WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
April 8-9, 2021
Second Revised

2021 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The meeting dates for 2021 have been approved. Due to the COVID-19 event, these meetings may be done virtually instead of in person. Updates to the meeting locations will be made available via our GovDelivery and our Event Calendar at https://wmc.wa.gov/calendar.

Dates	Location	Meeting Type
January 14-15	Virtual	Regular Meeting
March 4-5	Virtual	Regular Meeting
April 8-9	Virtual	Regular Meeting
May 13-14	Virtual	Regular Meeting
July 8-9	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
August 19-20	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
Sept 30-Oct 2	TBD	Educational Conference
November 18-19	TENTATIVE Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting

2022 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 13-14	TBD	Regular Meeting
March 3-4	TBD	Regular Meeting
April 14-15	TBD	Regular Meeting
May 26-27	TBD	Regular Meeting
July 7-8	TBD	Regular Meeting
August 25-26	TBD	Regular Meeting
October 6-8	TBD	Educational Conference
November 17-18	TBD	Regular Meeting

2023 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 12-13	TBD	Regular Meeting
March 2-3	TBD	Regular Meeting
April 13-14	TBD	Regular Meeting
May 25-26	TBD	Regular Meeting
July 6-7	TBD	Regular Meeting
August 24-25	TBD	Regular Meeting
October 5-7	TBD	Educational Conference
November 16-17	TBD	Regular Meeting

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Hearing	Respondent	SPECIALTY	Case No.	Counsel	AAG	Staff Atty	PANEL	Presiding Officer	Location	Panel Composition (as of 3/31/21)
31-Mar										
2021 April		*Commission Meeting 4/8/2021*								
26-28 April	HAKKARAINEN, Timo W., MD	BC- Surgery	M2019-877	Katharine Brindley Michelle Q. Pham	Bahm	Wolf	A	Kavanaugh	TBD	
2021 May		*Commission Meeting 5/14/2021*								
14-May	RUSSELL, Trent J., PA-C	Physician Asst.	M2020-687	Connie Elkins McKelvey	Pfluger	Berg	B	Blye	TBD	
14-May	GREEN, Roland H., MD	Non-BC Self designated Internal Medicine	M2020-1037	Pro Se	Bahm	Karinen	A	Herington	TBD	
2021 June		*NO COMMISSION MEETING THIS MONTH*								
2-3 Jun	HARRIS, Anthony E., MD	BC- Neurological Surgery	M2020-711	Deanna Bui Scott O'Halloran	Defreyn	Wolf	B	Herington	TBD	
18-Jun	HADUONG, Quan, MD	BC-Anesthesiology	M2020-495 M2020-657	Adam Snyder Mallory Barnes-Ohlson	Defreyn	Page Landstrom	L	Herington	TBD	
28-Jun	LU, Kang, MD	Non-BC Self-designated Radiology	M2019-822	Pro Se	Defreyn	Karinen	A	Kavanaugh	TBD	
2021 July		*Commission Meeting 7/8/2021*								
12-Jul	ANDERSON, Jodee M., MD	Non-BC Self designated Neonatal/Perinatal Medicine	M2019-1000	Connie McKelvey	Bahm	Wright	A	Herington	TBD	
21-23 Jul	JACKSON, George F., MD	BC- Psychiatry	M2019-365	James B. Meade, II	Brewer	Wolf	B	Blye	TBD	
2021 August		*Commission Meeting 8/19/2021*								
2-6 Aug	BRECHT, Kristine S., MD	BC - Family Medicine	M2019-94	Ketia B. Wick	Anderson	Wolf	B	Wareham	TBD	Golden; Hopkins;
5-6 Aug	DE, Monya, MD	Non-BC Self designated Internal Medicine	M2020-396	Mark Kimball Farnoosh Faryabi	Pfluger	Little	B	Donlin	TBD	
13-Aug	WOLIN, Jessica A., MD	BC-Anesthesiology	M2020-699	Pro Se	Bahm	Karinen	A	Kuntz	TBD	
23-25 Aug	KIM, Jeong H., MD	BC- Internal Medicine	M2019-699	Jennifer M. Smitrovich	Bahm	Page Landstrom	A	Kavanaugh	TBD	
25-27 Aug	LEE, Gerald	BC-Anesthesiology	M2020-699	Pro Se	Bahm	Karinen	A	Kuntz	TBD	
2021 September		*NO COMMISSION MEETING THIS MONTH*								
8-Sep	BEVERLY, James M., PA	Phys. Asst.	M2019-482	Pro Se	Brewer	Berg	L	Donlin	TBD	
20-23 Sept	ATTEBERRY, Dave S., MD	Non-BC Self-designated Neurological Surgery	M2015-1151 M2020-804	Stephen M. Lamberson	Defreyn	Karinen	A	Kavanaugh	TBD	

Commission Meeting Agenda
April 8-9, 2021 – *Second Revised*

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead. The access links can be found below.

Thursday – April 8, 2021

Closed Sessions

8:00 am Case Reviews – Panel A
8:00 am Case Reviews – Panel B

Open Session

12:30 pm **Highly Reliable Organizations**
Jimmy Chung, MD, Commissioner
Please join this meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/155067101

Closed Sessions

1:30 pm Case Reviews – Panel A
1:30 pm Case Reviews – Panel B

4:00 pm Policy Committee Meeting

Please **register** for this meeting at:
https://attendee.gotowebinar.com/rt/1970281270522044171
After registering, you will receive an email containing a link that is unique to you to join the webinar.

Agenda Items	Presented By:	Page #:
Policy – Practitioners Exhibiting Disruptive Behavior *Review of revised document and possible revisions.*	Mike Farrell	23
Procedure – Panel Composition *Review of revised document and possible revisions.*	Mike Farrell	28
Procedure – Review procedure for Update!, the quarterly newsletter of the Washington Medical Commission *Periodic review and possible revisions.*	Mike Farrell	32
Board of Naturopathy position on naturopaths performing lipo-aspiration *Review and discussion of letter from the Department of Health/Board of Naturopathy.*	Mike Farrell	34
Addition: **Chapter 246-918 WAC Physician Assistants Including Implementation of Substitute House Bill 2378 Rulemaking** *Review draft language and request to initiate CR-102 process.*	Amelia Boyd	43

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Friday – April 9, 2021

Open Session

8:00 am –9:30 am **Business Meeting**

Please **register** for this meeting at:
https://attendee.gotowebinar.com/rt/1356190832269635339
After registering, you will receive an email containing a link that is unique to you to join the webinar.

1.0 Chair Calls the Meeting to Order

2.0 Housekeeping

3.0 Chair Report

4.0 Consent Agenda

Items listed under the Consent Agenda are considered routine agency matters and will be approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Business Agenda. — Action

4.1 Minutes – Approval of the March 5, 2021 Business Meeting minutes. — Pages 9-12

4.2 Agenda – Approval of the April 9, 2021 Business Meeting agenda.

5.0 Old Business

5.1 **Committee/Workgroup Reports** — Update
The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 13.

See page 15 for a list of committees and workgroups.

5.2 **Nominating Committee** — Action
Announcement of candidates. The election for leadership will take place at the May 14, 2021 Business Meeting.

5.3 **Rulemaking Activities** — Update
Rules Progress Report provided on page 18.

5.4 **Lists & Labels Request** — Action
The Commission will discuss the requests received for lists and labels, and possible approval or denial of these requests. Approval or denial of these applications is based on whether the requestor meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- RussoCME — Pages 19-22

6.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment during this time, please limit your comments to two minutes. Please identify yourself and who you represent, if applicable, when the Chair opens the floor for public comment.***

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7.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on April 8, 2021. See the Policy Committee agenda on page 1 of this agenda for the list of items to be presented.

Report/Action Begins on page 23

8.0 Member Reports

The Chair will call for reports from Commission members.

9.0 Staff Member Reports

The Chair will call for further reports from staff.

Written reports begin on page 35

10.0 AAG Report

Heather Carter, AAG, may provide a report.

11.0 Adjournment of Business Meeting

Open Sessions

9:45 am	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/243475405	Page 41
9:45 am	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 42

Closed Sessions

Noon to 1:00 pm Lunch Break

Open Sessions

1:15 pm	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/243475405	Page 41
1:15 pm	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 42

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (Commission) meetings. This agenda is subject to change. The Policy Committee Meeting will begin at 4:00 pm on April 8, 2021 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting. The Business Meeting will begin at 8:00 am on April 9, 2021 until all agenda items are complete. The Commission will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Business Meeting Minutes
March 5, 2021

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Virtual Meeting via GoToWebinar

Commission Members

James E. Anderson, PA-C
Christine Blake, Public Member
Toni Borlas, Public Member
Charlie Browne, MD
Jimmy Chung, MD, 2nd Vice Chair
Diana Currie, MD
Karen Domino, MD
April Jaeger, MD
Charlotte Lewis, MD
John Maldon, Public Member, Chair
Terry Murphy, MD
Alden Roberts, MD
Scott Rodgers, JD, Public Member
Theresa Schimmels, PA-C
Robert Small, MD
Claire Trescott, MD, 1st Vice Chair
Richard Wohns, MD
Yanling Yu, PhD, Public Member

Commission Staff

Christine Babb, Investigator
Colleen Balatbat, Staff Attorney
Jennifer Batey, Legal Support Staff Manager
Larry Berg, Staff Attorney
Amelia Boyd, Program Manager
Reneé Bruess, Investigator
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Adam Calica, Chief Investigator
Sarah Chenvert, Performance Manager
Gina Fino, MD, Investigator
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Mike Hively, Information Liaison
Jenelle Houser, Legal Assistant
Kyle Karinen, Staff Attorney
Becca King, Administrative Assistant
Richelle Little, Staff Attorney
Stephanie Mason, Legislative Liaison & PIO
Melissa McEachron, Director of Operations & Informatics
Joe Mihelich, Health Services Consultant
Freda Pace, Director of Investigations
Ariele Page Landstrom, Staff Attorney
Trisha Wolf, Staff Attorney

Others in Attendance

Chris Bundy, MD, Executive Medical Director, Washington Physicians Health Program
Heather Carter, Assistant Attorney General
Mary Curtis, MD, Pro Tem Commissioner
Katerina LeMarche, Washington State Medical Association
Gregory Terman, MD, Pro Tem Commissioner

1.0 Call to Order

John Maldon, Public Member, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:00 a.m. on March 5, 2021.

2.0 Housekeeping

Amelia Boyd, Program Manager, gave an overview of how the meeting would proceed.

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3.0 Chair Report

Mr. Maldon gave an overview of a recent meeting he; Melanie de Leon, Executive Director; and Stephanie Mason, Legislative Liaison & Public Information Officer, had with the leadership team at the Washington State Medical Association (WSMA).

Mr. Maldon reported that the Executive Committee began a pilot program to provide the Commissioners with laptop furnished by the Commission. This program is in an effort to reduce the technical issues for Commissioners.

He reported that there will be a strategic plan for 2021-2023 for the Commission as a whole as well as for the Commissioners.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Minutes from the January 15, 2021 Business Meeting.
4.2 Agenda for March 5, 2021.

***Motion**:* The Chair entertained a motion to approve the Consent Agenda. The motion was seconded and approved unanimously.

5.0 New Business

5.1 Ethics for Commission Members

Heather Carter, AAG, provided a refresher training on ethics.

5.2 Structure of Future Meetings

The Commissioners discussed how future meetings may be structured once the Governor's restrictions on gatherings are lifted. Ms. de Leon announced that at this time, the annual Educational Conference held in October will be held in person.

6.0 Old Business

6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet.

Ms. de Leon announced that Commissioner Diana Currie, MD was selected to serve on the Federation of State Medical Boards ad-hoc task force on health equity and medical regulation.

6.2 Nominating Committee

Mr. Maldon announced the members:

- Christine Blake, Public Member
- Karen Domino, MD
- Alden Roberts, MD

The Committee will announce the slate of candidates at the April 9, 2021 Business meeting.

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6.3 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. Ms. Boyd reported there are seven workshops to be held beginning in April and ending in June.

6.4 Lists & Labels Request

The following lists and labels request were discussed for possible approval or denial. Approval or denial of these requests is based on whether the entity meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- Pierce County Medical Society

  Motion: The Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

7.0 Public Comment

There were no public comments.

8.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on March 4, 2012:

Policy – Practitioners Exhibiting Disruptive Behavior

Dr. Domino explained that this document was presented at a previous meeting. It was deferred for additional edits. She explained what the amendments were and stated that the Committee recommended approval of this document with those amendments.

Motion: The Chair entertained a motion to approve the policy with the noted revisions. The motion was approved unanimously.

Procedure – Panel Composition

Dr. Domino lost connection with the meeting at this point. Instead, Mike Farrell, Policy Development Manager reported that the Committee had several suggested revisions and so it will be brought back at a future meeting. Mr. Farrell asked if anyone had suggestions for this document to send them to him.

Policy – Self-Treatment or Treatment of Immediate Family Members

Mr. Farrell explained that this document was due for its four-year review. He reviewed one change that was made from the previous version. He stated that the Committee recommended approval of the policy with the noted revision.

Motion: The Chair entertained a motion to approve the policy with the noted revisions. The motion was approved unanimously.

Policy – Self-Treatment or Treatment of Immediate Family Members

Mr. Farrell explained that this document was due for its four-year review. He gave some background on the policy. He stated that the Committee recommended approval of the policy.

Motion: The Chair entertained a motion to approve the policy. The motion was approved unanimously.

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8.0 Member Reports

Robert Small, MD, reported that in the background of the COVID pandemic there has also been a mental health and substance use disorder pandemic. He stated he wanted to bring awareness to these significant issues.

Jimmy Chung, MD, stated that in his facility they have seen a significant decrease in the number of positive flu tests compared to previous year's data. He stated that social distancing, hand hygiene, and masking has contributed to this decrease.

Richard Wohns, MD, stated that there is a lag of a week or two, sometimes more, when counties begin implementing CDC's changes to COVID procedures for national implementation.

Yanling Yu, PhD, Public Member, reported that the Washington Patient Safety Coalition will partner with the Washington State Medical Association and Washington State Hospital Association to host a diagnostic excellence webinar series.

Scott Rodgers, Public Member, commented on the significant decrease in the number of pediatric deaths related to the flu.

9.0 Staff Reports

The reports below are in addition to those available in the packet.

Melanie de Leon, Executive Director expanded on Mr. Maldon's report about the meeting with WSMA. She added that staff will be meeting with WSMA's leadership team on a monthly basis to discuss issues, priorities, and collaborations. Additionally, WSMA's team would like the WMC to provide more transparency into the WMC's processes. To meet this ask, Ms. de Leon will do a series of articles in the WMC's quarterly newsletter discussing those processes.

10.0 AAG Report

Heather Carter, AAG, had nothing to report.

11.0 ADJOURNMENT

The Chair called the meeting adjourned at 9:27 am.

Submitted by

Amelia Boyd, Program Manager

John Maldon, Public Member, Chair
Washington Medical Commission

Approved April 9, 2021

Committee/Workgroup Reports: April 2021

Reduction of Medical Errors Workgroup – Chair: Dr. Chung Staff: Mike Farrell
John Maldon, Jimmy Chung, MD, and Mike Farrell presented a webinar on March 25 on the Commission's support for Communication and Resolution Programs, and the certification process. The committee is due to meet to go over its guideline and statement of understanding with the Foundation for Health Care Quality.

Annual Educational Conference Workgroup – Chair: Toni Borlas Staff: Jimi Bush
We are continuing to provide CME for our licensees via Webinar. All events are recorded and available on demand for Category 1 CME credit on our webpage. Please let Jimi know if you have a suggestion for an upcoming CME webinar topic. We are looking at the feasibility of holding an in-person conference in October. There is still uncertainty about the ability to secure a physical location. I will keep you updated, but if you have any ideas for a theme for the 2021 conference, please let me know. Ms. Schimmels is scheduled to leave the commission this summer. If you are interested in becoming part of the conference planning workgroup, please let me know.

Commissioner Education Workgroup – Chair: None at this time Staff: Melanie de Leon
Nothing to report

Osteopathic Manipulative Therapy Workgroup – Chair: None at this time Staff: Micah Matthews
Workgroup will reconvene after 2021 legislative session to consider any legislative or policy impacts.

Office-Based Surgery Rules Workgroup – Chair: Dr. Domino Staff: Mike Farrell
Meeting scheduled for Tuesday, May 18 at 1:30 pm.

Health Equity Advisory Committee – Chair: Dr. Jaeger Staff: Jimi Bush
We have not received comments that require approval from the policy committee at this time. There has been minimal participation recently. We decided to change the format from a monthly public meeting to a quarterly meeting for the remaining lifespan of the committee. All remaining policies/rules/etc. will be open for written comment at any time through the end of the committee lifespan. More information is available on the committee webpage.

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Melanie de Leon
Met with two members of workgroup in March and developed to-do list. Staff will review what metrics DOH is currently capturing such as health equity maps by county; research community organizations that are currently helping individuals overcome healthcare disparities, such as expectant mother groups. Staff is researching what is already being done to mitigate disparities to determine gaps and where the WMC can assist. Once this research is complete, we will schedule another meeting of the workgroup to determine next steps.

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Executive Committee
John Maldon, Public Member, Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Dr. Domino, Policy Committee Chair
Dr. Roberts, Immediate Past Chair
Melanie de Leon
Micah Matthews
Heather Carter, AAG

Policy Committee
Dr. Domino, Chair (B)
Dr. Roberts (B)
Christine Blake, Public Member (B)
Jim Anderson, PA-C (A)
John Maldon, Public Member (B)
Scott Rodgers, Public Member (A)
Heather Carter, AAG
Melanie de Leon
Mike Farrell
Amelia Boyd

Newsletter Editorial Board
Dr. Currie
Dr. Chung
Dr. Wohns
Jimi Bush, Managing Editor
Micah Matthews

Legislative Subcommittee
Dr. Roberts, Chair
John Maldon, Public Member
Dr. Terman, Pro Tem Commissioner
Christine Blake, Public Member
Dr. Wohns
Melanie de Leon
Micah Matthews

Panel L
John Maldon, Public Member, Chair
Dr. Browne
Dr. Roberts
Christine Blake, Public Member
Dr. Chung
Theresa Schimmels, PA-C
Dr. Trescott
Dr. Barrett, Medical Consultant
Marisa Courtney, Licensing Supervisor
Ariele Page Landstrom, Staff Attorney
Micah Matthews

Finance Workgroup
Dr. Roberts, Immediate Past Chair, Workgroup Chair
John Maldon, Current Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Melanie de Leon
Micah Matthews
Jimi Bush

Annual Educational Conference Workgroup
Toni Borlas, Chair
Theresa Schimmels, PA-C
Dr. Domino
Jimi Bush, Organizer

Commissioner Education Workgroup
Dr. Domino
Dr. Chung
Dr. Roberts
Toni Borlas, Public Member
Scott Rodgers, Public Member
Dr. Terman, Pro Tem Commissioner
Melanie de Leon
Amelia Boyd
Jimi Bush

Updated: February 23, 2021

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Reduction of Medical Errors Workgroup
Dr. Chung, Chair
John Maldon, Public Member
Dr. Roberts
Dr. Domino
Dr. Jaeger
Christine Blake, Public Member
Scott Rodgers, Public Member
Melanie de Leon
Mike Farrell

Osteopathic Manipulative Therapy Workgroup
Dr. Roberts
Dr. Currie
John Maldon, Public Member
Micah Matthews
Michael Farrell
Amelia Boyd
Heather Carter, AAG

Health Equity Workgroup
Dr. Jaeger, Co-Chair
Dr. Roberts, Co-Chair
Yanling Yu, Public Member
Micah Matthews
Jimi Bush
Anjali Bhatt

Office-Based Surgery Rules Workgroup
Dr. Domino
Dr. Roberts
John Maldon, Public Member
Mike Farrell
Ariele Page Landstrom
Melanie de Leon
Amelia Boyd

Healthcare Disparities Workgroup
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, Public Member
Melanie de Leon

Collaborative Drug Therapy Agreements Rulemaking Committee
Dr. Roberts, Chair
Dr. Chung
Dr. Small
John Maldon, Public Member
Tim Lynch, PQAC Commissioner
Teri Ferreira, PQAC Commissioner
Melanie de Leon
Micah Matthews
Kyle Karinen, Staff Attorney
Amelia Boyd
Heather Carter, AAG
Laruen Lyles, Executive Director, PQAC
Christie Strouse, Deputy Director, PQAC
Lindsay Trant, DOH Rules Coordinator

PQAC E-prescribing Rulemaking Committee
Christine Blake, Public Member
Dr. Browne
Dr. Small
Melanie de Leon
Amelia Boyd
TBD, Staff Attorney
Heather Carter, AAG

Stem Cells Rulemaking Committee
TBD, Chair
TBD
Yanling Yu, Public Member
Micah Matthews
Mike Farrell
Amelia Boyd
Heather Carter, AAG

Committees & Workgroups

WASHINGTON Medical Commission
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Opioid Prescribing – Patient Exemptions Rulemaking Committee
Dr. Roberts, Chair
Dr. Small
Dr. Terman, Pro Tem Commissioner
James Anderson, PA-C
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

Telemedicine Rulemaking Committee
Christine Blake, Public Member, Chair
Toni Borlas, Public Member
Dr. Small
Dr. Roberts
Dr. Lewis
Dr. Wohns
Dr. Jaeger
Dr. Lisa Galbraith, BOMS
Dr. Kim Morrissette, BOMS
Micah Matthews
Stephanie McManus
Mike Farrell
Amelia Boyd
Tracie Drake, Program Manager, BOMS

PA Chapter 246-918 WAC & HB 2378 Rulemaking Committee
James Anderson, PA-C, Chair
Theresa Schimmels, PA
TBD, Public Member
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

SB 6551 – IMG Licensing Rulemaking Committee
TBD, Chair
TBD
TBD, Public Member
Micah Matthews
Ariele Landstrom, Staff Attorney
Marisa Courtney, Licensing Supervisor
Dawn Thompson
Becca King
Stephanie Mason
Rick Glein, Staff Attorney
Amelia Boyd
Heather Carter, AAG

Please note, any committee or workgroup that is doing any stakeholder work or getting public input must hold open public meetings.

WMC Rules Progress Report								Projected filing dates		
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**Submitted to RMS**	**SBEIS Check**	**CR-101**	**CR-102**	**CR-103**
Clinical Support MDs & PAs (formerly Technical Assistance)	Commission approved rescinding CR-102	1/17/2020	One more workshop	TBD	Keep Osteo updated.			Complete	TBD	TBD
Telemedicine	CR-101 filed	9/17/2019	Workshops	TBD	Keep Osteo updated.			Complete	TBD	TBD
Stem Cells	CR-101 Filed	4/21/2020	Workshops	TBD	Keep Osteo updated.			Complete	TBD	TBD
Opioid Prescribing - LTAC, SNF patient exemption	CR-101 filed	3/26/2020	Workshops	TBD				Complete	January 2021	April 2021
Collaborative Drug Therapy Agreements (CDTA)	CR-101 filed	7/22/2020	Workshops	TBD				Complete	January 2022	April 2022
Emergency Licensing Rules	Secretary Review	3/26/2020	File CR-105	TBD	Holding until proclamation is lifted.					
Chapter 246-918 WAC & HB 2378	CR-101 filed	11/19/2020	Workshops	April 2021	Collaborate with Osteo on HB 2378			Complete	June 2021	September 2021
SB 6551 - IMG licensing	CR-101 filed	8/6/2020	Workshops	TBD				Complete	July 2021	December 2021

Updated: 3/24/2021

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - Provides continuing education for health care professionals.

☐ We are a "professional association" ☒ We are an "educational organization."

Melissa Neighbors	509-431-0718	Russocme@gmail.com
Primary Contact Name ⮥	Phone ⮥	Email ⮥
		Www.russocme.com
Additional Contact Names (Lists are only sent to approved individuals) ⮥		Website URL⮥
RussoCME	30-0598736	
Professional Assoc. or Educational Organization ⮥	Federal Tax ID or Uniform Business ID number ⮥	
225 NW Thomas St	Pullman, WA 99163	
Street Address ⮥	City, State, Zip Code ⮥	

We will be mailing out Continuing Medical Education Brochures

1. How will the lists be used? ⮥

MD, DO, PA, NP, ND, DC, PT, RN, LPN, Psychologist, OD

2. What profession(s) are you seeking approval for? ⮥

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Email to: PDRC@DOH.WA.Gov
Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
Fax to: PDRC - 360-586-2171

Melissa Neighbors — March 16, 2021

Signature ⮥ Date ⮥

If you have questions, please call (360) 236-4836.

For Official Use Only

Approved: _____ (5-year) _____ (one-time)

Denied: _____

Authorizing Signature: _____

Printed Name: _____

Title: _____ Date: _____

The Colorado Medical Society

certifies that

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has fulfilled the accreditation requirements for

Accreditation

set forth by the Accreditation Council for Continuing Medical Education and is hereby accredited as a provider of continuing medical education for physicians

Date awarded August 31, 2019
Date of expiration, August 31, 2023

Signed _____
President, Colorado Medical Society

Signed _____
Chair, Professional Education and Accreditation Committee

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Conference will be held live on Zoom. Participants will be emailed a join link the week of the course.

Accreditation

- This live activity is accredited for 15 AMA PRA Category 1 Credits.™*
- 15 MOC points for the ABIM MOC Program
- Application for prescribed credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.
- Approved for a total of 5 NP Pharmacology hours. (Fri.-3 & Sat. - 2)
- Approved by Washington State Board of Pharmacy for 15 Pharmacist CE Hours.
- Washington State accepts AMA PRA Category 1 Credits for NP's & PA's
- ANCC accepts these credits as equivalent credits for recertification.
- 15 CE contact hours for Washington State Nursing Commision.

Questions

Melissa Neighbors

russocme@gmail.com or 509-431-0718

Faculty Speakers

Erin Bauer, MD
Board Cert: Rheumatology & Internal Medicine
Virginia Mason Medical Center
Seattle, WA

Edward Bilsky, PhD
PhD - Pharmacology
Pacific Northwest University
Yakima, WA

Steven Fowler, MD
Board Cert: PM&R
Confluence Health Wenatchee Campus
Wenatchee, WA

Andrew Friedman, MD
Board Cert: Anesthesia, PM&R - subspecialty PainManagement
Fellow - PM&R
Fellow - Electric Diagnostic Medicine
Virginia Mason Medical Center
Seattle, WA

Atul Gupta, MD
Board Cert: PM&R
Virginia Mason Medical Center
Seattle, WA

Guy Jones, MD
Board Cert: Radiation Oncology
Tri Cities Cancer Center
Kennewick, WA

Casey Kirkham, PT, DPT
Oasis Physical Therapy
Richland, WA

Katie Krause, MD, PhD
Board Eligible: Neurological Surgeons
Virginia Mason Medical Center
Seattle, WA

Philip Louie, MD
Board Eligible: Orthaepedic Surgery
Virginia Mason Medical Center
Seattle, WA

Irene Luc DPT, OCS, TPS, A-RSP
Board Cert: Orthopedic Clinical Specialist
Certified Anxiety Rehabilitation Service Provider
Mind Door, LLC and Therapy Solutions
Kennewick, WA

Lucas McCarthy, MD
Board Cert: Neurology
Virginia Mason Medical Center
Seattle, WA

Michael Pylman, MD
Board Cert: Pain Management
Lynx Healthcare
Albuquerque, New Mexico

Raymond Quock, PhD
PhD - Pharmacology
Washington State University
Pullman, WA

Nigel Sparks, MD
Board Cert: Orthopedic Surgery
Virginia Mason Medical Center
Seattle, WA

James Stevens, DMD
Stevens Health Alliance
Sunnyside, WA

* This live activity has been planned and implemented in accordance with accreditation requirements and policies of the Colorado State Medical Society through the joint providership of Gritman Medical Center and RussoCME. Gritman Medical Center is accredited by the Colorado State Medical Society to provide Continuing Medical Education for physicians. This educational activity is designated for a maximum of 15 hours of AMA PRA Category 1 Credits.

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Tri-Cities Pain Conference

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Continuing Medical Education

May 14 & 15, 2021

Early Registration : April 16
Regular Registration: May 5, 2021

www.RussoCME.com

Friday, May 14, 2021

7:30AM Registration/Exhibits

7:50AM Introduction

8:00AM Pain, Opioids and Addiction 2021
Andrew Friedman, MD
- Recent Trends in Opioid use and Regulation in WA State
- Best-Practices in Managing Chronic Opioid Therapy
- Office-Based Options for Management of Emerging opioid-use disorder

9:00AM Evaluation and Treatment of the Painful Knee
Nigel Sparks, MD
- Basic anatomy of the knee
- Examination and differential of knee pain
- Early treatment options for knee pain

10:00 AM Break/Exhibits

10:20AM Pandemics, Epidemics and Health Crises: Navigating Opioids, Pain Management & Substance Use Disorder
Edward Bilsky, PhD
- Impact of the pandemic on management of chronic disease
- Strategies to mitigate the impact of the pandemic & improve care • Filter disinformation from accurate information and uncertainty

11:20AM Platelet Rich Plasma Use in Musculoskeletal Care
Atul Gupta, MD
- Understand the current evidence based around the use of platelet rich plasma in musculoskeletal care
- How does platelet rich plasma work?

12:20PM Lunch Break/Exhibits

1:15 PM Review of Neuropathic Pain Syndromes
Katie Krause, MD, PhD
- Trigeminal Neuralgia • Glossopharyngeal Neuralgia
- Occipital Neuralgia

2:15 PM It's Not Too Late Too Start...Rules to live by for a Healthy Spine | **Steven Fowler, MD**
- Discuss proper ergonomics
- Discuss proper nutrition
- Discuss the biopsychosocial model of pain

3:15 PM Afternoon Break/Exhibits

3:30 PM Facet Mediated Pain
Michael Pylman, MD
- Pathophysiology
- Assessment and Treatment

4:30 PM Diagnosis & Management of Neuropathic Pain
Lucas McCarthy, MD
- Understand common neuropathic pain etiologies
- Differentiate neuropathic from musculoskeletal and visceral pain • Understand risks and benefits of guidelines based neuropathic pain medication and non-medication management

5:30 PM Conference Adjourned

Saturday, May 15, 2021

7:30AM Registration/Exhibits

7:50AM Introduction

8:00AM Cancer Pain
Guy Jones, MD
- Identify the most common cancer pain scenarios
- Recognize initial steps to address cancer-related pain
- Learn a radiation oncologist's role in cancer care

9:00AM Pharmacology of Opioids
Raymond Quock, PhD
- Describe the mechanism of action of Opioid drugs
- Describe the pharmacological and toxicological properties of opioids.
- Describe the consequences of long-term treatment with opioid painkillers

10:00 AM Break/Exhibits

10:20AM The TMJ & Bruxism Connection to Balance and CranioFacial Pain
James Stevens, DMD
- Etiology and sequela of bruxism
- The ramifications of Bruxism related to TMJ Balance.
- Dynamics of the OrthoGnathic / CranioMandibular complex
- A resolution to TMJ related pain

11:20AM Inflammatory Arthritis
Erin Bauer, MD
- Initial presentation and differential of autoimmune and inflammatory arthritis
- Initial work up for autoimmune arthritis
- Consider initial treatment options

12:20 PM Lunch Break/Exhibits

1:15 PM From the Weekend Warrior to the Professional Athlete: The Evaluation, Diagnosis, and Treatment of Injuries to the Spine
Philip Louie, MD
- Common injuries that occur during athletic endeavors
- Conversations and plan for "return to play" or return to "activities" • Identify concerning signs and symptoms that warrant additional workup and concern

2:15 PM Afternoon Break/Exhibits

2:30 PM The Role of Diagnostic Testing in Physical Therapy Practice
Casey Kirkham, PT, DPT
- Overview of the use of diagnostic testing in physical therapy
- Clinical examples of EMT and musculoskeletal ultrasound

3:30 PM Anxiety and Chronic Pain: A Somatosensory & Neuroscience Approach | **Irene Luc, DPT, OCS**
- Physiology and neurobiology of anxiety and other emotions and how they relate to chronic pain.
- How somatosensory & applied neuroscience can be combined with physical therapy for reducing anxiety related to pain.

4:30 PM Conference Ends

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Registration Information

Complete and mail in the attached registration form or

Register online at www.russocme.com

- **Early Registration** must be post marked by April 16
- **Regular Registration** must be post marked by May 5
- **Day of Registration available**. Additional $20 for registration day of or after May 5th. For day of registration, link to conference page will be online at russocme.com

Cancellations: All cancellations need to be emailed to Melissa at russocme@gmail.com on or before May 9th. There will be a $50 administration fee withheld. Cancellations between May 10th and May 13th: You can send someone in your place or transfer to another conference with in 12 months. Course is planned to be recorded and accredited, option to watch course after the live event for credits. No refunds once the conference begins.

Cut here

Registration Form

Tri-Cities Pain Conference

Please print legibly. Receipts will be e-mailed.

Name:_____

Degree:_____ Specialty:_____

Address:_____

City/State/Zip:_____

Phone:_____

E-mail_____

Clinic Name:_____

Clinic City:_____

Walk in registration available. An Additional $20 will be charged if post marked after May 5, 2020.

Regular Registration Due: May 5, 2021

Circle Selection	MD / DO	NP/PA	RN/Allied Health*
Complete Conference	$405	$380	$255
Friday Only	$265	$235	$165
Saturday Only	$265	$235	$165

*PT, DC, OD, PharmD, ND, Other **Students $75 a day

Early Registration Due: April 16, 2021

Circle Selection	MD / DO	NP/PA	RN/Allied Health*
Complete Conference	$390	$365	$240
Friday Only	$250	$220	$150
Saturday Only	$250	$220	$150

Please make checks payable to RussoCME
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State of Washington
Washington Medical Commission

Policy

Title:	Practitioners Exhibiting Disruptive Behavior		MD2021-0x
References:	N/A		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	Medical.commission@wmc.wa.gov
Effective Date:			
Supersedes:	MD2012-01		
Approved By:	John Maldon, Chair (signature on file)		

Background

Most physicians and physician assistants enter the field of medicine for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of practitioners carry out their duties with high levels of professionalism and recognize that quality care requires teamwork, communication and a collaborative work environment. However, several studies show that behavior that impedes teamwork and communication, and interferes with patient care—often referred to as disruptive behavior—may be prevalent in somewhere between 1 and 5% of practitioners. [1]

Disruptive behavior has been defined as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[2] Disruptive behavior comprises a wide variety of behaviors including overt actions such as verbal outbursts and physical threats, as well as passive activities such as failing to respond to repeated calls, not performing assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.[3] A list of examples of disruptive behavior can be found in appendix A.

Disruptive behavior interferes with the ability to work with other members of the health care team, disrupts the effectiveness of team communication, and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events.[4] The consequences of disruptive behavior include job dissatisfaction for physicians, nurses and other staff; voluntary turnover; increased stress; patient complaints; malpractice suits; medical errors; and compromised patient safety.

Disruptive behavior is not a diagnosis and should not be used to label a practitioner who has an occasional reaction out of character for that individual. The disruptive label should refer to a pattern of inappropriate behavior that is deep-seated, habitual, and pervasive.[5]

Disruptive behavior may be a sign of an illness or a condition that may affect clinical performance. Studies have shown that some physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of psychiatric disorders and medical disorders with significant psychiatric symptoms, most of which were treatable.[6] Referral for evaluation of impairment can identify health conditions, distress and other psychosocial factors that may be contributing to the disruptive behavior. If this is the case, an effective treatment and monitoring plan may resolve the disruptive behavior.[7] On the other hand, ruling-out impairment can provide reassurance in proceeding with progressive remediation. The Washington Physicians Health Program accepts referrals for disruptive behavior and will tailor its approach and recommendations based on the presence or absence of an impairing health condition.

When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment, education, a systems approach and a strong aftercare program.[8] The Joint Commission has developed a leadership standard that requires leaders to develop a code of conduct that defines behaviors that undermine a culture of safety, and to create and implement a process for managing such behaviors.[9] Psychiatrist Norman Reynolds, MD, has developed a set of strategies to manage this behavior and provides advice on the construction of medical staff policies and a program of remediation.[10]

While organizations may be the best place to address disruptive behavior, state medical boards may also play a role when the behavior is brought to their attention. The Federation of State Medical Boards recommends that legislatures amend the practice acts of state medical boards to include disruptive behavior as a grounds for disciplinary action, explaining that it is imperative that state medical boards have the power to investigate complaints of disruptive behavior and to take action to protect the public.[11]

The Commission has taken disciplinary action against several practitioners who exhibited disruptive behavior. In some cases, the basis for the action is that the conduct constitutes unprofessional conduct under RCW 18.130.180(4) because it is negligence that creates an unreasonable risk that a patient may be harmed. The Commission has also taken action under RCW 18.130.180(1) when it deemed that the conduct amounted to acts of moral turpitude relating to the profession.

In one case, the Commission took action against a physician engaging in disruptive behavior under RCW 18.130.170(1) on the theory that the practitioner had a mental condition that prevented him from practicing with reasonable skill and safety. The Washington State Court of Appeals, in a published opinion issued in 2017, upheld the Commission order imposing discipline for disruptive behavior, favorably citing the Commission's prior policy on disruptive behavior, and rejecting the respondent's argument that a diagnosable mental condition was required to proceed under RCW 18.130.170(1).[12]

Policy

The Commission considers disruptive behavior to be a threat to patient safety. If the Commission receives a complaint or report that a practitioner has engaged in disruptive behavior, the Commission may investigate a complaint and, if warranted, take disciplinary action against the practitioner to protect the public.

Disciplinary action may be based on the belief that the disruptive behavior constitutes unprofessional conduct under RCW 18.130.180(4)(negligence that creates an unreasonable risk of harm), RCW 18.130.180(1) (moral turpitude relating to the profession) or another subsection of RCW 18.130.180.

The Commission may also issue a statement of charges under RCW 18.130.170(1) if there is evidence that the practitioner is unable to practice with reasonable skill and safety due to a mental or physical condition. This statute does not require that the practitioner have a diagnosable mental condition under the DSM-.[13]

If the Commission is unsure whether the practitioner has a mental or physical condition that may impact his or her ability to practice with reasonable skill and safety, the Commission may choose to order the practitioner undergo a mental or physical examination under RCW 18.130.170(2). The results of such an examination may provide evidence to support a statement of charges under RCW 18.130.170(1). The Commission is aware that if a practitioner denies engaging in disruptive behavior, an evaluation under RCW 18.130.170(2) is particularly challenging, if not impossible, for the evaluator. In most cases, the preferred option is to issue a statement of charges under RCW 18.130.180 on the theory that the disruptive behavior constituted unprofessional conduct.

The Commission may refer the practitioner to the Washington Physician Health Program at any point in the process, beginning with making a recommendation during the initial investigation up to imposing a requirement in a disciplinary order.

Appendix A

Examples of disruptive behavior include, but are not limited to, the following:

Aggressive behaviors:

- Yelling
- Foul and abusive language
- Threatening gestures
- Public criticism of coworkers
- Insults and shaming others
- Intimidation
- Invading one's space
- Slamming down objects
- Physically aggressive or assaultive behavior

Passive-aggressive behaviors:

- Hostile avoidance or the "cold shoulder" treatment
- Intentional miscommunication
- Unavailability for professional matters, e.g., not answering pages or delays in doing so
- Speaking in a low or muffled voice
- Condescending language or tone
- Impatience with questions
- Malicious gossip
- Racial, gender, sexual, or religious slurs or "jokes"
- "Jokes" about a person's personal appearance, e.g., fat, skinny, short, ugly
- Sarcasm
- Implied threats, especially retribution for making complaints[14]

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[1] Williams, B. W., and Williams M.V. The Disruptive Physician: A Conceptual Organization, *Journal of Medical Licensure and Discipline.* 2008; 94(3):13.

[2] Lang, D., and others. *The Disabled Physician: Problem-Solving Strategies for the Medical Staff.* Chicago, Ill.: American Hospital Publishing, Inc., 1989. *See also* Neff, K., Understanding and Managing Physicians with Disruptive Behaviors, pp. 45 – 72 (2000).

[3] The Joint Commission. Behaviors that undermine a culture of safety. *Joint Commission Sentinel Event Alert.* 2008; issue 40 (updated September 2016).

[4] *Id*.

[5] Reynolds, N., "Disruptive Physician Behavior: Use and Misuse of the Label, Journal of Medical Regulation, Vol. 98, No. 1, p. 9-10 (2012).

[6] Williams and Williams, p. 14.

[7] Reynolds, p. 19.

[8] Williams and Williams, p. 17.

[9] The Joint Commission, Leadership Standard Clarified to Address Behaviors that Undermine a Safety Culture. *See also* Reynolds at pp. 14-17 for an excellent discussion of strategies for managing disruptive behavior.
[10] Reynolds, pp 14-19.
[11] Federation of State Medical Boards. *Report of Special Committee on Professional Conduct and Ethics.* 2000. https://www.fsmb.org/siteassets/advocacy/policies/report-of-the-special-committee-on-professional-conduct-and-ethics.pdf
[12] *Neravetla v. Department of Health*, 198 Wn. App. 647, 394 P.2d 1028 (2017).
[13] *Id*.
[14] This list comes from Reynolds, p. 9.

Panel Composition

Purpose

This document establishes a procedure for assembling a panel of Commission members to make disciplinary decisions. RCW 18.130.050(18) permits a board or commission to establish panels of at least three members to make a disciplinary decision. RCW 18.130.060(2) permits a board or commission to request the Secretary to appoint *pro tem* members to participate as members of a panel, but requires the chairperson of a panel to be a regular member of the board or commission. Consistent with this statute, a reference to a "regular" member of the Commission in this procedure means a current Governor-appointed member of the Commission. The procedure is organized according to the disciplinary decision being made.

Procedure

Decision to Authorize an Investigation

The Commission convenes a panel every week to review complaints and decide whether to investigate the complaint or to close the complaint as "below threshold." This panel will be composed as follows:

1. The panel will consist of three or more members.
2. A majority of the panel members should be regular Commission members.
3. At least two clinical members should be on the panel.

Case Reviews

The Commission uses panels to review cases that have been investigated and to decide whether to close these cases or take informal or formal disciplinary action. This includes a panel that convenes by phone, electronically or in person to authorize the Attorney General's Office to make a motion for summary action. A case review panel will be composed as follows:

1. The panel will consist of three or more members.
2. The chairperson must be a regular Commission member.
3. The Reviewing Commission Member may present the case and make a recommendation, but will not vote.
4. If an issue in the case is whether respondent met the standard of care, at least 50% of the panel should consist of physicians or physician assistants.

Hearing on a Statement of Charges or a Notice of Decision on Application

A hearing panel[1] sits for a hearing after the issuance of a Statement of Charges or a Notice of Decision on Application. A health law judge presides and prepares the order. A hearing panel will be composed as follows:

1. The panel will consist of three or more members.
2. At least one member must be a physician or a physician assistant.
3. The chairperson must be a regular Commission member.
4. The panel should include a public member.
5. At least one member of the panel must be a regular Commission member who has served on the Commission for at least a year.
6. The Reviewing Commission Member may not sit on the panel.[2]
7. First preference will be given to Commission members who did not serve on the panel that ordered the Statement of Charges.
8. In a sexual misconduct case, the panel should include a public member and must include members of both sexes.
9. The panel may include Commission members who served on a panel that ordered a summary action or who served on a show cause panel.

Hearing on Motion for Summary Action

The Commission must convene a panel to consider a motion to take summary action against a respondent.[3] A health law judge presides and prepares the order.

A summary action panel will be composed as follows:

1. The panel will consist of three members.
2. At least one member of the panel must be a physician or physician assistant.
3. At least one member of the panel must be a regular Commission member who has served on the Commission for at least a year. The panel may include members of the panel that ordered the Statement of Charges and authorized the Attorney General's Office to make the motion for summary action.
4. The Reviewing Commission Member may not sit on the panel.

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[1] Formal hearings are governed by the RCW 34.05, RCW 18.130.100, and WAC 246-11. These laws do not address the composition of a hearing panel.
[2] RCW 18.130.050(11).
[3] Summary actions are governed by RCW 34.05.479, RCW 18.130.050(8), and WAC 246-11-300-350. These laws do not address the composition of a panel.

Show Cause Hearing

A respondent who has been summarily suspended or restricted has the right to ask a show cause panel[4] to reconsider the summary action. A health law judge presides and prepares the order. Ideally, a show cause panel will consist of the same members who served on the summary action panel. Because of the tight time constraints, it may not be possible for the summary action panel members to serve on the show cause panel.

In such a case, the show cause panel will be composed as follows:

1. The panel will consist of three members.
2. At least one member of the panel must be a physician or physician assistant.
3. A *pro tem* member must have served for at least one year as a *pro tem* member of the Commission to be eligible to serve on this panel.
4. The panel may consist of members of the panel that ordered the Statement of Charges.
5. The Reviewing Commission Member may not sit on the panel.

Hearings on Challenges to Notices of Intent to Order Mental or Physical Examinations

The Commission may issue an order requiring a respondent to undergo a mental or physical evaluation under RCW 18.130.170(2)(a). To begin the process, the Commission issues a Notice of Intent to Order Mental or Physical Examination. A respondent may challenge the Notice of Intent by submitting a written response and relevant documents. The statute provides that a panel of the Commission that has "not been involved with the allegations against the license holder" will review the respondent's written material and decide whether the examination is justified. A health law judge presides and prepares the order.

A panel reviewing a challenge to a Notice of Intent will be composed as follows:

1. The panel will consist of three members.
2. A *pro tem* member must have served at least one year as a *pro tem* member of the Commission.
3. No panel member who voted to issue the Notice of Intent to Order Mental or Physical Examination can serve on this panel, in accordance with RCW 18.130.170(2)(b). This may eliminate any person who is on the same panel as the Reviewing Commission Member.
4. The Reviewing Commission Member may not sit on the panel.

Hearings on a Petition for Modification or Termination of an Order and on a Petition for Reinstatement of a License

When a respondent petitions for a modification or termination of an order, or reinstatement of a license, a panel convenes to consider the petition. A health law judge *may* preside and prepare the order. A panel considering a petition for a modification or termination of an order or a petition for reinstatement of a license will be composed as follows:

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[4] RCW 18.130.135, RCW 18.130.050(9) and WAC 246-11-340 govern the show cause process. These laws do not address the composition of a show cause panel.

1. The panel will consist of three or more members.
2. The chairperson must be a regular Commission member.
3. A majority of panel members should be regular Commission members.
4. The Reviewing Commission Member may not sit on the panel.
5. It does not matter whether members of this panel participated in the case by sitting on the charging panel, the hearing panel, a compliance review panel, or any other panel that made a decision at some point in the case.

Hearing on Review of Revocation of Physician's License

Under RCW 18.71.019, when the Commission revokes the license of a physician following a hearing, the physician may request a review of the revocation order "by the remaining members of the commission not involved in the initial investigation." The Commission adopted a rule setting forth the process in WAC 246-919-520.

WAC 246-919-520(4) provides that a review panel will review the final order and be "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.

In addition to the requirements of WAC 246-919-520, the review panel cannot include the RCM or *pro tem* members.

Exception: This procedure is intended to provide guidelines for composing panels. With the specific permission of the Commission Chair, staff may deviate from this procedure, except when mandated by statute.

Date of Adoption:	January 28, 2016
Reaffirmed/Updated:	N/A
Supersedes:	Panel Composition Procedure, adopted November 15, 2013

Procedure

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Review procedure for Update!, the quarterly newsletter of the Washington Medical Commission

Introduction

The Washington Medical Commission (Commission) produces a quarterly newsletter which informs the practitioners in the State of Washington on topics relevant to allopathic medical practice. The Commission recognizes that such specialized information requires knowledgeable oversight. To maintain the informational integrity of the Commission newsletter, the Commission appoints an Editorial Board to oversee and approve content and guide publication according to the wishes of the Commission. The Commission maintains all editorial control and review processes internally.

Background

The Commission has historically published a newsletter containing relevant information for physician and physician assistant licensees in the State of Washington. The content of the newsletter is specialized and relating to standard of practice, trends in practice, and alerts targeted at medical practitioners licensed with the Commission. The intent is to inform practitioners in Washington of acceptable clinical practice standards and trends. With such specialized information being prepared for publication and distribution to the practitioner population, the Commission established steps to maintain acceptable oversight and informational accuracy.

In response to the re-launch of the newsletter in 2011, the Commission established an Editorial Board composed of no less than four Commission members, three clinical members and one public member, to oversee the content and development on behalf of the Commission. One staff member was designated the Managing Editor.

The approval of the newsletter comes from the Commission Editorial Board, and the Executive Director. Final Review of the content is conducted by the Editorial Board, and the Managing Editor. Any specialized content relating to a specific business unit within the Commission is reviewed by the manager of that specific unit.

Conclusion

To maintain the informational integrity of the Commission newsletter, the Commission appoints an Editorial Board to oversee and approve content and guide publication according to the wishes of the Commission. The Commission maintains all editorial control and review processes internally.

Procedure

During the course of the production process, the Managing Editor will collect content ideas from senior management meetings, Medical Commission meetings, case reviews, and other resources as needed. Once these topics are assembled the review and approval process begins.

1. The Managing Editor submits a content list to the Editorial Board for approval.
   a. Content is listed by recurring content and new content, with proposed authors specified.
   b. The Chair of the Commission, the Executive Director, are copied on this communication.
2. Once the proposed content is approved by the Editorial Board it is developed under the direction of the Managing Editor.
   a. Development includes assignment, scheduling, and other functions as necessary. The Managing Editor has discretion during the development phase to assign, reassign, and edit content prior to being submitted to the Editorial Board.
3. Once content has been assembled, the Managing Editor conducts a review to reasonably ensure plain talk standards are met.
4. Non-standard content or content of a clinical and/or policy nature is forwarded to the Editorial Board for review and potential changes.
5. After content editing and approval, the newsletter goes through the layout process.
6. Once layout is complete, the Managing Editor conducts a review of the standard information and layout in an effort to correct any formatting or aged contact data.
7. The Managing Editor submits the completed newsletter as a PDF to the Editorial Board.
8. The final PDF copy of the newsletter is posted to the Medical Commission homepage and publications page.
9. The Managing Editor sends the newsletter PDF and link to the online edition through the Medical Commission Newsletter Listserv when the document is posted to the website.

Additional Information

To maintain the integrity of the Listerv, only newsletter related contest should be distributed through the listserv. To ensure the newsletter is timely and relevant, the entire production process, from topic collection to printing, should take no more than six weeks. Four of these weeks should be devoted to content development, one to layout, and one to the printing process.

Date of Adoption:	June 30, 2017
Reaffirmed / Updated:	None
Supersedes:	MD2013-01

You asked whether it is within the scope of practice for a naturopathic physician to perform lipo-aspiration of adipose tissue for the purpose of extracting stem cells. Please note that neither I nor the Board of Naturopathy (board) are attorneys and cannot provide legal advice. If you have specific questions regarding whether a treatment modality, prescriptive substance, or device is within the scope of practice for a naturopathic physician, please consult with a private attorney who is familiar with Washington law. It may also be beneficial to check with your malpractice carrier regarding liability coverage.

However, we have reviewed the question you presented. Specifically, department staff reviewed research materials related to lipo-aspiration of adipose tissue, [1] [2] [3] [4] as well as the materials you provided to the department. In addition, the Board of Naturopathy discussed your question at the board's November 20, 2020 meeting and at the board's February 12, 2021 meeting. This discussion included a review of these research materials as well as a review of RCW 18.36A, the statute governing the practice of naturopathic medicine in Washington.

RCW 18.36A.040 establishes the scope of practice for a naturopathic physician. This scope of practice includes but is not limited to "minor office procedures". This term is defined in RCW 18.36A.020(8) and includes "intramuscular, intravenous, subcutaneous, and intradermal injections of substances consistent with the practice of naturopathic medicine and in accordance with rules established by the secretary." Likewise, "RCW 18.36A.020(2) permits naturopathic physicians to "…obtain[] samples of human tissues, but excluding incision or excision beyond that which is authorized as a minor office procedure." However, RCW 18.36A does not expressly permit lipo-aspiration of adipose tissue for the purpose of extracting stem cells.

Notwithstanding, it is the Board's conclusion that, if a naturopathic physician is properly trained and follows the statutory requirements in RCW 18.36A and Chapter 246-836 WAC, there arguably may be circumstances in which a naturopathic physician may perform this procedure. Please note that this is not an endorsement of lipo-aspiration of adipose tissue, nor does this email represent an official department position. In addition, it is the board's position is that all health care practitioners, including naturopathic physicians, should have the appropriate education and training, and exercise the corresponding degree of care, when providing any service within their scope of practice.

I hope this information is helpful. Thank you.

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2861738/
[2] https://www.semanticscholar.org/paper/Intraoperative-use-of-enriched-collagen-and-elastin-Alharbi-Almakadi/89be81e167637ae82bd1fb41dadc811c4dd85017
[3] https://stemgenex.com/leading-edge-technology/
[4] https://academic.oup.com/asj/article/35/4/467/233388

Staff Reports: April 2021

Melanie de Leon, Executive Director

Laptop rollout: During the past year, with the increased use of virtual platforms, the addition of MS Teams as a meeting and gathering option, the rollout of Box.com in the coming months and the issues surrounding connectivity, the need for all commissioners to be working on DOH-supported devices has become a major priority. After seven Commissioners piloted the use of DOH-issued laptops for the past several months, we are now in the process of rolling out laptops to the remaining Commissioners.

Kayla has reached out to you to schedule a pickup time for your device which will also include some training from Mike Hively. Commissioners east of the mountains will be able to pick up their device at the Spokane office and Mike will contact you to provide virtual training.

Please let Kayla know dates that will work for you. Thanks for your cooperation in getting these devices to you.

Staffing Updates: Due to retirements, folks moving out of state, or an increase in workload, we have been recruiting to fill vacancies over the past month and we have some new names/faces at the Commission:

- Licensing: Kelsey Hunter, HSC 2, filled the vacancy when Emma was promoted to the Licensing Lead position. Jonathan Anson is temporarily filling a HSC 2 position that is vacant due to Teri Simpson moving to another agency. We will formally recruit for that position at a later date.
- Compliance: Anthony Elders, HSC 2, moved from Licensing to Compliance to fill the position vacated by Amanda Weyrauch. Anthony's move opens a position in Licensing for recruitment.
- Investigations: Meghan Howell, HSC 1, is backfilling Jonathan's position in Complaint Intake on a temporary basis. Natalie Oakes , HCI 1, is filling the position vacated by Jim Noss.

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Agency policy, requests submitted after the cutoff cannot be paid out.

Amelia Boyd, Program Manager

Recruitment

The following Commissioner terms ended June 30, 2020:

- Congressional District 6 – Claire Trescott, MD – eligible for reappointment
- Congressional District 8
- Physician-at-Large – Karen Domino, MD – eligible for reappointment

Amelia Boyd, Program Manager, continued

Recommendations have been sent to the Governor's office.

We also have vacancies in the following positions:

- Congressional District 2
- Public Member

The recommendations for both positions have been sent to the Governor's office.

On June 30, 2021 we will have the following vacancies:

- Congressional District 1 – Jimmy Chung, MD – eligible for reappointment
- Congressional District 7 – Charlotte Lewis, MD – not eligible for reappointment
- Physician Assistant – Theresa Schimmels, PA-C – not eligible for reappointment
- Public Member – Christine Blake – eligible for reappointment

The application deadline for these positions is March 31, 2021.

We are also seeking physicians with the following specialties to serve as Pro Tem Members:

- Radiologist
- Psychiatrist
- Ophthalmologist

If you know anyone who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

Rules

We have 8 rulemaking efforts in progress. For more information, please see the Rules Progress Report in this packet.

Melissa McEachron, Director of Operations and Informatics

Subpoenas for Records and other Compulsory Records Responses: During March, the team continues work on responses for the Office of Inspector General, HHS, requests under MOU with Medicare Fraud Control, private law firm(s), the DEA, and the Department of Justice.

The team:

- Scanned 6,000 pages of case files and medical records; and
- Redacted 3,000 pages of records, primarily case files.

Archiving: Electronic files from Case Management Team meetings are prepared for archiving weekly. The procedure for digitally archiving licensing applications is approved and archiving is underway.

Demographics: Staff members continue to enter Demographic census information into ILRS daily.

Morgan Barrett, MD, Medical Consultant

I am very pleased to announce that after a competitive recruitment process and a number of very qualified candidates, the Commission's own Anthony Elders was selected to join the Compliance Team as the second Compliance Officer effective April 16. Kayla Bryson had graciously agreed to continue in the role of CO for Panel A during Personal Appearances until the second CO was hired. Thank you Kayla for the many months that you so adeptly covered!

George Heye, MD, Medical Consultant

Nothing to report.

Rick Glein, Director of Legal Services

Orders Resulting from SOCs:

In re Ronald Sterling, MD, Case No. M2019-998. Agreed Order. On May 12, 2020, the Commission summarily restricted the license of Ronald M. Sterling, MD. Dr. Sterling was restricted from treating female patients pending final outcome of the matter. The Statement of Charges (SOC) alleges that Dr. Sterling, a psychiatrist, engaged in a sexual relationship with a patient. A hearing was scheduled for March 25, 2021. On March 4, 2021, the Commission approved an Agreed Order in which Dr. Sterling agreed to permanently surrender his medical license.

In re Alan Bunin, MD, Case No. M2020-713. Agreed Order. On August 5, 2020, the Commission served a SOC alleging that Dr. Bunin diagnosed a patient with dementia, without sufficient information regarding the patient's history and mental status, and subsequently wrote a letter regarding the patient's cognitive functioning, stating he had "significant dementia", which caused an adverse financial impact for the patient. Dr. Bunin did not file a response within the time allowed and a Default Order (Failure to Respond) was served on January 27, 2021, which indefinitely suspended Dr. Bunin's medical license. Dr. Bunin filed a motion to vacate the Default Order on February 3, 2021. On March 4, 2021, the Commission approved an Agreed Order which reinstates Dr. Bunin's medical license and requires him to engage in an in-person or virtual evaluation of his clinical skills; conduct an in-depth literature review and write a scholarly paper; attend personal appearances; and pay a fine of $4,000. Dr. Bunin may petition to terminate the Agreed Order after three years.

In re Matthew N. Ball, PA, Case No. M2021-50. Final Order of Default (Failure to Respond).* On February 24, 2021, the Commission served a SOC alleging Mr. Ball is unable to practice as a physician assistant with reasonable skill and safety to patients. Mr. Ball did not file a response to the SOC within the time allowed. The matter came before a Health Law Judge (HLJ) in March 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Mr. Ball's license and ordered that his license to practice as a physician assistant be indefinitely suspended.**

In re Adaobi Okonkwo, MD, Case No. 2020-937. Final Order of Default (Failure to Respond).* On February 2, 2021, the Commission filed a SOC alleging unprofessional conduct for failure

Rick Glein, Director of Legal Services, continued

to provide requested information or records in response to any of the Commission's Letters of Cooperation. Dr. Okonkwo did not file a response to the SOC within the time allowed. The matter came before a HLJ in March 2021. The HLJ concluded sufficient grounds existed to take disciplinary action against Dr. Okonkwo's license and ordered that Dr. Okonkwo's license to practice as a physician and surgeon be indefinitely suspended.**

*Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).
**A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

Virtual Hearings:
In re Rajninder K. Jutla, MD, Case No. M2020-230. On June 23, 2020, the Commission summarily suspended Dr. Jutla's medical license pending further disciplinary proceedings. The SOC simultaneously filed alleges that the Oregon Medical Board revoked Dr. Jutla's license to practice medicine in Oregon based on failure to meet the standard of care while treating chronic pain patients and failing to timely file an answer to the Oregon complaint. A virtual hearing was held in this matter March 8, 2021, regarding the merits of the SOC. A Final Order is expected to be issued by the Health Law Judge (HLJ) by mid-June 2021.***

In re Thomas Osten, MD, Case No. M2018-68. On October 30, 2019, the Commission filed a Statement of Charges alleging unprofessional conduct, sexual misconduct, and abuse of a patient. A virtual hearing was held in this matter March 18-19, 2021, regarding the merits of the SOC. A Final Order is expected to be issued by the Health Law Judge (HLJ) by the end of June 2021.***

***The HLJ has 90 days after the conclusion of the hearing to issue a decision.

Item of Interest: In March, Legal was notified by a local clinic group that over 60 of their physicians and physician assistants had their DEA numbers compromised by a hacker. Legal worked with Licensing and Quality & Engagement to identify the licensees and notate their licensing files about the jeopardized DEA numbers. Legal also worked with other DOH partners that may have licensees affected by the data breach.

Mike Farrell, Policy Development Manager

Dr. Chung, Mr. Maldon and I presented a one-hour webinar on March 25 on the Commission's collaboration with the Foundation for Health Care Quality to reduce medical error. Jimi Bush put it together.

Freda Pace, Director of Investigations

The Investigative Unit is actively recruiting to fill two vacant investigator positions - one position is to fill Jim Noss' position as he relocated to Colorado and the other vacancy is to fill Bonita James' position due to her recent retirement. We hope to have those positions filled soon.

Reminder: Please visit our CMT Signup sheet to fill vacancies beginning in May throughout the remainder of the year. If you have any questions about the signup process, please reach out to Chris Waterman at chris.waterman@wmc.wa.gov. If you have any other concerns related to CMT or Investigations, please do not hesitate to reach me at freda.pace@wmc.wa.gov.

Jimi Bush, Director of Quality and Engagement

Education and Outreach

We have been working on providing free CME to our licensees via webinar. We have provided over 1200 hours of free Category I CME since March of 2020. Upcoming learning opportunities are available on our website and all of our CME events are on-demand and can be viewed for CME credit until their respective due dates.

Strategic Plan

We have begun the planning process for the 2021-2023 strategic plan. Staff are working on creating a starting document for commissioner input and review. Please keep an eye out for an email about providing comments and let me know if you have any questions.

Performance Metrics

We have changed the format of our Performance Management Meetings. We will be having quarterly meetings with individual units (legal, investigations, licensing) so that we perform a deeper level of analysis. If you are interested in attending a meeting, please let me know.

LEAN Projects

One of our biggest undertakings recently has been to LEAN out and optimize the Panel L process. We are in the final stages of revamping to process to make sure that it is seamless for licensing, legal and Dr. Barrett to communicate and move applications through the process efficiently. These changes should have no impact on your work as a commission, but if there is an unintended impact, please let me know.

Marisa Courtney, Licensing Manager

Total licenses issued from 02/24/2021- 03/30/2021- 236

Credential Type	Total Workflow Count
Physician And Surgeon County/City Health Department License	0
Physician And Surgeon Fellowship License	0
Physician And Surgeon Institution License	0

Marisa Courtney, Licensing Manager, continued	
Credential Type	**Total Workflow Count**
Physician And Surgeon License	168
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	37
Physician And Surgeon Residency License	5
Physician And Surgeon Teaching Research License	0
Physician And Surgeon Temporary Permit	3
Physician Assistant Interim Permit	0
Physician Assistant License	52
Physician Assistant Temporary Permit	0
Totals:	**236**

Information on Renewals: February Renewals: 71.44% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	29	29
MD	848	326	1174
MDIN	1	0	1
MDTR	1	3	4
PA	158	45	203
	71.44%	**28.56%**	**100.00%**

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Panel A
Personal Appearance Agenda

Friday, April 9, 2021

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead.

Please join this meeting from your computer, tablet or smartphone:

https://global.gotomeeting.com/join/243475405

Panel Members: Jimmy Chung, MD, Panel Chair; James Anderson, PA-C; Charlie Browne, MD; Charlotte Lewis, MD; Yanling Yu, PhD, Public Member; Scott Rodgers, Public Member; Robert Small, MD; Richard Wohns, MD; Alan Brown, MD, Pro-Tem; Mary Curtis, MD, Pro-Tem

Compliance Officer: Morgan Barrett, MD, MPH

9:45am	**Jonathan Haas, MD** Attorney: Lara Lavi	M2017-1117 (2017-13426) RCM: Robert Small, MD SA: Kyle Karinen
10:30am	**Christopher J. Godbout, MD** Attorney: Pro Se	M2017-823 (2016-11981) RCM: James Anderson, PA-C SA: Kyle Karinen
11:15 a.m.	**William A. Agan, PA-C** Attorney: Thomas Fain	M2017-381 (2016-11931 et al) RCM: Yanling Yu, PhD SA: Colleen Balatbat
Lunch Break		
1:15 pm	**William J. Stanley, MD** Attorney: Colin F. Kearns	M2018-194 (2017-11213) RCM: Charlotte Lewis, MD SA: Gordon Wright
2:00 pm	**Filiz Millik, MD** Attorney: Patrick C. Sheldon	M2019-708 (2019-1851) RCM: Yanling Yu, PhD SA: Rick Glein

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WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Panel B
Personal Appearance Agenda

Friday, April 9, 2021

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead.

Please join this meeting from your computer, tablet or smartphone:

https://global.gotomeeting.com/join/345525861

Panel Members: April Jaeger, MD, Panel Chair
Toni Borlas, Public Member
Diana Currie, MD
Karen Domino, MD
Christine Hearst, Public Member
John Maldon, Public Member
Terry Murphy, MD
Alden Roberts, MD
Theresa Schimmels, PA-C
Claire Trescott, MD

Compliance Officer: Mike Kramer

9:45am	**Romeo A. Pavlic, MD** Attorney: Allen R. Bentley	M2019-501 (2018-15125) RCM: John Maldon SA: Larry Berg
10:30am	**Stephen L. Smith, MD** Attorney: Stephen Rose	M2014-409 (2012-7950) RCM: Alden Roberts, MD SA: Larry Berg
11:15am	**Rutherford P. Hayes, MD** Attorney: Pro Se	M2018-197 (2017-8062) RCM: Claire Trescott, MD SA: Larry Berg
LUNCH BREAK		
1:15pm	**Paul A. Madsen, MD** Attorney: Philip J. VanDerhoef	M2018-192 (2017-8453 et al.) RCM: Diana Currie, MD SA: Richelle Little
2:00pm	**Romeo S. Puzon, MD** Attorney: Pro Se	M2018-85 (2017-8777) RCMs: Toni Borlas, Alden Roberts, MD SA: Kyle Karinen
2:45pm	**Michael H. Shannon, MD** Attorney: Ketia Wick	M2019-78 (2018-4636) RCMs: John Maldon, Theresa Schimmels, PA-C SA: Trisha Wolf

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Chapter 246-918 WAC

PHYSICIAN ASSISTANTS—WASHINGTON MEDICAL COMMISSION

Commented [AB1]: For those changes that take effect July 1, 2022 we will request an expedited rulemaking for both this chapter and the physician's chapter 246-919 WAC to make the necessary updates to the opioid prescribing sections.

Last Update: 3/26/20

WAC 246-918-005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Commission" means the Washington medical commission.

(2) "Commission approved program" means a physician assistant program accredited by the committee on allied health education and accreditation (CAHEA); the commission on accreditation of allied health education programs (CAAHEP); the accreditation review committee on education for the physician assistant (ARC-PA); or other substantially equivalent organization(s) approved by the commission.

~~(3) "Delegation agreement" means a mutually agreed upon plan, as detailed in WAC 246-918-055, between a sponsoring physician and physician assistant, which describes the manner and extent to which the physician assistant will practice and be supervised.~~

(~~4~~3) "NCCPA" means National Commission on Certification of Physician Assistants.

(~~5~~4) "Osteopathic physician" means an individual licensed under chapter 18.57 RCW.

(~~6~~5) "Physician" means an individual licensed under chapter 18.71 RCW.

(~~7~~6) "Physician assistant" means a person who is licensed under chapter 18.71A RCW by the commission to practice medicine to a limited extent only under the supervision of a physician or osteopathic physician ~~as defined in chapter 18.71 RCW~~.

(a) "Certified physician assistant" means an individual who has successfully completed an accredited and commission approved physician assistant program and has passed the initial national boards examination administered by the National Commission on Certification of Physician Assistants (NCCPA).

(b) "Noncertified physician assistant" means an individual who:

(i) Successfully completed an accredited and commission approved physician assistant program, is eligible for the NCCPA

examination, and was licensed in Washington state prior to July 1, 1999;

(ii) Is qualified based on work experience and education and was licensed prior to July 1, 1989;

(iii) Graduated from an international medical school and was licensed prior to July 1, 1989; or

(iv) Holds an interim permit issued pursuant to RCW 18.71A.020(1).

(c) "Physician assistant-surgical assistant" means an individual who was licensed under chapter 18.71A RCW as a physician assistant between September 30, 1989, and December 31, 1989, to function in a limited extent as authorized in WAC 246-918-250 and 246-918-260.

~~(8) "Remote site" means a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.~~

(7) "Practice agreement" means a mutually agreed upon plan, as detailed in WAC 246-918-055, between a supervising physician

and physician assistant, which describes the manner and extent to which the physician assistant will practice and be supervised.

(8~~9~~) "Supervising physician" means ~~a sponsoring or alternate physician providing clinical oversight for a physician assistant.~~

~~(a) "Sponsoring physician" means~~ any physician ~~licensed under chapter 18.71 RCW~~or osteopathic physician ~~and~~ identified in a ~~delegation~~ practice agreement as providing primary clinical and administrative oversight for a physician assistant.

(b) "Alternate physician" means any physician ~~licensed under chapter 18.71 or 18.57 RCW~~or osteopathic physician who provides clinical oversight of a physician assistant in place of or in addition to the ~~sponsoring~~ supervising physician.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2019 c 55. WSR 20-08-069, § 246-918-005, filed 3/26/20, effective 4/26/20. Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-005, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-005, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-

073, § 246-918-005, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-005, filed 10/11/93, effective 11/11/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-005, filed 6/3/92, effective 7/4/92.]

WAC 246-918-007 Application withdrawals. An applicant for a license or interim permit may not withdraw his or her application if grounds for denial exist.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-007, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-007, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-007, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-007, filed 6/3/92, effective 7/4/92.]

WAC 246-918-035 Prescriptions. (1) A physician assistant may prescribe, order, administer, and dispense legend drugs and Schedule II, III, IV, or V controlled substances consistent with the scope of practice in an approved ~~delegation~~ practice agreement filed with the commission provided:

(a) The physician assistant has an active DEA registration; and

(b) All prescriptions comply with state and federal prescription regulations.

(2) If a supervising physician's prescribing privileges have been limited by state or federal actions, the physician assistant will be similarly limited in his or her prescribing privileges, unless otherwise authorized in writing by the commission.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-035, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-035, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-035, filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71A.020. WSR 91-08-007 (Order 153B), § 246-918-035, filed 3/26/91, effective 4/26/91.]

WAC 246-918-050 Physician assistant qualifications for interim permits. An interim permit is a limited license. The permit allows an individual who has graduated from a commission approved program within the previous twelve months to practice

prior to successfully passing the commission approved licensing examination.

(1) An individual applying to the commission for an interim permit under RCW 18.71A.020(1) must have graduated from an accredited commission approved physician assistant program.

(2) An interim permit is valid for one year from completion of a commission approved physician assistant training program. The interim permit may not be renewed.

(3) An applicant for a physician assistant interim permit must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Applicable fees as specified in WAC 246-918-990; and

(c) Requirements as specified in WAC 246-918-080.

~~(4) An interim permit holder may not work in a remote site.~~

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-050, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-050, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017

and 18.71A.020. WSR 96-03-073, § 246-918-050, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-050, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-20-023, § 308-52-165, filed 9/27/89, effective 10/28/89.]

WAC 246-918-055 ~~Delegation~~ Practice agreements.

(1) A practice agreement must meet the requirements in RCW 18.71A.xxx. A model practice agreement~~, which conforms to the requirements of RCW 18.71A.--- (section 6, chapter 80, Laws of 2020)~~ is available on the commission's web site.

(2) A physician assistant may have more than one supervising physician if the practice agreement is entered into with a group of physicians and the language of the practice agreement designates the supervising physicians.

(3) It must be noted in the practice agreement that a physician assistant delivering general anesthesia or intrathecal anesthesia has completed an accredited anesthesiologist assistant program and received certification as an anesthesiologist assistant.

~~(1) The physician assistant and sponsoring physician must submit a joint delegation agreement on forms provided by the~~

Commented [AB2]: Suggested language from WANA:
A physician assistant delivering general anesthesia or intrathecal anesthesia pursuant to a practice agreement with a physician shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement. Adequate education and training will meet, at minimum, the education and training required for anesthesia providers licensed to perform anesthesia in the state, which are certified registered nurse anesthetists and physician anesthesiologists.

~~commission. A physician assistant may not begin practicing without written commission approval of a delegation agreement.~~

~~(2) The delegation agreement must specify:~~

~~(a) The names and Washington state license numbers of the sponsoring physician and alternate physician, if any. In the case of a group practice, the alternate physicians do not need to be individually identified;~~

~~(b) A detailed description of the scope of practice of the physician assistant;~~

~~(c) A description of the supervision process for the practice; and~~

~~(d) The location of the primary practice and all remote sites and the amount of time spent by the physician assistant at each site.~~

~~(3) The sponsoring physician and the physician assistant shall determine which services may be performed and the degree of supervision under which the physician assistant performs the services.~~

~~(4) The physician assistant's scope of practice may not exceed the scope of practice of the supervising physician.~~

~~(5) A physician assistant practicing in a multispecialty group or organization may need more than one delegation agreement depending on the physician assistant's training and the scope of practice of the physician(s) the physician assistant will be working with.~~

~~(6) It is the joint responsibility of the physician assistant and the supervising physician(s) to notify the commission in writing of any significant changes in the scope of practice of the physician assistant. The commission or its designee will evaluate the changes and determine whether a new delegation agreement is required.~~

~~(7) A physician may enter into delegation agreements with up to five physician assistants, but may petition the commission for a waiver of this limit. However, no physician may have under his or her supervision:~~

~~(a) More than three physician assistants who are working in remote sites as provided in WAC 246-918-120; or~~

~~(b) More physician assistants than the physician can adequately supervise.~~

~~(8) Within thirty days of termination of the working relationship, the sponsoring physician or the physician assistant shall submit a letter to the commission indicating the relationship has been terminated.~~

~~(9) Whenever a physician assistant is practicing in a manner inconsistent with the approved delegation agreement, the commission may take disciplinary action under chapter 18.130 RCW.~~

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-055, filed 2/3/15, effective 3/6/15.]

WAC 246-918-075 Background check—Temporary practice permit. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI)

fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

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

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as a physician assistant provided that the temporary practice permit holder has a ~~delegation~~ practice agreement ~~approved by~~on file with the commission.

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

(4) The temporary practice permit is no longer valid after the license is issued or the application for a full license is denied.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-075, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-918-075, filed 2/9/10, effective 2/11/10.]

WAC 246-918-076 How to obtain a temporary practice permit—Military spouse. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for physician assistants.

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

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

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

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

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

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

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

(a) The license is granted;

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

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

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

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

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

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

(d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards as a physician assistant in Washington;

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

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

(ii) A marriage license; or

(iii) A state registered domestic partnership; and

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

(5) For the purposes of this section:

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

(b) "Military person" means a person serving in the United States armed forces, the United States public health service commissioned corps, or the merchant marine of the United States. [Statutory Authority: RCW 18.71A.020 and 18.340.020. WSR 17-18-097, § 246-918-076, filed 9/6/17, effective 10/7/17.]

WAC 246-918-080 Physician assistant—Requirements for licensure. (1) Except for a physician assistant licensed prior to July 1, 1999, individuals applying to the commission for licensure as a physician assistant must have graduated from an accredited commission approved physician assistant program and successfully passed the NCCPA examination.

(2) An applicant for licensure as a physician assistant must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Proof the applicant has completed an accredited commission approved physician assistant program and successfully passed the NCCPA examination;

(c) All applicable fees as specified in WAC 246-918-990;

~~(d) Proof of completion of four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8;~~ and

(d~~e~~) Other information required by the commission.

(3) The commission will only consider complete applications with all supporting documents for licensure.

(4) A physician assistant may not begin practicing without ~~written commission approval of a delegation~~ filing a practice agreement with the commission.

(5) A physician assistant licensed under 18.57A RCW prior to July 1, 2021 renewing their license on or after July 1, 2021, must do so with the commission if they choose to renew their physician assistant license in this state. Individuals licensed under chapter 18.57A RCW and renewing their license after July 1, 2021 will follow the renewal schedule set forth in WAC 246-918-071. The commission shall issue a physician assistant license to the individuals described in this subsection without requiring full application or reapplication, but may require additional information from the renewing physician assistant.

Commented [AB3]: Deleted under WSR #21-07-055 filed 3/12/2021.

Commented [AB4]: New #3 suggested language from WSSA:
To perform general or intrathecal anesthesia services, a physician assistant must submit to the commission, in addition to the requirements of subsection (2), proof of current certification by the National Commission for the Certification of Anesthesiologist Assistants.

Commented [AB5]: This may not be needed as these rules are for Washington.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-080, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-080, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-080, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-080, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-080, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-06-077 (Order PM 822), § 308-52-139, filed 3/1/89. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 88-21-047 (Order PM 782), § 308-52-139, filed 10/13/88. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-139, filed 2/23/88; WSR 86-12-031 (Order PM 599), § 308-52-139, filed 5/29/86; WSR 82-24-013 (Order PL 412), § 308-52-139, filed 11/19/82; WSR 81-03-078 (Order PL 368), § 308-52-139, filed 1/21/81; WSR 80-15-031 (Order PL-353), § 308-52-139, filed 10/8/80; WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-139, filed 3/14/78.]

WAC 246-918-081 How to return to active status when a license has expired. (1) To return to active status the physician assistant must meet the requirements of chapter 246-12 WAC, Part 2, which includes paying the applicable fees under WAC

246-918-990 and meeting the continuing medical education requirements under WAC 246-918-180.

(2) If the license has expired for over three years, the physician assistant must meet requirements in subsection (1) of this section and the current licensure requirements under WAC 246-918-080.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-081, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-081, filed 2/13/98, effective 3/16/98.]

~~**WAC 246-918-082 Requirements for obtaining an allopathic physician assistant license for those who hold an active osteopathic physician assistant license.** A person who holds a full, active, unrestricted osteopathic physician assistant license that is in good standing issued by the Washington state board of osteopathic medicine and surgery and meets current licensing requirements may apply for licensure as an allopathic physician assistant through an abbreviated application process.~~

~~(1) An applicant for an allopathic physician assistant license must:~~

~~(a) Hold an active, unrestricted license as an osteopathic physician assistant issued by the Washington state board of osteopathic medicine and surgery;~~

~~(b) Submit a completed application on forms provided by the commission; and~~

~~(c) Submit any fees required under WAC 246-918-990.~~

~~(2) An allopathic physician assistant may not begin practice without written commission approval of the delegation agreement.~~

~~[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-082, filed 2/3/15, effective 3/6/15.]~~

Commented [AB6]: Repeal effective July 1, 2021.

~~**WAC 246-918-095 Scope of practice Osteopathic alternate physician.** The physician assistant shall practice under the delegation agreement and prescriptive authority approved by the commission whether the alternate supervising physician is licensed as an osteopathic physician under chapter 18.57 RCW or an allopathic physician under chapter 18.71 RCW.~~

Commented [AB7]: Repeal effective July 1, 2021.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-095, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-095, filed 1/17/96,

effective 2/17/96. Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-095, filed 7/19/94, effective 8/19/94.]

WAC 246-918-105 Practice limitations due to disciplinary action. (1) To the extent a supervising physician's prescribing privileges have been limited by any state or federal authority, either involuntarily or by the physician's agreement to such limitation, the physician assistant will be similarly limited in his or her prescribing privileges, unless otherwise authorized in writing by the commission.

(2) The physician assistant shall notify their ~~sponsoring~~ supervising physician whenever the physician assistant is the subject of an investigation or disciplinary action by the commission. The commission may notify the ~~sponsoring~~ supervising physician or other supervising physicians of such matters as appropriate.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-105, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-105, filed 7/19/94, effective 8/19/94.]

~~**WAC 246-918-120 Remote site.** (1) A physician assistant may not work in a remote site without approval of the commission or its designee. A physician may not supervise more than three physician assistants who are working in remote sites, or more physician assistants than the physician can adequately supervise.~~

~~(2) The commission or its designee may grant the use of a physician assistant in a remote site if:~~

~~(a) There is a demonstrated need for such use;~~

~~(b) Adequate provision for timely communication exists between the supervising physician and the physician assistant;~~

~~(c) The supervising physician spends at least ten percent of the practice time of the physician assistant in the remote site. In the case of part time or unique practice settings, the physician may petition the commission to modify the on-site requirement providing the supervising physician demonstrates that adequate supervision is being maintained by an alternate method including, but not limited to, telecommunication. The commission will consider each request on an individual basis.~~

~~(3) The names of the supervising physician and the physician assistant must be prominently displayed at the entrance to the clinic or in the reception area of the remote site.~~

~~(4) A physician assistant holding an interim permit may not work in a remote site.~~

~~[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-120, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71A.020 and chapter 18.71A RCW. WSR 04-11-100, § 246-918-120, filed 5/19/04, effective 6/30/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-120, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-120, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-120, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-147, filed 2/23/88.]~~

Commented [AB8]: Repeal effective July 1, 2021.

WAC 246-918-125 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 ASSISTANT RESPONSIBILITIES

(4) A physician assistant 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 assistant may use an LLRP device so long as it is with the consent of the ~~sponsoring or~~ supervising physician, it is in compliance with the practice ~~arrangement plan approved by~~agreement on file with the commission, and it is in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, a physician assistant 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.

PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

(7) A physician assistant 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; and

(d) 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.

(e) The delegating physician assistant has 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 assistant 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 assistant concerning specific decisions

made. Documentation shall be recorded after each procedure, and may be performed on the patient's record or medical chart.

(f) The physician assistant is responsible for ensuring 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 physician assistant shall be on the immediate premises during any use of an LLRP device and be able to treat complications, provide consultation, or resolve problems, if indicated.

[Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(12). WSR 07-03-177, § 246-918-125, filed 1/24/07, effective 3/1/07.]

WAC 246-918-126 Nonsurgical medical cosmetic procedures. (1) The purpose of this rule is to establish the duties and responsibilities of a physician assistant who injects medication or substances for cosmetic purposes or uses 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.

(2) This section 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) "Physician assistant" means an individual licensed under chapter 18.71A RCW.~~

(d) "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 ASSISTANT RESPONSIBILITIES

(4) A physician assistant may perform a nonsurgical medical cosmetic procedure only after the commission approves a practice plan permitting the physician assistant to perform such procedures. A physician assistant must ensure that the supervising ~~or sponsoring~~ physician is in full compliance with WAC 246-919-606.

(5) A physician assistant may not perform a nonsurgical cosmetic procedure unless his or her supervising ~~or sponsoring~~

Commented [AB9]: These are defined elsewhere. They can be deleted from this section.

physician is fully and appropriately trained to perform that same procedure.

(6) Prior to performing a nonsurgical medical cosmetic procedure, a physician assistant must have appropriate training in, at a minimum:

(a) Techniques for each procedure;

(b) Cutaneous medicine;

(c) Indications and contraindications for each procedure;

(d) Preprocedural and postprocedural care;

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

(f) Infectious disease control involved with each treatment.

(7) The physician assistant 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.

(8) Prior to performing a nonsurgical medical cosmetic procedure, either the physician assistant or the delegating 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 including disclosing the credentials of the person who will perform the procedure;

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

(g) Prepare an appropriate medical record.

(9) The physician assistant must ensure that there is a written office protocol for performing the nonsurgical medical cosmetic procedure. A written office protocol must include, at a minimum, the following:

(a) A statement of the activities, decision criteria, and plan the physician assistant must follow when performing procedures under this rule;

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

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

(d) A statement of the activities, decision criteria, and plan the physician assistant must follow if performing a procedure delegated by a physician pursuant to WAC 246-919-606, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(10) A physician assistant may not delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

(11) A physician assistant may perform a nonsurgical medical cosmetic procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, so long as the physician assistant's sponsoring or supervising physician is on-site during the entire procedure.

(12) ~~A physician assistant may perform a nonsurgical medical cosmetic procedure at a remote site. A physician assistant must comply with the established regulations governing physician assistants working in remote sites, including~~

~~obtaining commission approval to work in a remote site under WAC 246-918-120.~~

~~(13)~~ A physician assistant must ensure that each treatment is documented in the patient's medical record.

(14~~4~~3) A physician assistant 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.

(14~~5~~) A physician assistant 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.

(15~~6~~) A physician assistant must participate in a quality assurance program required of the supervising or sponsoring physician under WAC 246-919-606.

[Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(4). WSR 10-11-001, § 246-918-126, filed 5/5/10, effective 6/5/10.]

WAC 246-918-130 Physician assistant identification. (1) A physician assistant must clearly identify himself or herself as

a physician assistant and must appropriately display on his or her person identification as a physician assistant.

(2) A physician assistant must not present himself or herself in any manner which would tend to mislead the public as to his or her title.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-130, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-130, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-130, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-130, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-148, filed 2/23/88.]

WAC 246-918-171 Renewal and continuing medical education cycle. (1) Under WAC 246-12-020, an initial credential issued within ninety days of the physician assistant's birthday does not expire until the physician assistant's next birthday.

(2) A physician assistant must renew his or her license every two years on his or her birthday. Renewal fees are

accepted no sooner than ninety days prior to the expiration date.

(3) Each physician assistant will have two years to meet the continuing medical education requirements in WAC 246-918-180. The review period begins on the first birthday after receiving the initial license.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-171, filed 2/3/15, effective 3/6/15. 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, § 246-918-171, filed 11/16/99, effective 1/1/00.]

WAC 246-918-175 Retired active license. (1) To obtain a retired active license a physician assistant must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) A physician assistant with a retired active license must have a ~~delegation~~ practice agreement ~~approved by~~on file with the commission in order to practice except when serving as a "covered volunteer emergency worker" as defined in RCW 38.52.180 (5)(a) and engaged in authorized emergency management activities or serving under chapter 70.15 RCW.

(3) A physician assistant with a retired active license may not receive compensation for health care services.

(4) A physician assistant with a retired active license may practice under the following conditions:

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

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

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

(6) A physician assistant with a retired active license shall report one hundred hours of continuing education at every renewal.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-175, filed 2/3/15, effective 3/6/15.]

WAC 246-918-180 Continuing medical education requirements. (1) A physician assistant must complete one hundred hours of continuing education every two years as required in chapter 246-

12 WAC, Part 7, which may be audited for compliance at the discretion of the commission.

(2) In lieu of one hundred hours of continuing medical education the commission will accept:

(a) Current certification with the NCCPA; or

(b) Compliance with a continuing maintenance of competency program through the American Academy of Physician Assistants (AAPA) or the NCCPA; or

(c) Other programs approved by the commission.

(3) The commission approves the following categories of creditable continuing medical education. A minimum of forty credit hours must be earned in Category I.

Category I	Continuing medical education activities with accredited sponsorship
Category II	Continuing medical education activities with nonaccredited sponsorship and other meritorious learning experience.

(4) The commission adopts the standards approved by the AAPA for the evaluation of continuing medical education requirements in determining the acceptance and category of any continuing medical education experience.

(5) A physician assistant does not need prior approval of any continuing medical education. The commission will accept any

continuing medical education that reasonably falls within the requirements of this section and relies upon each physician assistant's integrity to comply with these requirements.

(6) A continuing medical education sponsor does not need to apply for or expect to receive prior commission approval for a 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 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 the program sponsors to present continuing medical education for the physician assistant that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-180, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-180, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-180, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-180, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-180, filed 2/26/91, effective 3/29/91. Statutory

Authority: RCW 18.71A.020. WSR 82-03-022 (Order PL 390), § 308-52-201, filed 1/14/82; WSR 81-03-078 (Order PL 368), § 308-52-201, filed 1/21/81.]

WAC 246-918-185 Training in suicide assessment, treatment, and management. (1) A licensed physician assistant must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.

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

(3) Until July 1, 2017, the commission must approve the training. The commission will approve an empirically supported training in suicide assessment, suicide treatment, and suicide management that meets the requirements of RCW 43.70.442.

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

(5) The hours spent completing training in suicide assessment, treatment, and management count toward meeting applicable continuing education requirements in the same category specified in WAC 246-918-180.

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

[Statutory Authority: RCW 18.71.017 and 43.70.442. WSR 17-07-044, § 246-918-185, filed 3/8/17, effective 4/8/17.]

WAC 246-918-250 Basic physician assistant-surgical assistant (PASA) duties. The physician assistant-surgical assistant (PASA) who is not eligible to take the NCCPA certifying exam shall:

(1) Function only in the operating room as approved by the commission;

(2) Only be allowed to close skin and subcutaneous tissue, placing suture ligatures, clamping, tying and clipping of blood vessels, and cauterizing for hemostasis under direct supervision;

(3) Only be allowed to assist the operating surgeon. The PASA may not perform any independent surgical procedures, even under direct supervision;

(4) Have no prescriptive authority; and

(5) Only write operative notes. The PASA may not write any progress notes or order(s) on hospitalized patients.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-250, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-250, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-250, filed 10/11/93, effective 11/11/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-250, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-250, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-650, filed 6/8/89, effective 9/30/89.]

WAC 246-918-260 Physician assistant-surgical assistant (PASA)—Use and supervision. The following section applies to the physician assistant-surgical assistant (PASA) who is not eligible to take the NCCPA certification exam.

(1) Responsibility of PASA. The PASA is responsible for performing only those tasks authorized by the supervising physician(s) and within the scope of PASA practice described in WAC 246-918-250. The PASA is responsible for ensuring his or her compliance with the rules regulating PASA practice and failure to comply may constitute grounds for disciplinary action.

(2) Limitations, geographic. No PASA may be used in a place geographically separated from the institution in which the PASA and the supervising physician are authorized to practice.

(3) Responsibility of supervising physician(s). Each PASA shall perform those tasks he or she is authorized to perform only under the supervision and control of the supervising physician(s). Such supervision and control may not be construed to necessarily require the personal presence of the supervising physician at the place where the services are rendered. It is

the responsibility of the supervising physician(s) to ensure that:

(a) The operating surgeon in each case directly supervises and reviews the work of the PASA. Such supervision and review shall include remaining in the surgical suite until the surgical procedure is complete;

(b) The PASA shall wear identification as a "physician assistant-surgical assistant" or "PASA." In all written documents and other communication modalities pertaining to his or her professional activities as a PASA, the PASA shall clearly denominate his or her profession as a "physician assistant-surgical assistant" or "PASA";

(c) The PASA is not presented in any manner which would tend to mislead the public as to his or her title.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-260, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-260, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.130.250. WSR 93-11-008 (Order 360B), § 246-918-260, filed 5/5/93, effective 6/5/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-260, filed 6/3/92, effective 7/4/92; WSR 91-06-

030 (Order 147B), recodified as § 246-918-260, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-660, filed 6/8/89, effective 9/30/89.]

WAC 246-918-410 Sexual misconduct. (1) The following definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician assistant-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 assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Physician assistant" means a person licensed to practice as a physician assistant under chapter 18.71A 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 assistant shall not engage in sexual misconduct with a current patient or a key third party. A physician assistant 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, except for examinations of an infant or prepubescent child when clinically appropriate;

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

(h) Encouraging the patient to masturbate in the presence of the physician assistant or masturbation by the physician assistant 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 assistant.

(3) A physician assistant 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 assistant:

(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 assistant's personal or sexual needs.

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

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

(a) Documentation of formal termination;

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

(c) The length of time that has passed;

(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 assistant;

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

(g) The degree of emotional dependence and vulnerability.

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

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

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

[Statutory Authority: RCW 18.71.017, 18.130.062, and Executive Order 06-03. WSR 16-06-009, § 246-918-410, filed 2/18/16, effective 3/20/16. Statutory Authority: RCW 18.130.180,

18.71.017, and 18.71A.020. WSR 06-03-028, § 246-918-410, filed 1/9/06, effective 2/9/06.]

WAC 246-918-420 Abuse. (1) A physician assistant commits unprofessional conduct if the physician assistant abuses a patient. A physician assistant 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, § 246-918-420, filed 1/9/06, effective 2/9/06.]

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-918-800 Intent and scope. The rules in WAC 246-918-800 through 246-918-935 govern the prescribing of opioids in the treatment of pain.

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

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physician assistants to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All physician assistants should become knowledgeable about assessing patients'

pain and effective methods of pain treatment, as well as statutory requirements for prescribing opioids, including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician assistant uncertainty and to encourage better pain management.

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

The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease,

illness, trauma, or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician assistant. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physician assistants should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use.

Accordingly, the commission expects that physician assistants incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physician assistants should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician assistant-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 assistant'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 physician assistants in providing appropriate medical care for patients.

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

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

For more specific best practices, the physician assistant may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors'

group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2019 c 55. WSR 20-08-069, § 246-918-800, filed 3/26/20, effective 4/26/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-800, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-918-800, filed 5/24/11, effective 1/2/12.]

WAC 246-918-801 Exclusions. WAC 246-918-800 through 246-918-935 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The provision of palliative, hospice, or other end-of-life care;

(3) The treatment of inpatient hospital patients who are patients who have been admitted to a hospital for more than twenty-four hours; or

(4) The provision of procedural medications.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-918-801, filed 5/24/11, effective 1/2/12.]

WAC 246-918-802 Definitions. The definitions apply to WAC 246-918-800 through 246-918-935 unless the context clearly requires otherwise.

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

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. Acute pain is of six weeks or less in duration.

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

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

(5) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an

injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain is considered to be pain that persists for more than twelve weeks.

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

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

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

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

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

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

(12) "Hospital" as defined in chapters 70.41, 71.12 RCW, and RCW 72.23.020.

(13) "Low-risk" is a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than a fifty milligram morphine equivalent dose per day.

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

(15) "Moderate-risk" is a category of patient at moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history of substance use disorder or abuse, aberrant behavior, and dose of opioids

between fifty to ninety milligram morphine equivalent doses per day.

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

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

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

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

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

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

(22) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or ~~18.57A RCW~~, or a podiatric physician licensed under chapter 18.22 RCW.

Commented [AB10]: This change cannot take effect until 7/1/2022.

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

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

(25) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as

physical dependence or tolerance that is a normal physiological consequence of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, filed 11/16/18, effective 1/1/19. Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-918-802, filed 5/24/11, effective 1/2/12.]

WAC 246-918-815 Patient notification, secure storage, and disposal. (1) The physician assistant shall discuss with the patient the following information at the first issuance of a prescription for opioids and at the transition from acute to subacute, and subacute to chronic:

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

(b) Pain management alternatives to opioids, including nonopioid pharmacological and nonpharmacological treatments,

whenever reasonable, clinically appropriate, evidence-based alternatives exist;

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

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

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

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

(a) Emergent care;

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

(c) Procedures involving the administration of anesthesia;

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

(e) MAT for substance use disorders.

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

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

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

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

[Statutory Authority: RCW 18.71.017, 18.71.810, 18.71A.810, and 69.50.317. WSR 20-04-026, § 246-918-815, filed 1/28/20, effective 2/28/20. Statutory Authority: RCW 18.71.017,

18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, filed 11/16/18, effective 1/1/19.]

WAC 246-918-820 Use of alternative modalities for pain treatment. The physician assistant shall exercise their professional judgment in selecting appropriate treatment modalities for acute nonoperative, acute perioperative, subacute, or chronic pain including the use of multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-820, filed 11/16/18, effective 1/1/19.]

WAC 246-918-825 Continuing education requirements for opioid prescribing. (1) To prescribe an opioid in Washington state, a physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids or the opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the physician assistant's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The hours spent completing training in prescribing of opioids count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-825, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

WAC 246-918-830 Patient evaluation and patient record—Acute nonoperative pain. Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the physician assistant shall:

(1) Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;

(2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and

(3) Inquire about any other medications the patient is prescribed or is taking.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-830, filed 11/16/18, effective 1/1/19.]

WAC 246-918-835 Treatment plan—Acute nonoperative pain. The physician assistant shall comply with the requirements in this section when prescribing opioids for acute nonoperative pain.

(1) The physician assistant should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-918-820.

(2) The physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-918-935.

(3) If the physician assistant prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient. The physician assistant shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity.

(4) The physician assistant shall reevaluate the patient who does not follow the expected course of recovery, and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.

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

(8) Medication assisted treatment medications must not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-918-925.

(9) If the physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician assistant shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-918-845 and 246-918-850 shall apply.
[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-835, filed 11/16/18, effective 1/1/19.]

WAC 246-918-840 Treatment plan—Acute perioperative pain. The physician assistant shall comply with the requirements in this section when prescribing opioids for perioperative pain.

(1) The physician assistant should consider prescribing nonopioids as the first line of pain control in patients unless not clinically appropriate in accordance with the provisions of WAC 246-918-820.

(2) The physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-918-935.

(3) If the physician assistant prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient. The physician assistant shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity.

(4) The physician assistant shall reevaluate a patient who does not follow the expected course of recovery and reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

(6) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.

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

(8) Medication assisted treatment medications must not be discontinued when treating acute perioperative pain, except as consistent with the provisions of WAC 246-918-925.

(9) If the physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the physician assistant shall document in

the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-918-845 and 246-918-850, shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-840, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-918-845 Patient evaluation and patient record—Subacute pain. The physician assistant shall comply with the requirements in this section when prescribing opioids for subacute pain.

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

(a) Conduct an appropriate history and physical examination;

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

(c) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-918-935;

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

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

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

(2) The physician assistant treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following is documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids beyond the acute pain episode;

(c) Pertinent concerns discovered in the PMP;

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

(e) The action plan for any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;

(f) Results of psychosocial screening or consultation;

(g) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy, and mitigation strategies; and

(h) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-845, filed 11/16/18, effective 1/1/19.]

WAC 246-918-850 Treatment plan—Subacute pain. The physician assistant, having recognized the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase shall develop an opioid treatment plan.

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

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

(3) If a prescription results in the patient receiving a combination of opioids with a sedative medication listed in WAC 246-918-920, such prescribing must be in accordance with WAC 246-918-920.

(4) If the physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the physician assistant shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-918-855 through 246-918-905, shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-850, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

WAC 246-918-855 Patient evaluation and patient record—Chronic pain. When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician assistant shall include in the patient's record:

(1) An appropriate history including:

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and

(d) Review of comorbidities with particular attention to psychiatric and substance use.

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

(a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;

(b) Any pertinent diagnostic, therapeutic, and laboratory results;

(c) Pertinent consultations; and

(d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.

(4) Assessment. The physician assistant must document medical decision making to include:

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

(b) Consideration of the risks and benefits of chronic opioid treatment for the patient;

(c) The observed or reported effect on function or pain control forming the basis to continue prescribing opioids; and

(d) Pertinent concerns discovered in the PMP.

(5) Treatment plan as provided in WAC 246-918-860. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-855, filed 11/16/18, effective 1/1/19.]

WAC 246-918-860 Treatment plan—Chronic pain. The physician assistant, having recognized the progression of a patient from the subacute phase to the chronic phase, shall develop an opioid treatment plan as follows:

(1) Treatment plan and objectives including:

(a) Documentation of any medication prescribed;

(b) Biologic specimen testing ordered;

(c) Any labs, diagnostic evaluations, referrals, or imaging ordered;

(d) Other planned treatments; and

(e) Written agreement for treatment as provided in WAC 246-918-865.

(2) The physician assistant shall complete patient notification in accordance with the provisions of WAC 246-918-815 or provide this information in the written agreement. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-860, filed 11/16/18, effective 1/1/19.]

WAC 246-918-865 Written agreement for treatment—Chronic pain. The physician assistant shall use a written agreement that outlines the patient's responsibilities for opioid therapy. This written agreement for treatment must include the following provisions:

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

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

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

(4) The requirement that all opioid prescriptions for chronic pain are provided by a single prescriber or a single clinic, except as provided in WAC 246-918-915 for episodic care;

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

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

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

(8) The patient's responsibility to safeguard all medications and keep them in a secure location.
[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-865, filed 11/16/18, effective 1/1/19.]

WAC 246-918-870 Periodic review—Chronic pain. (1) The physician assistant shall periodically review the course of

treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-918-935, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

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

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

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

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

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician

assistant's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

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

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

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-918-935 and subsection (1) of this section.

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-870, filed 11/16/18, effective 1/1/19.]

WAC 246-918-875 Long-acting opioids—Chronic pain. Long-acting opioids should only be prescribed by a physician assistant 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 assistant prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.
[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-875, filed 11/16/18, effective 1/1/19.]

WAC 246-918-880 Consultation—Recommendations and requirements—Chronic pain. (1) The physician assistant shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician assistant prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED per day, a consultation with a pain management specialist as

described in WAC 246-918-895 is required, unless the consultation is exempted under WAC 246-918-885 or 246-918-890.

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

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

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

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

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

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-880, filed 11/16/18, effective 1/1/19.]

WAC 246-918-885 Consultation—Exemptions for exigent and special circumstances—Chronic pain. A physician assistant is not required to consult with a pain management specialist as defined in WAC 246-918-895 when the physician assistant has documented adherence to all standards of practice as defined in WAC 246-918-855 through 246-918-875 and when one or more of the following conditions are met:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with an expected return to their baseline dosage level or below;

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-885, filed 11/16/18, effective 1/1/19.]

WAC 246-918-890 Consultation—Exemptions for the physician assistant—Chronic pain. The physician assistant is exempt from the consultation requirement in WAC 246-918-880 if one or more of the following qualifications are met:

(1) The physician assistant is a pain management specialist under WAC 246-918-895;

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

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

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-890, filed 11/16/18, effective 1/1/19.]

WAC 246-918-895 Pain management specialist—Chronic pain. A pain management specialist shall meet one or more of the following qualifications:

(1) If ~~an allopathic~~a physician assistant ~~or osteopathic physician assistant,~~ must have a ~~delegation~~ practice agreement with a physician pain management specialist and meet~~s~~ the educational requirements and practice requirements listed below:

Commented [AB11]: This change must be made as of July 1, 2022.

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

(b) Credentialed in pain management by an entity approved by the commission ~~for an allopathic physician assistant or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant~~;

Commented [AB12]: This change takes effect July 1, 2022.

(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 physician assistant's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

(2) If an allopathic physician, in accordance with WAC 246-919-945.

(3) If an osteopathic physician, in accordance with WAC 246-853-750.

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

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

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

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2019 c 55. WSR 20-08-069, § 246-918-895, filed 3/26/20, effective 4/26/20. Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-895, filed 11/16/18, effective 1/1/19.]

WAC 246-918-900 Tapering considerations—Chronic pain. The physician assistant shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

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

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

(4) Other treatment modalities are indicated;

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

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

(7) There is unauthorized escalation of doses; or

(8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-900, filed 11/16/18, effective 1/1/19.]

WAC 246-918-905 Patients with chronic pain, including those on high doses of opioids, establishing a relationship with a new physician assistant. (1) When a patient receiving chronic opioid pain medications changes to a new physician assistant, it is normally appropriate for the new physician assistant to initially maintain the patient's current opioid doses. Over

time, the physician assistant may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A physician assistant's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-918-880 if:

(a) The patient was previously being treated with a dosage of opioids in excess of a one hundred twenty milligram MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and nonescalating;

(c) The patient has a history of compliance with treatment plans and written agreements documented by medical records and PMP queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control at the presenting opioid dose.

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-918-880 shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-905, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-918-910 Special populations—Children or adolescent patients, pregnant patients, and aging populations. (1) Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician assistant shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

(2) Pregnant patients. The physician assistant shall not initiate opioid detoxification without consultation with a provider with expertise in addiction medicine. Medication assisted treatment for opioids, such as methadone or buprenorphine, must not be discontinued during pregnancy without consultation with a MAT prescribing practitioner.

(3) Aging populations. As people age, their sensitivities to and metabolizing of opioids may change. The physician assistant shall consider the distinctive needs of patients who

are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment. [Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-910, filed 11/16/18, effective 1/1/19.]

WAC 246-918-915 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the physician assistant knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the physician assistant, or their designee, shall review the PMP and document their review and any concerns.

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

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-915, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-918-920 Coprescribing of opioids with certain medications. (1) The physician assistant shall not knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics.

(2) If, because of a prior prescription by another provider, a prescription written by a physician assistant results in a combination of opioids and medications described in subsection (1) of this section, the physician assistant issuing

the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications. This provision does not apply to emergency care.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-920, filed 11/16/18, effective 1/1/19.]

WAC 246-918-925 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient who is known to be receiving MAT medications shall prescribe opioids when appropriate for pain relief either in consultation with a MAT prescribing practitioner or a pain specialist.

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-925, filed 11/16/18, effective 1/1/19.]

WAC 246-918-930 Coprescribing of naloxone. The opioid prescribing physician assistant shall confirm or provide a current prescription for naloxone when opioids are prescribed to a high-risk patient.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-930, filed 11/16/18, effective 1/1/19.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-918-935 Prescription monitoring program—Required registration, queries, and documentation. (1) The physician assistant shall register to access the PMP or demonstrate proof of having assured access to the PMP if they prescribe Schedule II-V medications in Washington state.

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

(3) At a minimum, the physician assistant shall ensure a PMP query is performed prior to the prescription of an opioid or of a medication listed in WAC 246-918-920 at the following times:

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

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

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

(4) For chronic pain management, the physician assistant shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

(a) For a high-risk patient, a PMP query shall be completed at least quarterly;

(b) For a moderate-risk patient, a PMP query shall be completed at least semiannually; and

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

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

(6) The physician assistant shall ensure a PMP query is performed when providing episodic care to a patient who the

physician assistant knows to be receiving opioids for chronic pain, in accordance with WAC 246-918-915.

(7) If the physician assistant is using an electronic medical record (EMR) that integrates access to the PMP into the workflow of the EMR, the physician assistant shall ensure a PMP query is performed for all prescriptions of opioids and medications listed in WAC 246-918-920.

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

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

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-935, filed 11/16/18, effective 1/1/19.]

FEES

WAC 246-918-990 Physician assistants 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.

(2) The applicant or licensee must pay the following nonrefundable fees:

Title of Fee	Fee
Physician assistants:	
Original application	
Application	$50.00
UW HEAL-WA surcharge*	16.00
Washington physician health program surcharge	50.00
Active license renewal	
Two-year renewal	247.00
UW HEAL-WA surcharge*	32.00
Washington physician health program surcharge*	100.00
Late renewal fee	124.00
Expired license reissuance	50.00
Retired active license renewal	
Two-year renewal	35.00
Washington physician health program surcharge*	100.00
Late renewal fee	35.00
Duplicate license	15.00

* The Washington physician health program surcharge (RCW 18.71A.020(3)) is 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.

** The Washington physician health program surcharge is assessed at $50.00 per year.

[Statutory Authority: RCW 43.70.250 and 43.70.280. WSR 19-21-052, § 246-918-990, filed 10/10/19, effective 2/1/20. Statutory Authority: RCW 18.130.250, 43.70.250, 18.130.186, and 43.70.280. WSR 15-20-050, § 246-918-990, filed 9/30/15, effective 1/1/16. Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-

19-088, § 246-918-990, 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, § 246-918-990, filed 8/4/09, effective 8/15/09. Statutory Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-918-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250. WSR 06-11-167, § 246-918-990, 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, § 246-918-990, 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, § 246-918-990, 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, § 246-918-990, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 18.71.017 and 18.71A.020(3). 99-13-087, § 246-918-990, filed 6/14/99, effective 7/15/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-990, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 43.70.040. WSR 91-06-027 (Order 131), § 246-918-990, filed 2/26/91, effective 3/29/91.]