is provided in the state of Washington to protect the health and well-being of the people. The Centers for Disease Control and Prevention *Guidelines for Infection Control in Dental Health-Care Settings* 2003, MMWR Vol. 52, No. RR-17, and the *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*, March 2016, are the basis for these rules. Case reports and public health events regarding the transmission of diseases from patient to patient, practitioner to patient, and patient to practitioner have been published that demonstrate risks that were either unrecognized in the past or new. This includes people accompanying patients and visitors. A strong educational component for practitioners is necessary to prevent disease transmission from patient to practitioner, practitioner to patient, and patient to patient.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-601, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-601, filed 10/10/95, effective 11/10/95.]

WAC 246-817-610 Definitions. The following definitions apply throughout WAC 246-817-601 through 246-817-660 unless the context clearly requires otherwise.

(1) "Hand hygiene" means the use of soap and water when hands are visibly soiled; or use of an alcohol-based hand rub.

(2) "Practitioner" means a licensed dentist under chapter 18.32 RCW, licensed dental hygienist under chapter 18.29 RCW, a licensed expanded function dental auxiliary under chapter 18.260 RCW, a certified dental anesthesia assistant, or a registered dental assistant under chapter 18.260 RCW.

(3) "The Centers for Disease Control and Prevention" or "CDC" means a federal agency that conducts and supports health promotion, prevention and preparedness activities in the United States.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-610, filed 12/23/20, effective 1/23/21. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-610, filed 10/10/95, effective 11/10/95.]

WAC 246-817-615 Administrative, education, and training. (1) A licensed dentist shall develop and maintain written infection prevention policies and procedures appropriate for the dental services provided by the facility.

(2) A licensed dentist shall review with all practitioners the current office infection prevention policies and procedures annually. A licensed dentist shall maintain documentation of the annual review with all practitioners for five years.

(3) A practitioner shall complete one hour of current infection prevention standards education annually provided by a qualified individual or organization.

(4) Infection prevention standards education must include:

(a) Standard precautions and prevention of disease transmission;

(b) Prevention of cross-contamination;

(c) Practitioner safety and personal protection equipment;

(d) Hand hygiene;

(e) Respiratory hygiene and cough etiquette;

(f) Sharps safety and safe injection practices;

(g) Sterilization and disinfection of patient care items and devices;

(h) Environmental infection prevention and control;

(i) Dental unit water quality; and

(j) The requirements in WAC 246-817-601 through 246-817-660.

(5) A practitioner shall maintain their personal documentation of infection control prevention standards education for a period of five years.

(6) For the purposes of this section, a qualified individual or organization means a person or entity that has verifiable training, expertise, or experience in all aspects of infection control.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-615, filed 12/23/20, effective 1/23/21.]

WAC 246-817-625 Personnel safety. A practitioner shall comply with the applicable requirements of the Washington Industrial Safety and Health Act under chapter 49.17 RCW.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-625, filed 12/23/20, effective 1/23/21.]

WAC 246-817-635 Hand hygiene. A practitioner shall perform hand hygiene as defined in WAC 246-817-610 in any of these situations:

(1) When hands are visibly soiled;

(2) In the event of barehanded touching of instruments, equipment, materials, and other objects likely to be contaminated by blood, saliva, or respiratory secretions; or

(3) Before and after treating each patient.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-635, filed 12/23/20, effective 1/23/21.]

WAC 246-817-640 Personal protective equipment. (1) A practitioner shall wear gloves whenever there is a potential for contact with blood, body fluids, mucous membranes, nonintact skin, or contaminated equipment.

(a) New gloves are required for each patient.

(b) Gloves must not be washed or reused.

(c) Gloves selection must be based on the performance characteristics of the glove in relation to the task to be performed as applicable in WAC 296-800-16065 and 296-823-15010.

(2) A practitioner shall wear mouth, nose, and eye protection during procedures that are likely to generate aerosols or splashes or splattering of blood or other body fluids.

(3) A practitioner shall comply with Washington state occupational exposure to bloodborne pathogens WAC 296-823-150.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-640, filed 12/23/20, effective 1/23/21.]

WAC 246-817-645 Respiratory hygiene and cough etiquette. (1) A licensed dentist shall post signs in a place visible to individuals receiving services in the premises with instructions to patients with symptoms of respiratory infection to:

(a) Cover their mouth/nose when coughing or sneezing;

(b) Use and dispose of tissues;

(c) Perform hand hygiene after hands have been in contact with respiratory secretions.

(2) A licensed dentist shall provide tissues and no-touch receptacles for disposal of tissues in the dental office.

(3) A licensed dentist shall offer masks to coughing patients and accompanying individuals in the dental office.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-645, filed 12/23/20, effective 1/23/21.]

WAC 246-817-650 Safe injection and sharps safety. (1) A practitioner shall follow the CDC *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*, March 2016, guidelines for safe injection practices in dental settings.

(2) A practitioner shall use either a one-handed scoop technique or mechanical device designed for holding the needle cap when recapping needles. A practitioner shall not recap used needles by using both hands or any other technique that involves directing the point of a needle toward any part of the body.

(3) A practitioner shall place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture-resistant containers in each operatory.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-650, filed 12/23/20, effective 1/23/21.]

WAC 246-817-655 Sterilization and disinfection, environmental infection prevention and control. A practitioner shall:

(1) Follow the CDC *Guidelines for Infection Control in Dental Health-Care Settings* 2003, MMWR Vol. 52, No. RR-17, Appendix C for Methods for Sterilizing and Disinfecting Patient-Care Items and Environmental Surfaces, including:

(a) Clean and reprocess through disinfection or sterilization reusable critical, semicritical, and noncritical dental equipment and devices according to manufacturer instructions before use on another patient.

(i) Effective August 31, 2022, sterilization of low-speed hand piece motors after use on a patient is required.

(ii) Sterilization is not required for those sections of a battery operated hand piece system that cannot be sterilized according to manufacturer's instructions. However, battery operated hand piece systems that have specific engineering controls to isolate the sections that cannot be sterilized, render those sections "noncritical," must be used if commercially available; those sections that cannot be sterilized must be processed according to manufacturer's instructions between patient uses.

(b) Clean and reprocess through disinfection or sterilization reusable critical, semicritical, and noncritical dental equipment and devices according to manufacturer instructions.

(c) Clean and reprocess reusable dental equipment according to the manufacturer instructions.

(d) All disposable and single-use items, as labeled by the United State Food and Drug Administration, must be discarded after use on a single patient.

(i) Single-use items that need to be tested for size are not considered used unless cemented in the mouth. Single-use items can be cleaned or reprocessed (disinfected or sterilized) when following manufacturer's instructions.

(ii) If a single-use item is not used, but is contaminated or exposed to aerosols during the appointment by being placed on a surface ready to use, it may only be sterilized if the process of doing so does not compromise the efficacy of the item including, but not limited to, anesthetic carpules.

(2) Bag or wrap contaminated instruments in packages, containers, or cassettes in preparation for sterilization.

(a) Store sterile instruments and supplies in a covered or closed area.

(b) Wrapped packages, containers, or cassettes of sterilized instruments must be inspected before opening and use to ensure the packaging material has not been compromised.

(c) Wrapped packages, containers, or cassettes of sterilized instruments must be opened as close to the time of the procedure as possible. Opening in the presence of the patient is preferred.

(d) Instruments sterilized for immediate use do not mandate the use of a bag or a wrap. If the instrument is not used immediately, it must be bagged or wrapped.

(3) Use all mechanical, chemical, and biological monitors according to manufacturer instructions to ensure the effectiveness of the sterilization process.

(4) Test sterilizers by biological spore test method as recommended by the manufacturer on at least a weekly basis when scheduled patients are treated.

(a) In the event of a positive biological spore test, the licensed dentist shall take immediate remedial action as recommended by the manufacturer.

(b) A licensed dentist shall record biological spore tests and results either in the form of a log reflecting dates and person or persons conducting the testing or copies of reports from an independent testing entity. A licensed dentist shall maintain this documentation for a period of five years.

(5) Thoroughly rinse items such as impressions contaminated with blood or saliva. Place and transport items such as impressions to a dental laboratory off-site in a case containment device that is sealed and labeled.

(6) Disinfect all work surfaces after each patient.

(7) Disinfect using an intermediate-level disinfectant having, but not limited to, a tuberculocidal claim, when a surface is visibly contaminated with blood.

(8) Use only United States Environmental Protection Agency registered disinfectants or detergents/disinfectants with label claims for use in health care setting, following the manufacturer's instructions.

(9) Use high volume evacuation (HVE) whenever possible in all clinical situations expected to produce aerosol or spatter, such as, but not limited to, ultrasonics, high-speed hand pieces and air polishing devices. HVE equipment must be installed and maintained to manufacturer's specifications to ensure proper evacuation at the treatment site. HVE devices must be used as intended for HVE. A saliva ejector does not qualify as an HVE device.

(10) The following definitions apply to WAC 246-817-655.

(a) "Critical," "semicritical," and "noncritical" means categories given to patient care items including, but not limited to, dental instruments, devices, and equipment depending on the potential risk of infection associated with intended use.

(i) "Critical items" means those items used to penetrate soft tissue, contact bone, enter into or contact the bloodstream or other normally sterile tissue. Critical items must be sterilized by heat.

(ii) "Noncritical items" means those items used to contact intact skin. Noncritical items must be disinfected with United States Environmental Protection Agency registered hospital disinfectant or detergent.

(iii) "Semicritical items" means those items used to contact mucous membranes or nonintact skin. Semicritical items must be sterilized by heat if heat-tolerant, or by high-level disinfection if a semicritical item is heat-sensitive.

(b) "Disinfect" or "disinfection" means use of a chemical agent on inanimate objects, such as floors, walls, or sinks, to destroy vir-

tually all recognized pathogenic microorganisms, but not necessarily all microbial forms such as bacterial endospores.

(c) "High-level disinfection" means disinfection that inactivates vegetative bacteria, mycobacteria, fungi, and viruses but not necessarily high numbers of bacterial spores.

(d) "High volume evacuation" or "HVE" means the equipment used to remove debris, aerosols, and liquids.

(e) "Remedial action" means manufacturer recommended action necessary to obtain a negative spore test result.

(f) "Sterilize" or "sterilization" means the use of heat, chemical, or other nonchemical procedure to destroy all microorganisms.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-655, filed 12/23/20, effective 1/23/21.]

WAC 246-817-660 Dental unit water quality. (1) A licensed dentist shall use water for nonsurgical procedures that meets United States Environmental Protection Agency regulatory standards for drinking water of five hundred or less colony-forming units or CFUs/mL.

(2) A licensed dentist shall follow dental equipment manufacturer's instructions when testing the water delivery system for acceptable water quality. If manufacturer's instructions are unavailable, a licensed dentist shall test the water delivery system for acceptable water quality quarterly. A licensed dentist shall test the water delivery system five to ten days after repair or changes in the plumbing system and again at twenty-one to twenty-eight days later.

(a) Effective December 1, 2021, all water lines must be tested.

(i) All water lines for each operatory or dental unit can be pooled as one single sample.

(A) A pooled sample must use an equal amount of water from each water line.

(B) A pooled sample can have up to ten water lines included.

(C) The number of water lines pooled into one sample must be documented.

(ii) All water lines for each operatory or dental unit can be tested individually.

(b) In the event of an unacceptable level of colony-forming units or CFUs, a licensed dentist shall take immediate remedial action. For the purposes of this section, remedial action means any action necessary to reduce the CFUs to five hundred or a lesser number currently recognized by the United States Environmental Protection Agency as acceptable for drinking water.

(c) A licensed dentist shall record the water delivery system testing and maintenance either in the form of a log reflecting dates and person or persons conducting the test or maintenance or copies of reports from an independent testing entity. A licensed dentist shall maintain this documentation for a period of five years.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. WSR 21-01-214, § 246-817-660, filed 12/23/20, effective 1/23/21.]

ADMINISTRATION OF ANESTHETIC AGENTS FOR DENTAL PROCEDURES

WAC 246-817-701 Administration of anesthetic agents for dental procedures. The purpose of WAC 246-817-701 through 246-817-790 is to govern the administration of anesthetic, sedation, and general anesthesia by dentists licensed in the state of Washington in settings other than hospitals as defined in WAC 246-320-010 and ambulatory surgical facilities as defined in WAC 246-310-010, pursuant to the DQAC authority in RCW 18.32.640.

(1) The DQAC has determined that sedation and anesthesia permitting should be based on the level of sedation or anesthesia because sedation or anesthesia is a continuum, and the route of administration and drug combinations are both capable of producing a deeper level of sedation or anesthesia than is initially intended. Practitioners intending to produce a given level of sedation should be able to rescue patients who enter a state deeper than initially intended.

(2) All anesthesia providers must provide 24-hour, on-call availability following an anesthesia procedure.

(a) A licensed dentist that only administers local anesthesia shall provide timely telephonic or electronic communication with the patient or their representative by the provider or a designated provider.

(b) In the event a licensed dentist will be unavailable for timely assistance, the licensed dentist shall have a prearranged agreement with another provider that is available to provide timely care to a patient.

(3) The dental assistant and expanded function dental auxiliary may not administer any general or local anesthetic, including intravenous sedation.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-701, filed 12/11/23, effective 1/11/24; WSR 10-23-001, § 246-817-701, filed 11/3/10, effective 12/4/10; WSR 09-04-042, § 246-817-701, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-701, filed 10/10/95, effective 11/10/95.]

WAC 246-817-710 Definitions. The definitions in this section apply throughout WAC 246-817-701 through 246-817-790 unless the context clearly requires otherwise.

(1) "Advanced cardiac life support" or "ACLS" means a set of clinical interventions for the urgent treatment of cardiac arrest, stroke, and other life-threatening medical emergencies, as well as the knowledge and skills to deploy those interventions.

(2) "American Society of Anesthesiologists patient classification I" means a normal healthy patient.

(3) "American Society of Anesthesiologists patient classification II" means a patient with mild systemic disease.

(4) "American Society of Anesthesiologists patient classification III" means a patient with severe systemic disease.

(5) "American Society of Anesthesiologists patient classification IV" means a patient with severe systemic disease that is a constant threat to life.

(6) "Analgesia" means the diminution of pain in the conscious patient.

(7) "Anesthesia" means the loss of feeling or sensation, especially loss of sensation of pain.

(8) "Anesthesia monitor" means a credentialed health care provider specifically trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

(9) "Anesthesia provider" means a dentist, physician anesthesiologist, dental hygienist, or certified registered nurse anesthetist (CRNA) licensed, authorized, competent, and qualified to perform anesthesia within the state of Washington.

(10) "Automated external defibrillator" or "AED" means a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and pulseless ventricular tachycardia, and is able to treat through defibrillation.

(11) "Basic life support" or "BLS" means a type of care health care providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress, or an obstructed airway.

(12) "Carbon dioxide" or "CO_2" means a gas consisting of one part carbon and two parts oxygen.

(13) "Close supervision" means that a supervising dentist whose patient is being treated has personally diagnosed the condition to be treated and has personally authorized the procedures to be performed. The supervising dentist is continuously on-site and physically present in the treatment facility while the procedures are performed by the assistive personnel and capable of responding immediately in the event of an emergency. Close supervision does not require a supervising dentist to be physically present in the operatory.

(14) "Commission on Dental Accreditation" or "CODA" means a national organization that develops and implements accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

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

(16) "Dental anesthesia assistant" means a health care provider certified under chapter 18.350 RCW and specifically trained to perform the functions authorized in RCW 18.350.040 under supervision of an oral and maxillofacial surgeon or dental anesthesiologist.

(17) "Enteral" means any technique of administration in which an agent is absorbed through the gastrointestinal tract.

(18) "General anesthesia" means a drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof may be impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(19) "Minimal sedation" means a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway

and respond normally to tactile stimulation and verbal commands. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

(20) "Moderate sedation" means a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate sedation can include both enteral and parenteral routes of administration.

(21) "Nothing by mouth" or "NPO" means the time before an examination or procedure during which a patient cannot eat or drink.

(22) "Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal (GI) tract including, but not limited to, intramuscular, intravenous, intranasal, submuscosal, subcutaneous, and intraosseous.

(23) "Pediatric" means a child 12 years of age or younger.

(24) "Pediatric advanced life support" or "PALS" means a type of care that focuses on providing advanced airway and life support skills in immediate emergency care to children.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-710, filed 12/11/23, effective 1/11/24. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-710, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.32.640 and 18.32.0365. WSR 09-04-042, § 246-817-710, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-710, filed 10/10/95, effective 11/10/95.]

WAC 246-817-720 Basic life support requirements. (1) Dental staff providing direct patient care in an in-office or out-patient setting must hold a current and valid health care provider BLS certification. Initial and renewal certification must include both didactic and hands-on components.

(2) Health care provider BLS certification must be obtained from an individual, organization, or training center who holds a current and valid BLS instructor certification and teaches the current International Liaison Committee on Resuscitation or ILCOR standard including, but not limited to, American Heart Association or American Red Cross.

(3) Health care provider BLS instruction must include online or in-person didactic instruction with a written assessment, in-person skills assessment on high quality chest compressions, rescue breathing using the bag valve mask, correct use of AED or defibrillator for adults, children, and infants, feedback to students, and a valid health care provider BLS certification card upon completion.

(4) Dental staff providing direct patient care include: Licensed dentists, licensed dental hygienists, licensed expanded function dental auxiliaries, certified dental anesthesia assistants, and registered dental assistants.

(5) Newly hired office staff providing direct patient care are required to obtain the required certification within 45 days from the date hired.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-720, filed 12/11/23, effective 1/11/24. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-720, filed 7/23/13, effective 8/23/13. Statutory Authority: RCW 18.32.640 and 18.32.0365. WSR 09-04-042, § 246-817-720, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-720, filed 10/10/95, effective 11/10/95.]

WAC 246-817-722 Defibrillator. When anesthetic agents of any kind are administered, the dentist and staff must have access to an AED or defibrillator. The AED or defibrillator must be available and in reach within 60 seconds.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-722, filed 12/11/23, effective 1/11/24; WSR 10-23-001, § 246-817-722, filed 11/3/10, effective 12/4/10; WSR 09-04-042, § 246-817-722, filed 1/30/09, effective 3/2/09.]

WAC 246-817-724 Recordkeeping, equipment, and emergency medications or drugs. When anesthetic agents of any kind are administered, the dentist must comply with the requirements in this section.

(1) The anesthesia provider or anesthesia monitor shall record the patient's condition. The record must include documentation of all medications administered with dosages, regular and consistent time intervals, and route of administration. The provider administering the sedation may determine time intervals.

(2) All patients receiving any anesthetic agent including local anesthesia or minimal sedation with nitrous oxide, vital signs including, but not limited to, blood pressure and heart rate must be recorded, unless the cooperation of the patient or circumstances of the case will not allow it. If pretreatment vitals cannot be obtained, the reason or reasons why must be recorded. Obtaining vital signs on ASA 1 age 13 and under will be at the dentist's discretion.

(3) The following equipment must be available and include:

(a) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(b) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen enriched ventilation to the patient;

(c) Blood pressure cuffor sphygmomanometer of appropriate size;

(d) Stethoscope or equivalent monitoring device.

(4) The following emergency drugs must be available and maintained:

(a) Bronchodilator including, but not limited to, albuterol;

(b) Sugar or glucose;

(c) Aspirin;

(d) Antihistaminic including, but not limited to, diphenhydramine;

(e) Coronary artery vasodilator including, but not limited to, nitroglycerin;

(f) Anti-anaphylactic agent including, but not limited to, epinephrine.

(5) A licensed dentist shall develop and maintain written emergency protocols and ensure:

(a) All staff are trained in the protocols wherever anesthetic agents of any kind are administered.

(b) The emergency preparedness written protocols include training requirements and procedures specific to the licensed dentist's equipment and drugs for responding to emergency situations involving sedation or anesthesia, including information specific to respiratory emergencies.

(c) The protocols are reviewed annually, updated as necessary, and the review is documented.

(d) The protocols include basic life support protocols, advanced cardiac life support protocols, or pediatric advanced life support protocols based on the level of anesthetics being administered.

(6) Equipment used for monitoring patients must be calibrated or performance verified according to manufacturer's instructions.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-724, filed 12/11/23, effective 1/11/24; WSR 16-06-106, § 246-817-724, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-724, filed 1/30/09, effective 3/2/09.]

WAC 246-817-730 Local anesthesia. Local anesthesia must only be administered by a provider qualified under this chapter and dental hygienists as provided in chapter 18.29 RCW.

(1) "Local anesthesia" means the elimination of sensations, especially pain, in one part of the body by the topical application or regional injection of a drug.

(2) A licensed dentist administering local anesthetic agents shall comply with recordkeeping, equipment, and emergency medication requirements in WAC 246-817-724.

(3) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-730, filed 12/11/23, effective 1/11/24; WSR 09-04-042, § 246-817-730, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-730, filed 10/10/95, effective 11/10/95.]

WAC 246-817-740 Minimal sedation with nitrous oxide. (1) To administer minimal sedation with nitrous oxide, a licensed dentist shall successfully complete a minimum of 14 hours of education and training in one of the following:

(a) Minimal sedation with nitrous oxide;

(b) Moderate sedation with nitrous oxide;

(c) Advanced education program accredited by the CODA that meets comprehensive and appropriate training necessary to administer and manage minimal sedation with nitrous oxide; or

(d) Education and training must be consistent with ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, adopted by ADA House of Delegates October 2016 or prior adopted version in effect at the time training was completed.

(2) A licensed dentist shall ensure:

(a) Delegation of administration for minimal sedation with nitrous oxide is under the close supervision of an anesthesia provider qualified under this chapter.

(b) A second individual is in the office and able to immediately respond to any request from the licensed dentist or anesthesia provider.

(c) The patient must be continuously observed while minimal sedation with nitrous oxide is administered.

(3) A licensed dentist shall comply with recordkeeping, equipment, and emergency medication requirements in WAC 246-817-724.

(4) Dental records must contain documentation in the chart of nitrous oxide, and oxygen administered or dispensed.

(a) In the case of nitrous oxide sedation only, the record must include the maximum nitrous oxide concentration used and the times started and stopped or total time of administration.

(b) Other inhalation agents require a dose record noting the time each concentration or agent was administered or dispensed.

(5) A licensed dentist who administers minimal sedation with nitrous oxide shall complete seven hours of continuing education every five years as required in WAC 246-817-773.

(6) A licensed dentist who administers minimal sedation with nitrous oxide must hold a current and valid BLS certification.

(7) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-740, filed 12/11/23, effective 1/11/24; WSR 16-06-106, § 246-817-740, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-740, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-740, filed 10/10/95, effective 11/10/95.]

WAC 246-817-745 Minimal sedation. (1) To administer minimal sedation which is limited to a single dose of a single oral agent with or without nitrous oxide, a licensed dentist shall successfully complete a minimum of 16 hours of education and training in one of the following:

(a) Minimal sedation; or

(b) Moderate sedation; or

(c) Advanced education program accredited by the CODA that meets comprehensive and appropriate training necessary to administer and manage minimal sedation; or

(d) Education and training must be consistent with ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, adopted by ADA House of Delegates October 2016 or prior adopted version in effect at the time training was completed.

(2) A licensed dentist shall:

(a) Evaluate patient considered for minimal sedation prior to the administration of any sedative procedure.

(i) Review of the patient's current medical history and medication use is required for healthy or medically stable individuals with American Society of Anesthesiologists patient classification of I or II.

(ii) Consultation with the patient's primary care physician or consulting medical specialist is required for patients with significant medical considerations whom have American Society of Anesthesiologists patient classification III or IV. If the licensed dentist is

unsuccessful in contacting or consulting with the patient's physician or physicians, the licensed dentist shall document the attempt or document the patient has no physician to contact.

(b) Administer oral sedative agents in the treatment setting or prescribe for patient dosage prior to the appointment. Single oral agents must be in a dose that is not to exceed the manufacturer's maximum recommended for home use.

(c) Ensure a second individual is in the office and able to immediately respond to any request from the anesthesia provider administering minimal sedation.

(d) Ensure the patient is continuously observed while in the office under the influence of minimal sedation.

(e) Comply with the recordkeeping, equipment, and emergency medication requirements in WAC 246-817-724.

(f) Ensure any adverse reactions are documented in the patient record.

(g) If a patient unintentionally enters into a moderate level of sedation, ensure the patient is returned to a level of minimal sedation as quickly as possible. While returning the patient to the minimal sedation level, periodic monitoring of pulse, respiration, and blood pressure must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(3) A licensed dentist shall document in the patient record all agents administered, time administered, and dosage for minimal sedation.

(4) A licensed dentist who administers minimal sedation shall complete seven hours of continuing education every five years as required in WAC 246-817-773.

(5) A licensed dentist who administers minimal sedation must hold a current and valid BLS certification.

(6) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-745, filed 12/11/23, effective 1/11/24; WSR 16-06-106, § 246-817-745, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-745, filed 1/30/09, effective 3/2/09.]

WAC 246-817-755 Moderate sedation with enteral agents. (1) A licensed dentist is required to hold a permit of authorization to administer moderate sedation with enteral agents.

(2) To obtain a moderate sedation with enteral agents permit, a licensed dentist shall:

(a) Comply with the permitting and renewal requirements in WAC 246-817-774; and

(b) Successfully complete:

(i) A minimum of 16 hours of education and training in minimal sedation as required in WAC 246-817-745(1); and

(ii) A minimum of 21 hours of education and training in moderate sedation.

(iii) Moderate sedation education and training must:

(A) Meet ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, adopted by ADA House of Delegates October 2016 or prior adopted version in effect at the time training was completed; and

(B) Include medical emergency management, not limited to airway management, conducted in-person with hands-on skills.

(3) A licensed dentist shall:

(a) Ensure the patient is evaluated for moderate sedation with enteral agents prior to the administration of any sedative.

(i) Review at an appropriate time the patient's medical history and medication use and NPO or nothing by mouth status.

(ii) Consult with the patient's primary care physician or consulting medical specialist for a patient with significant medical considerations whom have American Society of Anesthesiologists patient classification of III or IV. If the anesthesia provider is unsuccessful in contacting or consulting with the patient's physician or physicians, document the attempt or document the patient has no physician to contact.

(iii) Patients body mass index must be assessed as part of a preprocedural workup.

(b) Administer oral sedative agents in the treatment setting or prescribe for patient dosage prior to the appointment.

(c) Ensure a second individual is in the office who can immediately respond to any request from the anesthesia provider.

(d) Ensure the patient is continuously observed while in the office.

(e) Record any adverse reactions in the patient record.

(f) Ensure the patient is returned to a level of moderate sedation as quickly as possible, if a patient unintentionally enters a deeper level of sedation. While returning the patient to the moderate level of sedation, periodic monitoring of pulse, respiration, and blood pressure and pulse oximetry must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(g) Ensure a patient receiving moderate sedation with enteral agents is accompanied by a responsible adult upon departure from the treatment facility.

(4) A licensed dentist shall comply with the recordkeeping, equipment, and emergency medication requirements in WAC 246-817-724.

(a) When a sedative drug is used that has a reversal agent, the reversal agent must be in the office emergency kit and the equipment to administer the reversal agent must be stored with the delivery device.

(b) Pulse oximetry equipment or equivalent respiratory monitoring equipment must be available in the office.

(5) A licensed dentist who holds a valid moderate sedation with enteral agents permit shall complete seven hours of continuing education every three years as required in WAC 246-817-773.

(6) A licensed dentist who holds a valid moderate sedation with enteral agents permit must hold a current and valid BLS certification.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-755, filed 12/11/23, effective 1/11/24; WSR 16-06-106, § 246-817-755, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-755, filed 1/30/09, effective 3/2/09.]

WAC 246-817-760 Moderate sedation with parenteral agents. (1) A licensed dentist is required to hold a permit of authorization to ad-

minister moderate sedation with parenteral agents. A moderate sedation with parenteral agents permit allows the holder to deliver moderate sedation with enteral agents without obtaining a separate permit.

(2) To obtain a moderate sedation with parenteral agents permit, a licensed dentist shall:

(a) Comply with the permitting and renewal requirements in WAC 246-817-774;

(b) Successfully complete a postdoctoral course or courses of 60 clock hours or more which includes:

(i) Basic moderate sedation;

(ii) Physical evaluation;

(iii) Venipuncture and intravenous drug administration, training is a hands-on skill and must be completed in-person;

(iv) Technical administration;

(v) Recognition and management of complications and emergencies, training is a hands-on skill and must be completed in-person;

(vi) Monitoring; and

(vii) Supervised experience in providing moderate sedation with parenteral agents to 20 or more patients.

(c) Training in adult sedation, if treating an adult; and

(d) Training in pediatric sedation, if treating a pediatric patient.

(3) In addition to meeting the criteria in subsection (2) of this section, the licensed dentist shall hold and maintain a current certification in ACLS or PALS.

(a) If treating an adult, the dentist must have ACLS certification.

(b) If treating a pediatric patient, the dentist must have PALS certification.

(4) The use of any drugs classified under the Food and Drug Administration as general anesthetic agents including, but not limited to, Propofol, Ketamine, Sevoflurane, Halothane, and Isoflurane are considered outside the scope of a moderate sedation with parenteral agents permit.

(5) The drugs, drug amounts, and techniques used must carry a margin of safety wide enough to render unintended loss of consciousness highly unlikely.

(6) A licensed dentist shall:

(a) Ensure a patient receiving moderate sedation with parenteral agents receives the sedation from an anesthesia provider qualified under this chapter.

(b) Ensure the patient is evaluated for moderate sedation with parenteral agents prior to the administration of any sedative.

(i) Review, at an appropriate time, the patient's medical history and medication use and NPO or nothing by mouth status.

(ii) Consult with the patient's primary care physician or consulting medical specialist for a patient with significant medical considerations whom have American Society of Anesthesiologists patient classification of III or IV.

(iii) Patient's body mass index must be assessed as part of a preprocedural workup.

(iv) A focused physical examination to include vital signs, evaluation of the airway, and auscultation of the heart and lungs is required before administration of any sedative or anesthesia agent.

(c) Ensure a patient is not left alone in a room and is continually monitored by an anesthesia provider or trained anesthesia monitor as defined in WAC 246-817-772.

(d) Ensure an intravenous infusion is maintained during the administration of a parenteral agent. Two exceptions for intravenous infusion may occur, but reasons why intravenous infusion was not used must be documented for:

(i) Pediatric sedation cases using agents for brief procedures; and

(ii) When the pediatric patient is uncooperative or the emotional condition is such that intravenous access is not possible.

(e) Ensure when the operative dentist is also the provider administering the moderate sedation with parenteral agents, the operative dentist is continuously assisted by a trained anesthesia monitor as defined in WAC 246-817-772. The trained anesthesia monitor may function as the dental or surgical assistant.

(i) If treating an adult, the additional individual must have experience or training in adult sedation.

(ii) If treating a pediatric patient, the additional individual must have experience or training in pediatric sedation.

(f) Ensure a patient is visually and tactilely monitored either by themselves or an individual trained in monitoring sedated patients. Patient monitoring must include:

(i) Heart rate;

(ii) Blood pressure;

(iii) Respiratory rate;

(iv) Oxygen saturation;

(v) Continuous electrocardiographic monitoring when the patient has clinically significant cardiovascular disease.

(A) Clinically significant cardiovascular disease can be classified, but not limited to, coronary artery disease, arrhythmias, congenital heart defects, heart valve disease, disease of the heart muscle, and heart infection.

(B) Electrocardiographic monitoring of a pediatric patient is not required when the pediatric patient is uncooperative, the emotional condition is such that monitoring is not possible, or who does not tolerate the monitor pads or wiring. Reasons why electrocardiographic monitoring was not used must be documented.

(vi) End-tidal CO_2. Monitoring is not required when:

(A) A pediatric sedation case uses agents for a brief procedure; or

(B) A pediatric patient is uncooperative or the emotional condition is such that end-tidal CO_2 monitoring is not possible.

(C) Reasons why end-tidal CO_2 monitoring was not performed must be documented.

(g) Comply with requirements of immobilization devices for pediatric patients.

(i) Immobilization devices, such as, papoose boards, must be applied in such a way as to avoid airway obstruction or chest restriction.

(ii) The pediatric patient head position and respiratory excursions must be checked frequently to ensure airway patency.

(iii) If an immobilization device is used, a hand or foot must be kept exposed.

(h) Ensure the patient's blood pressure, heart rate, pulse oximetry, and respiration rate is recorded every five minutes.

(i) Ensure the patient's level of consciousness is recorded prior to the dismissal of the patient.

(j) Ensure patient is accompanied by a responsible adult upon departure from the treatment facility.

(k) Ensure the patient is returned to a level of moderate sedation as quickly as possible, if the patient unintentionally enters a deeper level of sedation. While returning the patient to the moderate level of sedation, periodic monitoring of pulse, respiration, blood pressure and continuous monitoring of oxygen saturation must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(7) A licensed dentist shall document in the patient record appropriate medical history and patient evaluation. Sedation records must be recorded during the procedure in a timely manner and must include:

(a) Blood pressure;

(b) Heart rate;

(c) Respiration;

(d) Pulse oximetry;

(e) End-tidal CO_2. Monitoring is not required when:

(i) Pediatric sedation case uses agents for brief procedure; or

(ii) A pediatric patient is uncooperative or the emotional condition is such that end-tidal CO_2 monitoring is not possible.

(iii) Reasons why end-tidal CO_2 monitoring was not performed must be documented.

(f) Drugs administered including amounts and time administered;

(g) Length of procedure; and

(h) Any complications of sedation.

(8) A licensed dentist shall comply with the following record-keeping, equipment, and emergency medication requirements:

(a) Equipment used for monitoring patients must be calibrated or performance verified according to manufacturer's instructions.

(b) An operating theater must be large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to freely move about the patient;

(c) An operating table or chair must permit the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the administration of basic life support;

(d) A lighting system must be adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any procedure underway at the time of general power failure;

(e) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A backup suction device must be available;

(f) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system;

(i) If treating an adult, the equipment must be appropriate for adult sedation;

(ii) If treating a pediatric patient, the equipment must be appropriate for pediatric sedation;

(iii) Appropriate sized laryngeal mask airway must be ready for emergency use;

(g) A blood pressure cuff or sphygmomanometer of appropriate size and stethoscope; or equivalent monitoring devices;

(h) End-tidal CO_2 monitor;

(i) Pulse oximetry; and

(j) An emergency drug kit with minimum contents of:

(i) Sterile needles, syringes, and tourniquet;

(ii) Narcotic antagonist;

(iii) Alpha and beta adrenergic stimulant;

(iv) Vasopressor;

(v) Coronary vasodilator including, but not limited to, nitroglycerin;

(vi) Antihistamine including, but not limited to, diphenhydramine;

(vii) Parasympatholytic;

(viii) Intravenous fluids, tubing, and infusion set;

(ix) Sedative antagonists for drugs used, if available;

(x) Bronchodilator agent including, but not limited to, albuterol;

(xi) ACLS or PALS emergency drugs; and

(xii) Anti-hypoglycemic agent.

(9) A licensed dentist who holds a valid moderate sedation with parenteral agents permit and administers moderate sedation with parenteral agents in another licensed dentist office, must have a contract in place that contains the provisions described in WAC 246-817-778 (1)(a) through (c).

(10) A licensed dentist who holds a valid moderate sedation with parental agents permit shall complete 14 hours of continuing education every three years as required in WAC 246-817-773.

(11) A licensed dentist who holds a valid moderate sedation with parenteral agents permit must hold a current and valid ACLS certification.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-760, filed 12/11/23, effective 1/11/24; WSR 17-07-037, § 246-817-760, filed 3/8/17, effective 4/8/17; WSR 16-06-106, § 246-817-760, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-760, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-760, filed 10/10/95, effective 11/10/95.]

WAC 246-817-765 Pediatric sedation endorsement. A pediatric patient is physiologically and anatomically unlike an adult, and different sedation drugs and practices may be used for this population, it is necessary to ensure that adequately trained and skilled individuals are treating pediatric patients.

(1) Effective January 1, 2025, a pediatric sedation endorsement is required to administer moderate sedation with enteral agents or moderate sedation with parenteral agents, to pediatric patients.

(2) A licensed dentist who holds a valid moderate sedation with enteral agents permit and a pediatric sedation endorsement may administer intranasal midazolam to a pediatric patient. This modality may be administered without a moderate sedation with parenteral agents permit. Administration of intranasal drugs on patients over the age of

12 requires the licensed dentist to hold a moderate sedation with parenteral agents or general anesthesia permit.

(3) To obtain a pediatric sedation endorsement a licensed dentist shall:

(a) Hold a valid moderate sedation with enteral agents or moderate sedation with parenteral agents permit;

(b) Comply with the permitting and renewal requirements in WAC 246-817-774;

(c) Provide evidence of education and training in:

(i) A CODA postgraduate instruction in pediatric dentistry, oral and maxillofacial surgery, or dental anesthesiology; or

(ii) Predoctoral dental school, postgraduate instruction, or continuing education of at least 37 hours in minimal and moderate sedation and an additional 14 hours in pediatric sedation.

(A) The 14 hours in pediatric sedation must include:

(I) Pediatric specific anatomical and physiological considerations;

(II) Pediatric behavioral management during administration of sedating medication and intraoperatively;

(III) Pediatric drugs, dosages, and routes of administration;

(IV) Appropriate use of immobilization devices;

(V) Recordkeeping;

(VI) Nitrous oxide in combination with other sedating medications;

(VII) Prevention, recognition and management of complications; and

(VIII) Four or more hours must include hands-on instruction, simulations, live supervised pediatric sedation case management, or a combination of those modalities. Observation alone is not acceptable.

(B) The 37 hours in minimal and moderate sedation must include:

(I) Physical evaluation;

(II) Technical administration;

(III) Drugs and routes of administration;

(IV) Recognition and management of complications and emergencies; and

(V) Monitoring and monitoring equipment including training in expired CO_2; and

(d) Provide current health care provider BLS and PALS certifications.

(4) A licensed dentist who holds a valid pediatric sedation endorsement shall complete 14 hours of continuing education every three years as required in WAC 246-817-773.

(5) A licensed dentist who holds a valid pediatric endorsement must maintain a current and valid BLS and PALS certification.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-765, filed 12/11/23, effective 1/11/24.]

WAC 246-817-770 General anesthesia and deep sedation. (1) A licensed dentist is required to hold a permit of authorization to administer deep sedation or general anesthesia. A general anesthesia permit allows the holder to deliver moderate sedation with enteral or moderate sedation with parenteral agents without obtaining a separate permit.

(2) To obtain a general anesthesia permit, a licensed dentist shall:

(a) Comply with permitting and renewal requirements in WAC 246-817-774;

(b) Successfully complete two years of continuous full-time anesthesia training in at least one of the following:

(i) A dental anesthesiology program accredited by CODA at the time the training was completed; or

(ii) A dental anesthesiology program approved by the DQAC; or

(iii) An anesthesia residency training, with a minimum of two years full-time, at a medical program accredited by the Accreditation Council for Graduate Medical Education; or

(iv) An oral and maxillofacial surgery residency and obtain at least one of the following:

(A) Diplomate status of the American Board of Oral and Maxillofacial Surgery;

(B) Fellow status of the American Association of Oral and Maxillofacial Surgeons; or

(C) Diploma in an Oral and Maxillofacial Residency Program accredited by CODA at the time the training was completed.

(3) In addition to meeting one or more of the requirements in subsection (1) of this section, the licensed dentist shall have a current ACLS certification.

(4) A licensed dentist shall:

(a) Ensure a patient is evaluated for general anesthesia prior to the administration of any sedative.

(i) Review the patient's medical history, medication use, and NPO or nothing by mouth status.

(ii) Consult with the patient's primary care physician or consulting medical specialist for significant medical considerations whom have American Society of Anesthesiologists patient classification of III or IV.

(iii) A patient's body mass index must be assessed as part of a preprocedural workup.

(iv) A focused physical examination to include vital signs, evaluation of the airway, and auscultation of the heart and lungs is required before administration of any sedative or anesthesia agent.

(b) Ensure a patient receiving deep sedation or general anesthesia has continual monitoring of their heart rate, blood pressure, respiration, and expired CO_2.

(i) The licensed dentist shall utilize electrocardiographic monitoring, pulse oximetry, and end-tidal CO_2 monitoring.

(ii) Electrocardiograph monitoring must be continuously displayed from the beginning of general anesthesia and until the patient reaches the level of stage 1 anesthesia after treatment is completed.

(c) The patient's blood pressure, heart rate, and respiration rate shall be recorded every five minutes.

(d) To complete dental procedures under general anesthesia, the anesthesia permit holder, the anesthesia monitor, and the dental assistant shall all be present in the operating or treatment room. During deep sedation or general anesthesia, the anesthesia provider and the provider monitoring the patient may not leave the immediate area.

(e) During the recovery phase, the patient must be continually observed by the anesthesia provider or credentialed personnel acting within their scope of practice and trained in recovery phase of anesthesia.

(f) A discharge entry must be made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.

(5) A licensed dentist who holds a valid general anesthesia permit shall document in the patient record appropriate medical history and patient evaluation. Anesthesia records must be recorded during the procedure in a timely manner and must include:

(a) Blood pressure;

(b) Heart rate;

(c) Respiration;

(d) Pulse oximetry;

(e) End-tidal CO_2;

(f) Drugs administered including amounts and time administered;

(g) Length of procedure; and

(h) Any complications of anesthesia.

(6) A licensed dentist shall comply with the following record-keeping, equipment, and emergency medication requirements:

(a) Equipment used for monitoring patients must be calibrated or performance verified according to manufacturer's instructions;

(b) An operating theater must be large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient;

(c) An operating table or chair must permit the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the administration of basic life support;

(d) A lighting system must be adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any procedure underway at the time of general power failure;

(e) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A backup suction device must be available;

(f) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system;

(g) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater;

(h) Ancillary equipment must include the following:

(i) Laryngoscope complete with adequate selection of blades, spare batteries, and bulb;

(ii) Endotracheal tubes and appropriate connectors, and laryngeal mask airway and other appropriate equipment necessary to do an intubation;

(iii) Oral airways;

(iv) Tonsillar or pharyngeal suction tip adaptable to all office outlets;

(v) Endotracheal tube forceps;

(vi) Sphygmomanometer and stethoscope;

(vii) Adequate equipment to establish an intravenous infusion;

(viii) Pulse oximeter or equivalent;

(ix) Electrocardiographic monitor;

(x) End-tidal CO_2 monitor; and

(xi) AED or defibrillator as defined in WAC 246-817-722.

(i) Emergency drugs of the following types must be maintained:

(i) Vasopressor or equivalent;

(ii) Corticosteroid or equivalent;

(iii) Bronchodilator including, but not limited to, albuterol;

(iv) Muscle relaxant;

(v) Intravenous medications for treatment of cardiac arrest;

(vi) Narcotic antagonist;

(vii) Benzodiazepine antagonist;

(viii) Antihistaminic including, but not limited to, diphenhydramine;

(ix) Anticholinergic;

(x) Antiarrhythmic;

(xi) Coronary artery vasodilator including, but not limited to, nitroglycerin;

(xii) Antihypertensive;

(xiii) Anticonvulsant; and

(xiv) ACLS or PALS emergency drugs.

(7) A licensed dentist who holds a valid general anesthesia permit and administers general anesthesia in another licensed dentist office, must have a contract in place that contains the provisions required in WAC 246-817-778 (1)(a) through (c).

(8) A licensed dentist who holds a valid general anesthesia permit shall complete 18 hours of continuing education every three years as required in WAC 246-817-773.

(9) A licensed dentist who holds a valid general anesthesia permit must hold a current and valid ACLS certification.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-770, filed 12/11/23, effective 1/11/24. Statutory Authority: RCW 18.32.0365, 18.32.640 and 18.32.002. WSR 14-21-068, § 246-817-770, filed 10/10/14, effective 11/10/14. Statutory Authority: RCW 18.32.640 and 18.32.0365. WSR 09-04-042, § 246-817-770, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-770, filed 10/10/95, effective 11/10/95.]

WAC 246-817-771 Dental anesthesia assistant. (1) A dental anesthesia assistant shall be certified under chapter 18.350 RCW and WAC 246-817-205.

(2) A dental anesthesia assistant may only accept delegation from an oral and maxillofacial surgeon or dental anesthesiologist who holds a valid Washington state general anesthesia permit.

(3) Under close supervision, the dental anesthesia assistant may:

(a) Initiate and discontinue an intravenous line for a patient being prepared to receive intravenous medications, sedation, or general anesthesia; and

(b) Adjust the rate of intravenous fluids infusion only to maintain or keep the line patent or open.

(4) Under direct visual supervision, the dental anesthesia assistant may:

(a) Draw up and prepare medications;

(b) Follow instructions to deliver medications into an intravenous line upon verbal command;

(c) Adjust the rate of intravenous fluids infusion beyond a keep open rate;

(d) Adjust an electronic device to provide medications, such as an infusion pump;

(e) Administer emergency medications to a patient in order to assist the oral and maxillofacial surgeon or dental anesthesiologist in an emergency.

(5) The responsibility for monitoring a patient and determining the selection of the drug, dosage, and timing of all anesthetic medications rests solely with the supervising oral and maxillofacial surgeon or dental anesthesiologist.

(6) A certified dental anesthesia assistant shall notify the DQAC in writing, on a form provided by the department, of any changes in his or her supervisor.

(a) The DQAC must be notified of the change prior to the certified dental anesthesia assistant accepting delegation from another supervisor. The certified dental anesthesia assistant may not practice under the authority of this chapter unless he or she has on file with the DQAC such form listing the current supervisor.

(b) A supervisor must be an oral and maxillofacial surgeon or dental anesthesiologist who holds a valid Washington state general anesthesia permit.

(c) For the purposes of this subsection:

(i) "Any change" means the addition, substitution, or deletion of supervisor from whom the certified dental anesthesia assistant is authorized to accept delegation.

(ii) "Direct visual supervision" means supervision by an oral and maxillofacial surgeon or dental anesthesiologist by verbal command and under direct line of sight.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-771, filed 12/11/23, effective 1/11/24. Statutory Authority: Chapter 18.350 RCW, RCW 18.32.0365, 18.32.640, 18.130.050(14), and 18.260.120. WSR 13-15-144, § 246-817-771, filed 7/23/13, effective 8/23/13.]

WAC 246-817-772 Anesthesia monitor requirements. (1) When a licensed dentist is also administering moderate sedation with parenteral agents, deep sedation or general anesthesia, one additional appropriately trained team member must be designated for patient monitoring. The team member designated for patient monitoring when general anesthesia is being administered may not also perform dental assistant tasks.

(2) When moderate sedation with parenteral agents, deep sedation or general anesthesia is administered by a dedicated anesthesia provider who is not the operative dentist, the anesthesia provider may serve as the monitoring personnel.

(3) A licensed dentist cannot employ an individual to monitor patients receiving moderate sedation with parenteral agents, deep sedation or general anesthesia unless that individual has received a minimum of 14 hours of documented training, such as national certification American Association of Oral and Maxillofacial Surgeons, on-site or in-office training by a licensed dentist with a moderate sedation with parenteral agents or general anesthesia permit, or other education course specifically designed to include instruction and practical experience in use of equipment to include, but not be limited to, the following equipment:

(a) Sphygmomanometer or a device able to measure blood pressure;

(b) Pulse oximeter or other respiratory monitoring equipment;
(c) Electrocardiogram;
(d) Bag-valve-mask resuscitation equipment;
(e) Oral and nasopharyngeal airways;
(f) Defibrillator or automatic external defibrillator.

(4) The training referred to in subsection (3) of this section must also include instruction in:

(a) Basic sciences;
(b) Evaluation and preparation of patients with systemic diseases;
(c) Anesthetic drugs and techniques;
(d) Anesthesia equipment and monitoring; and
(e) Office anesthesia emergencies.

(5) A licensed dentist shall maintain training or certification documentation of the anesthesia monitor.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-772, filed 12/11/23, effective 1/11/24; WSR 16-06-106, § 246-817-772, filed 3/1/16, effective 4/1/16; WSR 09-04-042, § 246-817-772, filed 1/30/09, effective 3/2/09.]

WAC 246-817-773 Continuing education for dentists administering sedation. Continuing education must contribute to the professional knowledge and development of the licensed dentist to enhance sedation services provided to patients.

(1) The continuing education reporting period for a licensed dentist that administers sedation in Washington before December 31, 2023, begins January 1, 2024.

(2) The five-year continuing education reporting period for a licensed dentist that administers minimal sedation with nitrous oxide or minimal sedation in Washington on January 1, 2024, or later begins the date of first administration of sedation.

(3) The three-year continuing education reporting period for a licensed dentist initially issued a moderate sedation with enteral agents, moderate sedation with parenteral agents, pediatric sedation endorsement, or general anesthesia permit in Washington on January 1, 2024, or later begins the date of permit issuance.

(4) A licensed dentist who holds a valid permit or endorsement shall complete required hours of continuing education in one or more of the subject categories as required in below table.

	WAC 246-817-740 Minimal sedation with nitrous oxide – 7 hours	WAC 246-817-745 Minimal sedation – 7 hours	WAC 246-817-755 Moderate sedation with enteral agents – 7 hours	WAC 246-817-760 Moderate sedation with parenteral agents – 14 hours	WAC 246-817-765 Pediatric sedation endorsement – 14 hours	WAC 246-817-770 General anesthesia and deep sedation – 18 hours
Appropriate use of immobilization devices					X	
ACLS	X	X	X			
Behavioral management						X
General anesthesia						X
Inhalation analgesia						X
Medical emergencies	X	X	X	X	X	X
Nitrous oxide analgesia	X	X	X	X	X	
Oral or intravenous sedation				X		
Oral sedation	X	X	X			

	WAC 246-817-740 Minimal sedation with nitrous oxide – 7 hours	WAC 246-817-745 Minimal sedation – 7 hours	WAC 246-817-755 Moderate sedation with enteral agents – 7 hours	WAC 246-817-760 Moderate sedation with parenteral agents – 14 hours	WAC 246-817-765 Pediatric sedation endorsement – 14 hours	WAC 246-817-770 General anesthesia and deep sedation – 18 hours
PALS	X	X	X	X		X
Patient evaluation	X	X	X	X	X	X
Patient monitoring	X	X	X	X	X	X
Pediatric behavioral management					X	
Pediatric pharmacology					X	
Pediatric physiological					X	
Pediatric sedation					X	
Pharmacology				X		X
Physiology	X	X	X	X		X

(5) Verification of completion of continuing education hours will be due on the dentist's sedation permit renewal date beginning in 2027.

(6) Continuing education in subject categories identified in subsection (4) of this section may be completed using any of the activities or methods authorized in WAC 246-817-440(4).

(7) Proof of continuing education requirements are listed in WAC 246-817-440(5).

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-773, filed 12/11/23, effective 1/11/24.]

WAC 246-817-774 Permitting and renewal requirements. (1) To administer moderate sedation with enteral agents, moderate sedation with parenteral agents, or general anesthesia,including deep sedation, a licensed dentist shall:

(a) Meet the requirements of this chapter;

(b) Possess and maintain a valid dentist license pursuant to chapter 18.32 RCW; and

(c) Obtain a permit of authorization from the DQAC.

(2) A pediatric sedation endorsement is required to administer moderate sedation with enteral agents or moderate sedation with parenteral agents to pediatric patients. A moderate sedation with enteral agents or moderate sedation with parenteral agents permit is required to obtain the pediatric sedation endorsement as described in WAC 246-817-765.

(3) An applicant for a permit or an endorsement as identified in this section shall complete and submit to the department an application as provided by the department and the applicable application fee.

(4) A permit of authorization is valid for three years from the date of issuance.

(5) The permit holder shall renew the permit prior to the expiration date by providing to the department:

(a) Written declaration of continuing compliance with this chapter.

(b) For a licensed dentist with a moderate sedation with parenteral agents or general anesthesia permit a written declaration of an acceptable on-site inspection by a DQAC approved organization, as described in WAC 246-817-775, within the previous five years.

(i) The permit holder shall maintain on-site inspection documentation for five years.

(ii) The DQAC may randomly audit up to 25 percent of permit holders after the permit is renewed.

(c) Written declaration of continuing education hours as required in WAC 246-817-773.

(i) The permit holder shall maintain continuing education documentation for four years in compliance with WAC 246-12-170 through 246-12-240.

(ii) The DQAC may randomly audit up to 25 percent of permit holders as required in WAC 246-12-190.

(d) Written declaration that a minimum of 12 emergency drill scenarios were performed at least two times per year.

(i) The permit holder shall maintain emergency drill documentation for three years.

(ii) The DQAC may randomly audit up to 25 percent of permit holders after the permit is renewed.

(e) The applicable renewal fee.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-774, filed 12/11/23, effective 1/11/24; WSR 09-04-042, § 246-817-774, filed 1/30/09, effective 3/2/09.]

WAC 246-817-775 On-site inspections. (1) A licensed dentist shall conduct a self-assessment of their office preparedness for emergencies, proper emergency equipment, and emergency drugs annually. The annual self-assessment attestation must be maintained for five years.

(2) A licensed dentist who holds a valid moderate sedation with parenteral agents or general anesthesia permit shall conduct a self-inspection using the appropriate DQAC's on-site inspection form annually. The annual self-inspection form shall be maintained for five years.

(3) A licensed dentist who holds a moderate sedation with parenteral agents or general anesthesia permit must:

(a) Obtain an on-site inspection every five years at the location where moderate sedation with parenteral agents or general anesthesia is provided by an approved organization or by a self-arranged inspection using the DQAC approved on-site inspection form.

(i) The self-arranged on-site inspection must be completed by at least two providers with the same or higher level permit as the licensed dentist being evaluated.

(ii) Volunteer evaluators may be a certified registered nurse anesthetist, licensed physician anesthesiologist, or a licensed dentist who holds an appropriate moderate sedation with parenteral agents or general anesthesia permit for at least five years.

(b) Choose one office to have inspected, if the permit holder provides sedation or anesthesia in more than one office. The permit holder must provide an attestation that all the same standards from the inspection are met in all offices where sedation or anesthesia is provided.

(4) On-site inspections by approved organizations include:

(a) The Washington state society of oral and maxillofacial surgeons;

(b) Accreditation Association for Ambulatory Health Care;

(c) Department of health ambulatory surgical facility license survey as required in chapter 246-330 WAC;

(d) Joint commission;

(e) American Association for Accreditation of Ambulatory Surgery Facilities;

(f) The Centers for Medicare and Medicaid Services; or

(g) Substantially equivalent organizations approved by the DQAC.

(5) On-site inspections for general anesthesia permit holders must begin by the end of the first full permit renewal period after June 30, 2023, or five years after initial permit issuance, whichever is later.

(6) On-site inspection for moderate sedation with parenteral agents permit holders must begin by the end of the first full permit renewal period after June 30, 2024, or five years after initial permit issuance, whichever is later.

(7) A licensed dentist who holds a moderate sedation with parenteral agents or general anesthesia permit shall maintain completed and signed on-site inspection forms for at least five years.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-775, filed 12/11/23, effective 1/11/24.]

WAC 246-817-776 Discharge criteria for all levels of sedation or general anesthesia. The licensed dentist shall ensure an anesthesia provider assesses patient responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met, except when their prior baseline is below the noted criteria:

(1) Vital signs including blood pressure, pulse rate and respiratory rate are stable. Vital signs are not required when:

(a) A pediatric ASA I or ASA II patient is undergoing a routine dental procedure using either local anesthetic, nitrous oxide, or both with no other sedating medications; or

(b) A pediatric patient is uncooperative or the emotional condition is such that obtaining vital signs is not possible.

(c) Reasons why vital signs were not obtained must be documented.

(2) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(3) The patient can talk and respond coherently to verbal questioning as appropriate to age and preoperative psychological status;

(4) The patient can sit up unassisted;

(5) The patient can walk with minimal assistance;

(6) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness;

(7) The anesthesia provider has made a discharge entry in the patient's record. Discharge entries must include:

(a) The patient's condition upon discharge; and

(b) The name of the responsible party to whom the patient is released, if a patient is required to be released to a responsible party;

(8) If the patient does not meet established discharge criteria, the anesthesia provider must evaluate the patient and determine if the patient has safely recovered to be discharged. The evaluation determining that the patient can be safely discharged must be noted in the patient's record.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-776, filed 12/11/23, effective 1/11/24; WSR 09-04-042, § 246-817-776, filed 1/30/09, effective 3/2/09.]

WAC 246-817-778 Nondentist anesthesia providers. (1) A licensed dentist shall have a contract in place when working with a nondentist anesthesia provider. The contract must include:

(a) That all facility, equipment, monitoring, and training requirements, for all personnel required in WAC 246-817-701 through 246-817-790 have been met.

(b) That the anesthesia provider is responsible for the pre, intra, postoperative, and discharge anesthetic management of the patient.

(c) Delineation of responsibilities. The dentist and the anesthesia provider shall agree upon and arrange for the provision of items such as facility, equipment, monitoring, and training requirements to be met by either party. The dentist and the anesthesia provider shall establish written emergency protocols, as required in WAC 246-817-724, and all clinical staff must be trained.

(2) A nondentist anesthesia provider may be a certified registered nurse anesthetist or licensed physician anesthesiologist.

(3) Sedation or general anesthesia must be provided by a competent and qualified certified registered nurse anesthetist, licensed physician anesthesiologist, or a licensed dentist with an appropriate sedation or general anesthesia permit.

(4) A licensed dentist must ensure compliance with WAC 246-817-701 through 246-817-790 whenever sedation or general anesthesia is administered in their dental facility.

(5) A licensed dentist with a moderate sedation, moderate sedation with parenteral agents, or general anesthesia permit must ensure compliance with WAC 246-817-701 through 246-817-790 everywhere they administer sedation or general anesthesia.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-778, filed 12/11/23, effective 1/11/24; WSR 09-04-042, § 246-817-778, filed 1/30/09, effective 3/2/09.]

WAC 246-817-780 Mandatory reporting. A licensed dentist shall submit a report of any patient death or other life-threatening incident or complication, permanent injury or admission to a hospital that results in a stay at the hospital for more than 24 hours, which is or may be a result of a dental procedure caused by a dentist or dental treatment.

(1) A licensed dentist shall notify the DQAC, by telephone, email, or facsimile within 72 hours of discovery and must submit a complete written report to the DQAC within 30 days of the incident.

(2) When a patient comes into an office with an existing condition, and hospital admission is the result of that condition and not the dental procedure, it is not reportable.

(3) The written report must include the following:

(a) Name, age, and address of the patient.

(b) Name of the dentist and other personnel present during the incident.

(c) Address of the facility or office where the incident took place.

(d) Description of the type of sedation or anesthetic being utilized at the time of the incident.

(e) Dosages, if any, of drugs administered to the patient.

(f) A narrative description of the incident including approximate times and evolution of symptoms.

(g) Hospital discharge records if available.
(h) Additional information which the DQAC may require or request.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-780, filed 12/11/23, effective 1/11/24; WSR 09-04-042, § 246-817-780, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-780, filed 10/10/95, effective 11/10/95.]

WAC 246-817-790 Application of chapter 18.130 RCW. The provisions of the Uniform Disciplinary Act, chapter 18.130 RCW, apply to the permits and endorsements of authorization that may be issued and renewed under this chapter.

[Statutory Authority: RCW 18.32.0365 and 18.32.640. WSR 24-01-033, § 246-817-790, filed 12/11/23, effective 1/11/24. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-790, filed 10/10/95, effective 11/10/95.]

SUBSTANCE ABUSE MONITORING PROGRAMS

WAC 246-817-801 Intent. It is the intent of the legislature that the DQAC seek ways to identify and support the rehabilitation of dentists where practice or competency may be impaired due to an applicable impairing or potentially impairing health condition. The legislature intends that these dentists be treated so that they can return to or continue to practice dentistry in a way which safeguards the public. The legislature specifically intends that the DQAC establish an alternate program to the traditional administrative proceedings against such dentists.

In lieu of disciplinary action under RCW 18.130.160 and if the DQAC determines that the unprofessional conduct may be the result of an applicable impairing or potentially impairing health condition, the DQAC may refer the license holder to a physician health program or a voluntary substance use disorder monitoring program approved by the DQAC.

[Statutory Authority: RCW 18.32.0365 and 2022 c 43. WSR 23-16-006, § 246-817-801, filed 7/19/23, effective 8/19/23. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-801, filed 10/10/95, effective 11/10/95.]

WAC 246-817-810 Terms used in WAC 246-817-801 through 246-817-830. "Aftercare" is that period of time after intensive treatment that provides the dentist or the dentist's family with group or individual counseling sessions, discussions with other families, ongoing contact and participation in self-help groups, and ongoing continued support of treatment and/or monitoring program staff.

"Approved substance use disorder monitoring program" or **"approved physician health monitoring program"** is a program the DQAC has determined meets the requirements of the law and the criteria established by the DQAC in the Washington Administrative Code which enters into a contract with dentists who have substance use disorders or other po-

tentially impairing health conditions regarding the required components of the dentist's recovery activity and oversees the dentist's compliance with these requirements. Substance use disorder or other potentially impairing health conditions monitoring programs may provide evaluation or treatment to participating dentists.

"Approved treatment facility" is a facility approved by the bureau of alcohol and substance abuse, department of social and health services according to RCW 18.130.175.

"Contract" is a comprehensive, structured agreement between the recovering dentist and the approved physician health program or substance use disorder monitoring program wherein the dentist consents to comply with the physician health program or substance use disorder monitoring program and the required components for the dentist's recovery activity.

"Dentist support group" is a group of dentists and/or other health 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.

"Random drug screens" are laboratory tests to detect the presence of drugs of abuse in bodily fluids collected under observation which are performed at irregular intervals not known in advance by the person to be tested.

"Substance use disorder" is the impairment, as determined by the DQAC, of a dentist's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.

"Twelve-steps groups" are groups such as Alcoholics Anonymous, Narcotics Anonymous, and related organizations based on a philosophy of anonymity, belief in a power outside of oneself, peer group association, and self-help.

[Statutory Authority: RCW 18.32.0365 and 2022 c 43. WSR 23-16-006, § 246-817-810, filed 7/19/23, effective 8/19/23. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-810, filed 10/10/95, effective 11/10/95.]

WAC 246-817-820 Approval of physician health programs or substance use disorder monitoring programs. The DQAC will approve the physician health program or substance use disorder monitoring program(s) which will participate in the recovery of dentists. The DQAC will enter into a contract with the approved physician health program or substance use disorder monitoring program(s) on an annual basis.

(1) An approved physician health program or substance use disorder monitoring program may provide evaluations and/or treatment to the participating dentists.

(2) An approved physician health program or substance use disorder monitoring program staff must have the qualifications and knowledge of both substance use disorders, other potentially impairing health conditions, and the practice of dentistry as defined in this chapter to be able to evaluate:

(a) Drug screening laboratories;

(b) Laboratory results;

(c) Providers of substance abuse treatment for substance use disorders or other potentially impairing health conditions, both individual and facilities;

(d) Dentists' support groups;

(e) The dentists' work environment; and

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

(3) An approved physician health program or substance use disorder monitoring program shall enter into a contract with the dentist and the DQAC to oversee the dentist's compliance with the requirements of the program.

(4) An approved physician health program or substance use disorder monitoring program staff shall evaluate and recommend to the DQAC, on an individual basis, whether a dentist will be prohibited from engaging in the practice of dentistry for a period of time and restrictions, if any, on the dentist's access to controlled substances in the work place.

(5) An approved physician health program or substance use disorder monitoring program shall maintain records on participants.

(6) An approved physician health program or substance use disorder monitoring program shall be responsible for providing feedback to the dentist as to whether treatment progress is acceptable.

(7) An approved physician health program or substance use disorder monitoring program shall report to the DQAC any dentist who fails to comply with the requirements of the physician health program or substance use disorder monitoring program.

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

(9) The approved physician health program or substance use disorder monitoring program shall receive from the DQAC guidelines on treatment, monitoring, and/or limitations on the practice of dentistry for those participating in the program.

(10) An approved physician health program or substance use disorder monitoring program shall provide for the DQAC a complete financial breakdown of cost for each individual dental participant by usage at an interval determined by the DQAC in the annual contract.

(11) An approved physician health program or substance use disorder monitoring program shall provide for the DQAC a complete annual audited financial statement.

(12) An approved physician health program or substance use disorder monitoring program shall enter into a written contract with the DQAC and submit monthly billing statements supported by documentation.

[Statutory Authority: RCW 18.32.0365 and 2022 c 43. WSR 23-16-006, § 246-817-820, filed 7/19/23, effective 8/19/23. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-820, filed 10/10/95, effective 11/10/95.]

WAC 246-817-830 Participation in physician health programs or approved substance use disorder monitoring programs. (1) In lieu of disciplinary action, the dentist may accept DQAC referral into an approved physician health program or substance use disorder monitoring program.

(a) The dentist shall undergo a complete physical and psychosocial evaluation before entering the approved physician health program or substance use disorder monitoring program. This evaluation shall be performed by health care professionals with expertise in substance use disorders or other potentially impairing health conditions.

(b) The dentist shall enter into a contract with the approved physician health program or substance use disorder monitoring program to comply with the requirements of the physician health program or substance use disorder program which shall include, but not be limited to, the following:

(i) The dentist shall agree to remain free 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.

(ii) The dentist shall submit to random drug screening as specified by the approved physician health program or substance use disorder monitoring program.

(iii) The dentist shall sign a waiver allowing the approved physician health program or substance use disorder monitoring program to release information to the DQAC if the dentist does not comply with the requirements of this contract.

(iv) The dentist shall undergo intensive treatment of a substance use disorder or other potentially impairing health condition in an approved treatment facility.

(v) The dentist must complete the prescribed aftercare program of the approved physician health program or substance use disorder treatment facility, which may include individual or group psychotherapy.

(vi) The treatment counselor(s) shall provide reports, as requested by the dentist, to the approved physician health program or substance use disorder monitoring program at specified intervals. Reports shall include treatment prognosis and goals.

(vii) The dentist shall attend dentists' support groups and/or twelve-step group meetings as specified by the contract.

(viii) The dentist shall comply with specified practice conditions and restrictions as defined by the contract.

(ix) Except for (b)(i) through (iii) of this subsection, an approved physician health program or substance use disorder monitoring program may make an exception to the foregoing comments on individual contracts.

(c) The dentist is responsible for paying the costs of the physical and psychosocial evaluation, substance use disorder or other potentially impairing health condition treatment, random drug screens, and therapeutic group sessions.

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

(2) A dentist who is not being investigated by the DQAC or subject to current disciplinary action, not currently being monitored by the DQAC for substance use disorder or other potentially impairing health condition, may voluntarily participate in the approved physician health program or substance use disorder monitoring program without being referred by the DQAC. Such voluntary participants shall not be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for their substance use disorder or other potentially impairing health condition, and shall not have their participation made known to the

DQAC if they meet the requirements of the approved physician health program or substance use disorder monitoring program:

(a) The dentist shall undergo a complete physical and psychosocial evaluation before entering the approved physician health program or substance use disorder monitoring program. This evaluation shall be performed by health care professional(s) with expertise in substance use disorders or other potentially impairing health conditions.

(b) The dentist shall enter into a contract with the approved physician health program or substance use disorder monitoring program to comply with the requirements of the program which may include, but not be limited to the following:

(i) The dentist shall undergo approved substance use disorder or other potentially impairing health condition treatment in an approved treatment facility.

(ii) The dentist shall agree to remain free 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.

(iii) The dentist must complete the prescribed aftercare program of the approved physician health program or substance use disorder treatment facility, which may include individual or group psychotherapy.

(iv) The dentist must cause the treatment counselor(s) to provide reports to the approved physician health program or substance use disorder monitoring program at specified intervals. Reports shall include treatment prognosis and goals.

(v) The dentist shall submit to random observed drug screening as specified by the approved physician health program or substance use disorder monitoring program.

(vi) The dentist shall attend dentists' support groups or twelve-step group meetings as specified by the contract.

(vii) The dentist shall comply with practice conditions and restrictions as defined by the contract.

(viii) The dentist shall sign a waiver allowing the approved physician health program or substance use disorder monitoring program to release information to the DQAC if the dentist does not comply with the requirements of this contract.

(c) The dentist is responsible for paying the costs of the physical and psychosocial evaluation, substance use disorder or other potentially impairing health condition treatment, random drug screens, and therapeutic group sessions.

(3) Treatment and pretreatment records shall be confidential as provided by law.

[Statutory Authority: RCW 18.32.0365 and 2022 c 43. WSR 23-16-006, § 246-817-830, filed 7/19/23, effective 8/19/23. Statutory Authority: RCW 18.32.035. WSR 95-21-041, § 246-817-830, filed 10/10/95, effective 11/10/95.]

OPIOID PRESCRIBING

Opioid Prescribing—General Provisions

WAC 246-817-901 Intent and scope. WAC 246-817-901 through 246-817-980 govern the prescribing of opioids in the treatment of pain.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-901, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-901, filed 5/2/11, effective 7/1/11.]

WAC 246-817-905 Exclusions. WAC 246-817-901 through 246-817-980 do not apply to:

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

(2) The provision of palliative, hospice, or other end-of-life care;

(3) The treatment of inpatient hospital patients. Inpatient means a person who has been admitted to the hospital for more than twenty-four hours; or

(4) The provision of procedural medications.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-905, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-905, filed 5/2/11, effective 7/1/11.]

WAC 246-817-906 Definitions. The definitions in this section apply to WAC 246-817-901 through 246-817-980 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 renewals, or obtaining prescriptions for the same or similar drugs from more than one dentist 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) "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.

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

(6) "High dose" means ninety milligram 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 life expectancy of six months or less.

(9) "Hospital" means any institution, place, building, or agency licensed 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 50 MED.

(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 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 50-90 MED.

(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 used to alleviate moderate to severe pain 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 care" means care that maintains or 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) "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.

(21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 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 that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-906, filed 12/26/18, effective 1/26/19.]

WAC 246-817-907 Patient notification, secure storage, and disposal. (1) The dentist shall discuss with the patient educating them of risks associated with the use of opioids, including the risk of dependence and overdose. The dentist 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 phase of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient written notification must include information regarding:

(a) Pain management alternatives to opioid medications as provided in RCW 69.50.317 (1)(b) and WAC 246-817-908;

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

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

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

(4) The requirements in this section do not apply to the administration of an opioid including, but not limited to, the following situations:

(a) Emergent care;

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

(c) Procedures involving the administration of anesthesia;

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

(e) MAT for substance use disorders.

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

(6) The requirements of this section may be satisfied with a document provided by the department of health.

(7) The requirements of this section may be satisfied by a dentist designating any individual who holds a credential issued by a disciplining authority under RCW 18.130.040 to provide the information.

[Statutory Authority: RCW 18.32.0365, 18.32.810, and 69.50.317. WSR 20-04-080, § 246-817-907, filed 2/4/20, effective 3/6/20. Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-907, filed 12/26/18, effective 1/26/19.]

WAC 246-817-908 Use of alternative modalities for pain treatment. The dentist 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.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-908, filed 12/26/18, effective 1/26/19.]

WAC 246-817-909 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, a dentist licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the rules in this chapter. The continuing education must be at least three hours in length.

(2) The dentist shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the dentist's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The hours spent completing the training in opioid prescribing under this section count toward meeting applicable continuing education requirements for dentist license renewal.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-909, filed 12/26/18, effective 1/26/19.]

WAC 246-817-911 Diagnosis identified on prescription. The practitioner shall include the diagnosis, indication for use, or the International Classification of Diseases (ICD) code on all opioid prescriptions.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-911, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Acute Nonoperative Pain and Acute Perioperative Pain

WAC 246-817-913 Treatment plan—Acute nonoperative pain and acute perioperative pain. The dentist shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain or acute perioperative pain and shall document completion of these requirements in the patient record:

(1) The dentist shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-817-908 unless not clinically appropriate.

(2) The dentist, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-817-980 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns in the patient record.

(3) If the dentist 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 dentist shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the dentist may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree collaborative.

(4) The dentist 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 dentist 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; and

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

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

(7) A dentist shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-817-976.

(8) If the dentist elects to prescribe a combination of opioids with a medication listed in WAC 246-817-975 or to a patient known to be receiving a medication listed in WAC 246-817-975 from another practitioner, such prescribing must be in accordance with WAC 246-817-975.

(9) If the dentist elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain or acute perioperative pain, the dentist 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 246-817-915 and 246-817-916 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-913, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Subacute Pain

WAC 246-817-915 Patient evaluation and patient record. The dentist 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 an opioid for subacute pain, the dentist 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 246-817-980 to identify any Schedule II-V medications or drugs of concern received by the patient and document in their review and any concerns;

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

(f) 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 dentist 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 dentist 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 results 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-915, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-915, filed 5/2/11, effective 7/1/11.]

WAC 246-817-916 Treatment plan—Subacute pain. (1) The dentist 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 dentist 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 dentist shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The dentist 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 dentist prescribes opioids for effective pain control, such prescriptions must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. The dentist 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 dentist elects to prescribe a combination of opioids with a medication listed in WAC 246-817-975 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-817-975 from another practitioner, the dentist shall prescribe in accordance with WAC 246-817-975.

(5) If the dentist elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the dentist 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 246-817-919 through 246-817-967, shall apply.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-916, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Chronic Pain Management

WAC 246-817-919 Patient evaluation and patient record. The dentist shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

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

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and past treatments for pain, including medications and their efficacy;

(d) Review of any significant comorbidities;

(e) Any current or historical substance use disorder;

(f) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and

(g) Medication allergies.

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

(a) Appropriate physical examination;

(b) Consideration of the risks and benefits of chronic pain treatment for the patient;

(c) 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;

(d) 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 246-817-980;

(e) Any available diagnostic, therapeutic, and laboratory results;

(f) Use of a risk assessment tool and assignment of the patient to a high, moderate or low-risk category;

(i) The dentist should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;

(ii) "Risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

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

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

(i) Written agreements, as described in WAC 246-817-930, for treatment between the patient and the dentist;

(j) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy; and

(k) Treatment plan and objectives including:

(i) Documentation of any medication prescribed;

(ii) Biologic specimen testing ordered; and

(iii) Any labs or imaging ordered.

(3) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in subsections (1) and (2) of this section, as well as all other required components of the patient record, as set out in statute or rule.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-919, filed 12/26/18, effective 1/26/19.]

WAC 246-817-920 Treatment plan. (1) When the patient enters the chronic pain phase, the dentist 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, at a minimum:

(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 dentist shall adjust drug therapy to the individual health needs of the patient.

(4) The dentist shall complete patient notification in accordance with the provisions of WAC 246-817-907.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-920, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-920, filed 5/2/11, effective 7/1/11.]

WAC 246-817-930 Written agreement for treatment. The dentist 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 dentist;

(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. "Refill" or "renewal" 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 246-817-901 through 246-817-980, refills or renewals are subject to the same limitation and requirements as initial prescriptions;

(3) Reasons for which opioid therapy may be discontinued such as, but not limited to, violation of agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, a single clinic, or 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 dentist 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 dentist to release the agreement to other practitioners so other practitioners can report violations of the agreement to the dentist 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 dentist's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-930, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-930, filed 5/2/11, effective 7/1/11.]

WAC 246-817-935 Periodic review. (1) The dentist shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the dentist's discretion.

(2) During the periodic review, the dentist 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 dentist's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

(a) History and physical examination 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 Washington state 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 246-817-980 and subsection (1) of this section.

(4) The dentist shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The dentist shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-817-966.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-935, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-935, filed 5/2/11, effective 7/1/11.]

WAC 246-817-950 Consultation—Recommendations and requirements. (1) The dentist shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who

are under eighteen years of age or who are potential high-risk patients. 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 MED. Unless the consultation is exempted under WAC 246-817-955 or 246-817-960, the dentist who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold shall comply with the pain management specialist consultation requirements described in WAC 246-817-965. 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 dentist;

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

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

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

(4) The dentist shall use great caution when prescribing opioids to children and adolescents with chronic pain, appropriate referral to a specialist is encouraged.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-950, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-950, filed 5/2/11, effective 7/1/11.]

WAC 246-817-955 Consultation—Exemptions for exigent and special circumstances. A dentist is not required to consult with a pain management specialist as described in WAC 246-817-965 when the dentist has documented adherence to all standards of practice as defined in WAC 246-817-919 through 246-817-967 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 dentist 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 dentist documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-955, filed 12/26/18, effective 1/26/19.

Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-955, filed 5/2/11, effective 7/1/11.]

WAC 246-817-960 Consultation—Exemptions for the dentist. The dentist is exempt from the consultation requirement in WAC 246-817-950 if one or more of the following qualifications are met:

(1) The dentist is a pain management specialist under WAC 246-817-965;

(2) The dentist has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management, with at least two of these hours dedicated [to] substance use disorders;

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

(4) The dentist 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-960, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-960, filed 5/2/11, effective 7/1/11.]

WAC 246-817-965 Pain management specialist. A pain management specialist shall meet the following qualifications:

(1) A dentist shall be board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.

(2) An allopathic physician shall meet requirements in WAC 246-919-945 and an allopathic physician assistant shall meet requirements in WAC 246-918-895.

(3) An osteopathic physician shall meet requirements in WAC 246-853-750 and an osteopathic physician assistant shall meet requirements in WAC 246-854-330.

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

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

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-965, filed 12/26/18, effective 1/26/19. Statutory Authority: RCW 18.32.785 and 18.32.0365. WSR 11-10-061, § 246-817-965, filed 5/2/11, effective 7/1/11.]

WAC 246-817-966 Assessment of treatment plan. (1) The dentist 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 plan is unsatisfactory.

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

(a) The patient requests;

(b) The patient experiences 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 of 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-966, filed 12/26/18, effective 1/26/19.]

WAC 246-817-967 Patients with chronic pain, including those on high doses, establishing a relationship with a new dentist. (1) When a patient receiving chronic opioid pain medications changes to a new dentist, it is normally appropriate for the new dentist to initially maintain the patient's current opioid doses. Over time, the dentist may evaluate if any tapering or other adjustments in the treatment plan can or should be done.
(2) A dentist's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-817-950 and the tapering requirements of WAC 246-817-966 if:
(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligram MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;
(b) The patient's dose is stable and nonescalating;
(c) The patient has a 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, in excess of one hundred twenty milligram MED dose.
(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-817-950 and 246-817-966 shall apply.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-967, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Special Populations

WAC 246-817-970 Special populations—Patients twenty-four years of age or under, pregnant patients, and aging populations. (1) Patients twenty-four years of age or under. In the treatment of pain for patients twenty-four years of age or under, the dentist shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly. Eight to twelve tablets supply will often be sufficient. The dentist shall not prescribe beyond twelve tablets without clinical documentation in the patient record to justify the need for such a quantity.

(2) Pregnant patients. A dentist shall not discontinue use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The dentist 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 dentist 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-970, filed 12/26/18, effective 1/26/19.]

WAC 246-817-971 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the dentist knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the dentist 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) A dentist providing episodic care to a patient who the dentist 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 dentist 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 episodic care dentist shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

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

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

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-971, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Coprescribing

WAC 246-817-975 Coprescribing of opioids with certain medications. (1) The dentist shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation of clinical judgment and discussion of risks with patient:

(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 dentist 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 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-975, filed 12/26/18, effective 1/26/19.]

WAC 246-817-976 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the dentist 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 a pain specialist.

(2) A dentist shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so.

(3) A dentist shall not deny necessary operative intervention for use of these medications by a patient.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-976, filed 12/26/18, effective 1/26/19.]

WAC 246-817-977 Coprescribing of naloxone. The dentist shall confirm or provide a current prescription for naloxone or refer the patient to a pharmacist for further counseling and evaluation when opioids are prescribed to a high-risk patient.

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-977, filed 12/26/18, effective 1/26/19.]

Opioid Prescribing—Prescribing Monitoring Program

WAC 246-817-980 Prescription monitoring program—Required registration, queries, and documentation. (1) The dentist shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe opioids in Washington state.

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

(3) At a minimum, the dentist shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

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

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

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

(4) For chronic pain management, the dentist shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

(a) For a high-risk patient, a PMP query must be completed at least quarterly;

(b) For a moderate-risk patient, a PMP must be completed at least semiannually; and

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

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

(6) The dentist shall ensure a PMP query is performed when providing episodic care to a patient whom the dentist knows to be receiving opioids for chronic pain, in accordance with WAC 246-817-971.

(7) If the dentist is using an electronic medical record or EMR that integrates access to the PMP into the workflow of the EMR, the dentist shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-817-975.

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

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

[Statutory Authority: RCW 18.32.002, 18.32.0365, 18.32.800 and 2017 c 297. WSR 19-02-043, § 246-817-980, filed 12/26/18, effective 1/26/19.]

FEES

WAC 246-817-990 Dentist fees and renewal cycle. (1) Licenses must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, except faculty and resident licenses.

(2) Faculty and resident licenses must be renewed every year on July 1 as provided in chapter 246-12 WAC.

(3) The following nonrefundable fees will be charged:

Title of Fee	Fee
Original application by examination*	
Initial application	$500.00
Original application - Without examination	
Initial application	500.00
Initial license	500.00
Faculty license application	500.00
Resident license application	115.00
Active license renewal:	
Renewal	365.00
Surcharge - Impaired dentist	50.00
Late renewal penalty	185.00
Expired license reissuance	300.00
Inactive license renewal:	
Renewal	125.00
Surcharge - Impaired dentist	50.00
Late renewal penalty	50.00
Retired active license renewal	
Renewal	150.00

Title of Fee	Fee
Surcharge - Impaired dentist	50.00
Late renewal penalty	75.00
Duplicate license	15.00
Certification of license	25.00
Anesthesia permit	
Initial application	150.00
Renewal - (Three-year renewal cycle)	160.00
Late renewal penalty	80.00
Expired permit reissuance	50.00
On-site inspection fee	To be determined by future rule adoption.

* In addition to the initial application fee above, applicants for licensure via examination will be required to submit a separate application and examination fee directly to the dental testing agency accepted by the dental quality assurance commission.

[Statutory Authority: RCW 43.70.110, 43.70.250, and 43.70.280. WSR 23-07-057, § 246-817-990, filed 3/9/23, effective 6/1/23. Statutory Authority: RCW 18.130.250, 43.70.250 and 18.32.534. WSR 15-07-004, § 246-817-990, 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, § 246-817-990, filed 10/16/13, effective 1/1/14. Statutory Authority: RCW 43.70.110, 43.70.250, and 2010 c 37. WSR 10-19-071, § 246-817-990, filed 9/16/10, effective 10/15/10. Statutory Authority: RCW 43.70.110, 43.70.250 and 2008 c 329. WSR 08-16-008, § 246-817-990, filed 7/24/08, effective 7/25/08. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-817-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 18.32.0365 and 43.70.250. WSR 01-11-166, § 246-817-990, filed 5/23/01, effective 7/1/01. Statutory Authority: RCW 43.70.250. WSR 99-08-101, § 246-817-990, filed 4/6/99, effective 7/1/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-817-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.040. WSR 95-16-122, § 246-817-990, filed 8/2/95, effective 9/1/95.]

WAC 246-817-99005 Dental assistant, dental anesthesia assistant, and expanded function dental auxiliary fees and renewal cycle. (1) Credentials must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC.

(2) The following nonrefundable fees will be charged for dental assistant, dental anesthesia assistant, and expanded function dental auxiliary credentials:

Title of Fee - Dental Professionals	Fee
Registered dental assistant application	$40.00
Registered dental assistant renewal	25.00
Registered dental assistant late renewal	25.00
Registered dental assistant expired reactivation	20.00
Certified dental anesthesia assistant application	100.00
Certified dental anesthesia assistant renewal	85.00

Title of Fee - Dental Professionals	Fee
Certified dental anesthesia assistant late renewal	50.00
Certified dental anesthesia assistant expired reactivation	75.00
Licensed expanded function dental auxiliary application	175.00
Licensed expanded function dental auxiliary renewal	165.00
Licensed expanded function dental auxiliary late renewal	85.00
Licensed expanded function dental auxiliary expired reactivation	50.00
Duplicate credential	15.00
Certification of credential	25.00

[Statutory Authority: RCW 43.70.110, 43.70.250, and 43.70.280. WSR 23-07-057, § 246-817-99005, filed 3/9/23, effective 6/1/23. Statutory Authority: 2012 c 208, 2012 c 23, 2012 c 137, 2012 c 153, RCW 43.70.110, and 43.70.250. WSR 12-24-015, § 246-817-99005, filed 11/27/12, effective 7/1/13. Statutory Authority: RCW 43.70.110, 43.70.250, and 2010 c 37. WSR 10-19-071, § 246-817-99005, filed 9/16/10, effective 10/15/10. Statutory Authority: RCW 43.70.250. WSR 08-13-069, § 246-817-99005, filed 6/13/08, effective 7/1/08.]