Chapter 246-919 WAC
MEDICAL QUALITY ASSURANCE COMMISSION

WAC

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246-919-100 Panel composition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-100, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-120 Appearance and practice before agency—Solicitation of business unethical. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-120, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-130 Appearance and practice before agency—Standards of ethical conduct. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-130, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-140 Appearance and practice before agency—Appearance by former member of attorney general's staff. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-140, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-150 Appearance and practice before agency—Former employee and board/commission member as witness. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-150, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

246-919-200 Petitions for rule making, amendment or repeal—Who may petition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-200, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.

246-919-210 Petitions for rule making, amendment or repeal—Requisites. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-210, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.

246-919-220 Petitions for rule making, amendment or repeal—Agency must consider. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-220, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.

246-919-230 Petitions for rule making, amendment or repeal—Notice of disposition. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-230, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.

246-919-240 Declaratory rulings. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-240, filed 1/17/96, effective 2/17/96.] Repealed by WSR 96-

19-042, filed 9/12/96, effective 10/13/96. Statutory Authority: RCW 18.71.017.

246-919-305 Refunds. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-305, filed 1/17/96, effective 2/17/96.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-919-350 Examinations. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-350, filed 1/17/96, effective 2/17/96.] Repealed by WSR 03-20-109, filed 10/1/03, effective 11/1/03. Statutory Authority: RCW 18.71.017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) "Applicant" is an individual who has completed the application form and has paid the application fee.

(2) "Commission" means the Washington state medical quality assurance commission.

(3) "Emergent" means a circumstance calling for immediate action.

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

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

(6) "Mentally or physically disabled physician" means a physician who has either been determined by a court to be mentally incompetent or mentally ill or who is unable to practice medicine with reasonable skill and safety by reason of any mental or physical condition.

(7) "Nursing home" means any health care institution which comes under chapter 18.51 RCW.

(8) "Physician" means a physician licensed pursuant to chapter 18.71 RCW.

(9) "Unprofessional conduct" as used in these regulations shall mean the conduct described in RCW 18.71.0193 for conduct occurring before June 11, 1986, and the conduct described in RCW 18.130.180 for conduct occurring on or after June 11, 1986.

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

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

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

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

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

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

APPLICATIONS AND EXAMINATIONS

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

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

WAC 246-919-310 Credentialing of physicians and surgeons. All completed applications, for either limited or full licensure, must be reviewed by a member of the commission or a designee authorized in writing by the commission prior to examination and/or licensure.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-310, filed 1/17/96, effective 2/17/96.]

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

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

WAC 246-919-330 Postgraduate medical training defined. (1) For the purposes of this chapter, postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties and listed in the 2004 *Official ABMS Annual Report and Reference Handbook*, published March 18, 2004.

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

(a) Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) which are listed in the 1984-85 directory of residency programs, or programs approved by the Accreditation Council at the time of residency.

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

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

(4) The physician must acquire this training after completion of a formal course of undergraduate medical instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations.

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

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

(1) Been licensed in another state prior to 1958;

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

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

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

WAC 246-919-355 Examination scores. Examinations accepted by the Washington state medical quality assurance commission:

(1) The commission adopts the United States Medical Licensing Examination (USMLE) as the examination accepted by the commission.

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

(3) Applicants who do not pass Step 3 of the USMLE examination after three sittings within seven years after passing the first examination, either Step 1 or Step 2, or acceptable combination, shall demonstrate evidence satisfactory to the commission of having completed a remedial or refresher medical course approved by the commission prior to being permitted to sit for the examination again. Applicants who do not pass after the fourth sitting may not sit for another examination without completing an additional year of postgraduate training or satisfying any other conditions specified by the commission.

(4) To be eligible for USMLE Step 3, the applicant must:

(a) Have obtained the M.D. degree;

(b) Have successfully completed the Federation Licensure Examination (FLEX) Component 1 or both National Boards Examination (NBE) Parts I and II or USMLE Steps 1 and 2 or NBE Part I and USMLE Step 2 or Step 1 and NBE Part II; and

(c) Be certified by the ECFMG if a graduate of an international medical school, or have successfully completed a fifth pathway program; and postgraduate training year in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education.

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

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

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

Accepted Examinations taken in Sequence	Other Acceptable Combinations
NBME Part I *plus* NBME Part II *plus* NBME Part III	NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* NBME Part III or USMLE Step 3
FLEX Component 1 *plus* FLEX Component 2	FLEX Component 1 *plus* USMLE Step 3 or NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* FLEX Component 2
USMLE Step 1 *plus* USMLE Step 2 *plus* USMLE Step 3	

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

WAC 246-919-365 FLEX examination standards. Reciprocity applicants who were licensed in another state by passing the FLEX examination will be eligible for a waiver of examination if the applicant received a FLEX weighted average score of at least 75. The score may be obtained in a single setting of the three-day examination or by averaging the individual day scores from different examinations. The individual day scores will be averaged according to the following formula:

Day 1 equals 1/6.

Day 2 equals 2/6.

Day 3 equals 3/6.

The overall average score shall be truncated to the nearest whole number (i.e., an average of 74.9 equals 74). Single subject averaging is not permitted. The commission will accept the FLEX weighted average of 75 reported from the Federation of State Medical Boards. All FLEX scores must be submitted directly from the Federation of State Medical Boards. FLEX scores reported by other states will not be accepted.

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

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

(a) Resolved or pending malpractice suits;

(b) Pending action by another state licensing authority;

(c) Actions pertaining to privileges at any institution; or

(d) Not having practiced for an interval of time.

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

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

WAC 246-919-380 AIDS prevention and information education requirements. Applicants must complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-380, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-380, filed 1/17/96, effective 2/17/96.]

WAC 246-919-390 Temporary permits—Recognized jurisdictions. (1) For the issuance of temporary permits under RCW 18.130.075 to applicants who graduated from a school of medicine located in any state, territory, or posses-

sion of the United States, the District of Columbia, or the Dominion of Canada prior to July 28, 1985, the following jurisdictions are deemed to have licensing standards substantially equivalent to Washington state's licensing standards: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.

(2) For the issuance of temporary permits under RCW 18.130.075 to applicants who graduated from a school of medicine located in any state, territory, or possession of the United States, the District of Columbia, or the Dominion of Canada after July 28, 1985, the following jurisdictions are deemed to have licensing standards substantially equivalent to Washington state's licensing standards: Connecticut, Maine, Michigan, Nevada, and New Hampshire.

(3) For the issuance of temporary permits under RCW 18.130.075 to applicants who graduated from a school of medicine located outside the states, territories, and possessions of the United States, the District of Columbia, or the Dominion of Canada prior to July 28, 1985, the following jurisdictions are deemed to have licensing standards substantially equivalent to Washington state's licensing standards: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.

(4) For the issuance of temporary permits under RCW 18.130.075 to applicants who graduated from a school of medicine located outside the states, territories, and possessions of the United States, the District of Columbia, or the Dominion of Canada after July 28, 1985, the following jurisdictions are deemed to have licensing standards substantially equivalent to Washington state's licensing standards: Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, Tennessee, Texas, Virginia, West Virginia, and Wyoming.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-390, filed 1/17/96, effective 2/17/96.]

WAC 246-919-395 Temporary permits—Issuance and duration. (1) Upon submission of a completed license application form on which the applicant indicates that he or she wishes to receive a temporary practice permit; payment of the application fee and temporary practice permit fee; receipt of the American Medical Association's physicians' data profile verifying states in which the applicant is or was licensed; receipt of disciplinary action data bank report from the Federation of State Medical Boards and receipt of written verification attesting that the applicant has a license in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment from all states which the applicant is or was licensed, the applicant shall be issued a temporary practice permit unless there is a basis for denial of the license or issuance of a conditional license.

(2) The temporary permit shall expire upon the issuance of a license by the commission; initiation of an investigation by the commission of the applicant; or ninety days, whichever occurs first.

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

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-395, filed 1/17/96, effective 2/17/96.]

WAC 246-919-396 Background check—Temporary practice permit. The medical quality assurance commission (MQAC) conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The MQAC may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

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

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

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

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

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

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

RENEWAL AND CME REQUIREMENTS

WAC 246-919-421 Renewal and continuing medical education cycle revision. Beginning January 1, 2000, the one-year renewal cycle for physicians will transition to a two-year cycle and a four-year continuing medical education

reporting cycle. The renewal and continuing medical education reporting cycle will be as follows:

(1) Effective January 1, 2000, any physician whose birth year is an even number will renew their credential for twenty-four months and every two years thereafter. Those physicians must obtain two hundred hours of continuing medical education within the next forty-eight months from the date of the initial two-year license and every four years thereafter.

(2) Effective January 1, 2001, any physician whose birth year is an odd number will renew their credential for twenty-four months and every two years thereafter. Those physicians must obtain two hundred hours of continuing medical education within the next forty-eight months from the date of the initial two-year license and every four years thereafter.

(3) Effective January 1, 2000, in order to attain full license status, individuals with a post-graduate limited license will pay the fee difference between the limited license application and the full license application. This license will expire on their second birth date after issuance and every two years thereafter.

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

WAC 246-919-430 General requirements. (1) Licensed physicians must complete two hundred hours of continuing education every four years as required in chapter 246-12 WAC, Part 7.

(2) In lieu of the two hundred hours of continuing medical education, the commission will accept a current Physician's Recognition Award from the American Medical Association or a current certificate from any specialty board approved by the American Board of Medical Specialties (ABMS) which is considered by the specialty board as equivalent to the two hundred hours of continuing medical education required under WAC 246-919-430(1). The commission will also accept certification or recertification by a specialty board as the equivalent of two hundred hours of continuing medical education. A list of the approved specialty boards are designated in the *1995 Official American Boards of Medical Specialty Director of Board Certified Medical Specialist* and will be maintained by the commission. The list shall be made available upon request. The certification or recertification must be obtained in the four years preceding application for renewal.

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

WAC 246-919-450 Categories of creditable continuing medical education activities. The following are categories of creditable continuing medical education activities approved by the commission:

Category I	Continuing medical education activities with accredited sponsorship
Category II	Continuing medical education activities with nonaccredited sponsorship (maximum of eighty hours)
Category III	Teaching of physicians or other allied health professionals (maximum of eighty hours)
Category IV	Books, papers, publications, exhibits (maximum of eighty hours)
Category V	Self-directed activities: Self-assessment, self-instruction, specialty board examination preparation, quality of care and/or utilization review (maximum of eighty hours).

[Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-450, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-450, filed 1/17/96, effective 2/17/96.]

WAC 246-919-460 Continuing medical education requirement. (1) The credits must be earned in the forty-eight-month period preceding application for renewal of licensure.

(2) **Category I: Continuing medical education activities with accredited sponsorship.** The commission has approved the standards adopted by the Accreditation Council for Continuing Medical Education or its designated interstate accrediting agency, the Washington State Medical Association, in accrediting organizations and institutions offering continuing medical education programs, and will accept attendance at such programs offered by organizations and institutions offering continuing medical education programs, and will accept attendance at such programs offered by organizations and institutions so recognized as Category I credit towards the licensee's continuing medical education requirement for annual renewal of licensure. The licensee may earn all two hundred credit hours in Category I.

(3) **Category II: Continuing medical education activities with nonaccredited sponsorship.** A maximum of eighty credit hours may be earned by attendance at continuing medical education programs that are not approved in accordance with the provisions of Category I.

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

(5) **Category IV: Books, papers, publications, exhibits.**

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

(b) Ten credit hours may be claimed for a paper, exhibit, publication, or for each chapter of a book that is authored and published. A paper must be published in a recognized medical journal. A paper that is presented at a meeting or an exhibit that is shown must be to physicians or allied health

professionals. Credit may be claimed only once for the scientific materials presented. Credit should be claimed as of the date materials were presented or published.

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

(6) **Category V: Self-directed activities.**

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

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

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

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

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

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

WAC 246-919-470 Approval not required. (1) The commission will not give prior approval for any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these regulations and relies upon each individual physician's integrity in complying with this requirement.

(2) The commission will not give prior approval for any formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of creditable hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of program sponsors to present continuing medical education that constitutes a meritorious learning experience.

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

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

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

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

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

[Statutory Authority: RCW 18.71.017. WSR 01-03-115, § 246-919-475, filed 1/22/01, effective 2/22/01.]

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

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

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

(4) Physicians with a retired active license must renew every two years and must report one hundred hours of continuing medical education at every renewal.

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

ADJUDICATIVE PROCEDURES

WAC 246-919-520 Revocation of a physician's license. This section sets forth the procedure by which a respondent may request a review by the medical quality assurance commission of its decision to revoke the respondent's license under RCW 18.71.019:

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

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

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

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

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

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

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

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

(a) Shall review the final order;

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

(c) May hear oral argument by the parties.

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

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

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

OFFICE-BASED SURGERY RULES

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

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

(a) "Commission" means the medical quality assurance commission.

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

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

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

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

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

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

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

(i) "Physician" means an individual licensed under chapter 18.71 RCW.

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

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

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

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

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

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

(ii) Complies with dental quality assurance commission regulations;

(iii) Holds a valid:

(A) Moderate sedation permit; or

(B) Moderate sedation with parenteral agents permit; or

(C) General anesthesia and deep sedation permit; and

(iv) Practices within the scope of his or her specialty.

(4) Application of rule.

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

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia.

(5) Accreditation or certification. Within three hundred sixty-five calendar days of the effective date of this rule, a physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from one of the following:

(a) The Joint Commission;

(b) The Accreditation Association for Ambulatory Health Care;

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

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

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

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

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

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

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

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

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group (e.g., ACLS, PALS or APLS) must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility.

(9) Sedation assessment and management.

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

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

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

(10) Separation of surgical and monitoring functions.

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

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

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

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

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

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

(a) The medical record must include:

(i) Identity of the patient;

(ii) History and physical, diagnosis and plan;

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

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

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

(viii) Provision for continuity of postoperative care; and

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

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

(i) The type of sedation or anesthesia used;

(ii) Drugs (name and dose) and time of administration;

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

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

(vii) Estimated blood loss;

(viii) Duration of procedure; and

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

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

STANDARDS FOR PROFESSIONAL CONDUCT

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

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

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

(2) Because an LLRP device penetrates and alters human tissue, the use of an LLRP device is the practice of medicine under RCW 18.71.011. The use of an LLRP device can result in complications such as visual impairment, blindness, inflammation, burns, scarring, hypopigmentation and hyperpigmentation.

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

PHYSICIAN RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

PHYSICIAN DELEGATION OF LLRP TREATMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating physician provided that there is a local back-up physician who satisfies the requirements of subsection (4) of this section. The local back-up physician must agree in writing to treat complications, provide consultation or resolve problems if medically indicated. The local back-up physician shall be reachable by phone and able to see the patient within sixty minutes.

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

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

WAC 246-919-606 Nonsurgical medical cosmetic procedures. (1) The purpose of this rule is to establish the duties and responsibilities of a physician who delegates the injection of medication or substances for cosmetic purposes or the use of prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011(3).

(2) This rule does not apply to:

(a) Surgery;

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

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

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

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

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

(b) "Physician" means an individual licensed under chapter 18.71 RCW.

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

PHYSICIAN RESPONSIBILITIES

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

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

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent;

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

(g) Prepare an appropriate medical record.

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

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

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

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

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

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

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

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

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

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

PHYSICIAN DELEGATION

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

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

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

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

(i) Techniques for each procedure;

(ii) Cutaneous medicine;

(iii) Indications and contraindications for each procedure;

(iv) Preprocedural and postprocedural care;

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

(vi) Infectious disease control involved with each treatment.

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

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

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

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

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

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

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

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

(12) If a physician delegates the performance of a procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the par-

ticular purpose for which it is used, the physician must be on-site during the entire duration of the procedure.

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

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

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

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

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

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

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

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

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

WAC 246-919-620 Cooperation with investigation. (1) A licensee must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority pursuant to RCW 18.130.050(2) by submitting the requested items within fourteen calendar days of receipt of the request by the licensee or the licensee's attorney, whichever is first. If the licensee fails to comply with the request within fourteen calendar days, the investigator shall contact the licensee or the licensee's attorney by letter as a reminder.

(a) Investigators may extend the time for response if the licensee requests an extension for a period not to exceed seven calendar days. Other requests for extension may be granted by the commission chair or the commission's designee.

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

(2) A licensee must comply with a request for nonhealth care records or documents from an investigator who is acting on behalf of the commission pursuant to RCW 18.130.050(2) by submitting the requested items within fourteen calendar days of receipt of the request by the licensee or the licensee's attorney, whichever is first. If the licensee fails to comply with the request within fourteen calendar days, the investigator shall contact the licensee or the licensee's attorney by letter as a reminder.

(a) Investigators may extend the time for response if the licensee requests an extension for a period not to exceed seven calendar days. Other requests for extension may be granted by the commission chair or the commission's designee.

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

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

(3) A licensee must comply with a request for information from an investigator who is acting on behalf of the commission pursuant to RCW 18.130.050(2). This information may include, but is not limited to, an explanation of the matter under investigation, curriculum vitae, continuing medical education credits, malpractice action summaries, or hospital affiliations. The licensee will submit the requested information within fourteen calendar days of receipt of the request by the licensee or the licensee's attorney, whichever is first. If the licensee fails to comply with the request within fourteen calendar days, the investigator shall contact the licensee or the licensee's attorney by letter as a reminder.

(a) Investigators may extend the time for response if the licensee requests an extension for a period not to exceed seven calendar days. Other requests for extension may be granted by the commission chair or the commission's designee.

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

(4) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the reviewing commission member may take into consideration whether the licensee has complied with the request after the statement of charges has been issued. Any settlement proposal shall be presented to the commission or a duly constituted panel of the commis-

sion for a decision on ratification and until ratified, the settlement is not final.

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

WAC 246-919-630 Sexual misconduct. (1) Definitions:

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

(b) "Physician" means a person licensed to practice medicine and surgery under chapter 18.71 RCW.

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

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

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

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

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician.

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

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

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

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the physician;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(5) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(6) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

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

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-630, filed 1/9/06, effective 2/9/06.]

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

(a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;

(b) Removes a patient's clothing or gown without consent;

(c) Fails to treat an unconscious or deceased patient's body or property respectfully; or

(d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

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

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

MANDATORY REPORTING

WAC 246-919-700 Mandatory reporting. (1) All reports required by these regulations shall be submitted to the commission as soon as possible, but not later than sixty days after a determination is made.

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

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

(b) The name, address and telephone numbers of the physician being reported;

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

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

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

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

(3) The mandatory reporting shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept for the

confidential use of the commission as provided in the Uniform Disciplinary Act and shall not be subject to subpoena or discovery proceedings in any civil action as provided in RCW 4.24.250, and shall be exempt from public disclosure pursuant to chapter 42.17 RCW except for review as provided in RCW 18.71.0195.

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

WAC 246-919-710 Mandatory reporting requirement satisfied. The requirement for a report to the commission under RCW 18.71.0193(1) may be satisfied by submitting the report to the impaired physician program approved by the commission under this chapter.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-710, filed 1/17/96, effective 2/17/96.]

WAC 246-919-730 Medical associations or societies. The president or chief executive officer of any medical association or society within this state shall report to the commission when a medical society hearing panel or committee determines that a physician has committed unprofessional conduct or that a physician may not be able to practice medicine with reasonable skill and safety to patients as the result of any mental or physical condition and constitutes an apparent risk to the public health, safety or welfare. The report required by this subsection shall be made without regard to whether the license holder appeals, accepts or acts upon the determination made by the association or society. Notification of appeal shall be included.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-730, filed 1/17/96, effective 2/17/96.]

WAC 246-919-740 Health care service contractors and disability insurance carriers. The executive officer of every health care service contractor and disability insurer, licensed under chapters 48.20, 48.21, 48.21A and 48.44 RCW operating in the state of Washington, shall report to the commission all final determinations that a physician has engaged in flagrant overcharging for medical services or has flagrantly engaged in overutilization of medical services or has charged fees for medical services not actually provided.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-740, filed 1/17/96, effective 2/17/96.]

WAC 246-919-750 Courts. The commission requests the assistance of all clerks of trial courts within the state to report all medical malpractice judgments and all convictions of licensed medical doctors, other than minor traffic violations.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-750, filed 1/17/96, effective 2/17/96.]

WAC 246-919-760 State and federal agencies. The commission requests the assistance of executive officers of any state or federal program operating in the state of Washington, under which a physician is employed to provide patient care services, to report to the commission whenever such a physician has been judged to have demonstrated his/her incompetency or negligence in the practice of medicine, or has otherwise committed unprofessional conduct; or is a mentally or physically disabled physician.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-760, filed 1/17/96, effective 2/17/96.]

WAC 246-919-770 Professional standards review organizations. When authorized by federal law, every professional standards review organization operating within the state of Washington shall report to the commission any determinations that a physician has engaged or is engaging in consistent, excessive utilization of any medical or surgical test, treatment or procedure when such procedures are clearly not called for under the circumstances in which such services were provided.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-770, filed 1/17/96, effective 2/17/96.]

PAIN MANAGEMENT

WAC 246-919-850 Pain management—Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

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

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this rule has been developed to clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

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

The commission recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain,

whether due to cancer or noncancer origins. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

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

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

These rules are designed to assist practitioners in providing appropriate medical care for patients. They are not inflexible rules or rigid practice requirements and are not intended, nor should they be used, to establish a legal standard of care outside the context of the medical quality assurance committee's jurisdiction.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner based on all the circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken.

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-850, filed 5/24/11, effective 1/2/12.]

WAC 246-919-851 Exclusions. The rules adopted under WAC 246-919-850 through 246-919-863 do not apply:

(1) To the provision of palliative, hospice, or other end-of-life care; or

(2) To the management of acute pain caused by an injury or surgical procedure.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-851, filed 5/24/11, effective 1/2/12.]

WAC 246-919-852 Definitions. The definitions in WAC 246-919-850 through 246-919-863 apply unless the context clearly requires otherwise.

(1) "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. It is generally time-limited, often less than three months in duration, and usually less than six months.

(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:

(a) Impaired control over drug use;

(b) Craving;

(c) Compulsive use; or

(d) Continued use despite harm.

(3) "Chronic noncancer pain" means a state in which noncancer 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.

(4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.

(5) "Episodic care" means medical care provided by a practitioner other than the designated primary care practitioner in the acute care setting, for example, urgent care or emergency department.

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

plinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

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

(8) "Multidisciplinary pain clinic" means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines or treatment modalities, for example, medical care through physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, and physical therapy, occupational therapy, or other complementary therapies.

(9) "Palliative" means care that improves the quality of life of patients and their families facing 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.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-852, filed 5/24/11, effective 1/2/12.]

WAC 246-919-853 Patient evaluation. The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

(1) The patient's health history shall include:

(a) Current and past treatments for pain;

(b) Comorbidities; and

(c) Any substance abuse.

(2) The patient's health history should include:

(a) A review of any available prescription monitoring program or emergency department-based information exchange; and

(b) Any relevant information from a pharmacist provided to a physician.

(3) The initial patient evaluation shall include:

(a) Physical examination;

(b) The nature and intensity of the pain;

(c) The effect of the pain on physical and psychological function;

(d) Medications including indication(s), date, type, dosage, and quantity prescribed;

(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:

(i) History of addiction;

(ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;

(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;

(v) Poorly controlled depression or anxiety;

(vi) Evidence or risk of significant adverse events, including falls or fractures;

(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;

(viii) Repeated visits to emergency departments seeking opioids;

(ix) History of sleep apnea or other respiratory risk factors;

(x) Possible or current pregnancy; and

(xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

(a) Any available diagnostic, therapeutic, and laboratory results; and

(b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

(a) The diagnosis, treatment plan, and objectives;

(b) Documentation of the presence of one or more recognized indications for the use of pain medication;

(c) Documentation of any medication prescribed;

(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the physician; and

(f) The physician's instructions to the patient.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-853, filed 5/24/11, effective 1/2/12.]

WAC 246-919-854 Treatment plan. (1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall 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.

(2) After treatment begins the physician should adjust drug therapy to the individual health needs of the patient. The physician shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The physician shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-854, filed 5/24/11, effective 1/2/12.]

WAC 246-919-855 Informed consent. The physician shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-855, filed 5/24/11, effective 1/2/12.]

WAC 246-919-856 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psy-

chiatric comorbidities, the prescribing physician shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

(1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the physician;

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

(3) Reasons for which drug therapy may be discontinued (e.g., violation of agreement);

(4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;

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

(6) A written authorization for:

(a) The physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and

(b) Other practitioners to report violations of the agreement back to the physician;

(7) A written authorization that the physician may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;

(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-856, filed 5/24/11, effective 1/2/12.]

WAC 246-919-857 Periodic review. The physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

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

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

(b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and

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

(2) The physician 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 physician shall consider tapering, changing, or discontinuing treatment when:

(a) Function or pain does not improve after a trial period;

(b) There is evidence of significant adverse effects;

(c) Other treatment modalities are indicated; or

(d) There is evidence of misuse, addiction, or diversion.

(3) The physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.

(4) The physician should periodically review any relevant information from a pharmacist provided to the physician.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-857, filed 5/24/11, effective 1/2/12.]

WAC 246-919-858 Long-acting opioids, including methadone. Long-acting opioids, including methadone, should only be prescribed by a physician who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The physician prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-858, filed 5/24/11, effective 1/2/12.]

WAC 246-919-859 Episodic care. (1) When evaluating patients for episodic care, such as emergency or urgent care, the physician should review any available prescription monitoring program, emergency department-based information exchange, or other tracking system.

(2) Episodic care practitioners should avoid providing opioids for chronic pain management. However, if opioids are provided, the practitioner should limit the use of opioids for a chronic noncancer pain patient to the minimum amount necessary to control the pain until the patient can receive care from a primary care practitioner.

(3) Prescriptions for opioids written by an episodic care practitioner shall include indications for use or the International Classification of Diseases (ICD) code and shall be written to require photo identification of the person picking up the prescription in order to fill.

(4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under WAC 246-919-856(6) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-859, filed 5/24/11, effective 1/2/12.]

WAC 246-919-860 Consultation—Recommendations and requirements. (1) The physician shall consider, and document the consideration, referring the patient for

additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. 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 for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-919-863 is required, unless the consultation is exempted under WAC 246-919-861 or 246-919-862. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

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

(ii) A telephone consultation between the pain management specialist and the physician;

(iii) An electronic consultation between the pain management specialist and the physician; or

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

(b) A physician shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the physician, the physician shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-919-850 through 246-919-863, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-860, filed 5/24/11, effective 1/2/12.]

WAC 246-919-861 Consultation—Exemptions for exigent and special circumstances. A physician is not required to consult with a pain management specialist as described in WAC 246-919-863 when he or she has documented adherence to all standards of practice as defined in WAC 246-919-850 through 246-919-863 and when any one or more of the following conditions apply:

(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 or below their baseline dosage level; or

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-861, filed 5/24/11, effective 1/2/12.]

WAC 246-919-862 Consultation—Exemptions for the physician. The physician is exempt from the consultation requirement in WAC 246-919-860 if one or more of the following qualifications are met:

(1) The physician is a pain management specialist under WAC 246-919-863; or

(2) The physician has successfully completed, within the last two years, a minimum of twelve (Category I) continuing education hours on chronic pain management with at least two of these hours dedicated to long acting opioids; or

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-919-862, filed 5/24/11, effective 1/2/12.]

WAC 246-919-863 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) If a physician or osteopathic physician:

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

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

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

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

(i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and

(ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians; and

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

(2) If a dentist: 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.

(3) If an advanced registered nurse practitioner (ARNP):

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

(b) Credentialed in pain management by the Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity;

(c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

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

(4) If a podiatric physician:

(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or

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

(c) Credentialed in pain management by the Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity; and

(d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-919-863, filed 5/24/11, effective 1/2/12.]

PHYSICIAN AND SURGEON FEES

WAC 246-919-990 Physician and surgeon fees and renewal cycle. (1) Licenses must be renewed every two years on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2, except postgraduate training limited licenses.

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

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

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

Title of Fee	Fee
Physicians and surgeons: Chapter 18.71 RCW	
Application (annual)*	$491.00
Two-year renewal*	657.00
Late renewal penalty	262.50
Expired license reissuance	262.50
Certification of license	50.00
Duplicate license	15.00
Temporary permit	50.00
Application fee for transitioning from a postgraduate training limited license (annual)*	166.00
Retired active physicians and surgeons: (Two-year cycle)	
Retired active physician who resides and practices in-state per RCW 18.71.080 and 18.130.250 (Washington physician health program surcharge)	100.00
Retired active physician license renewal *(does not meet in-state exemption)	332.00
Retired active late renewal penalty	50.00
Postgraduate limited license fees: RCW 18.71.095 (One-year cycle)	
Limited license application*	391.00
Limited license renewal*	391.00
Limited duplicate license	15.00

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

[Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-19-088, § 246-919-990, filed 9/18/12, effective 11/1/12. Statutory Authority: RCW 43.70.250, 43.70.280, 18.31.310, 18.71A.020, 18.71.080, and 43.70.-110. WSR 09-16-120, § 246-919-990, filed 8/4/09, effective 8/15/09. Statutory Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-919-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250. WSR 06-11-167, § 246-919-990, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-919-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 18.71.017, 18.71A.020 and 43.70.280. WSR 02-05-009, § 246-919-990, filed 2/8/02, effective 3/11/02. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-990, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 43.70.250. WSR 97-15-100, § 246-919-990, filed 7/21/97, effective 8/21/97. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-990, filed 1/17/96, effective 2/17/96.]