WASHINGTON

# Medical Commission

Licensing. Accountability. Leadership.

## Regular Meeting
## March 2-3, 2023

# 2023 Meeting Schedule

WASHINGTON Medical Commission
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| Dates | Location | Meeting Type |
|---|---|---|
| **January 12-13** | Virtual options available for open sessions<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |
| **March 2-3** | Virtual options available for open session<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |
| **April 13-14** | Virtual options available for open sessions<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |
| **May 25-26** | Virtual | Regular Meeting |
| **July 13-14** | Virtual options available for open sessions<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |
| **August 24-25** | Virtual options available for open sessions<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |
| **October 5-6** | Tumwater, WA | Tentative:<br>Case Reviews<br>Commissioner Retreat |
| **November 16-17** | Virtual options available for open sessions<br>Capitol Event Center (ESD 113)<br>6005 Tyee Drive SW, Tumwater, WA | Regular Meeting |

**Association Meetings**

| Association | Date(s) | Location |
|---|---|---|
| Federation of State Medical Boards (FSMB) Annual Conf. | May 4-6, 2023 | Minneapolis, MN |
| WAPA Spring Conference | TBA | TBA |
| WSMA Annual Meeting | September 23-24, 2023 | Bellevue, WA |
| WAPA Fall Conference | TBA | TBA |

**Other Meetings**

| Program | Date(s) | Location |
|---|---|---|
| Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium | January 11, 2023 | Savannah, GA |
| CLEAR Annual Conference | September 27-30, 2023 | Salt Lake City, UT |
| FSMB Board Attorneys Workshop | TBA | TBA |

# 2024 Meeting Schedule

WASHINGTON Medical Commission
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| Dates | Location | Meeting Type |
|---|---|---|
| **January 11-12** | TBD | Regular Meeting |
| **March 7-8** | TBD | Regular Meeting |
| **April 18-19** | TBD | Regular Meeting |
| **May 23-24** | TBD | Regular Meeting |
| **July 11-12** | TBD | Regular Meeting |
| **August 22-23** | TBD | Regular Meeting |
| **October 3-5** | TBD | TBA |
| **November 21-22** | TBD | Regular Meeting |

# FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| Hearing | Respondent | Case No. | Location |
|---|---|---|---|
| **2023 March** | | | |
| 16-Mar **through** 17-Mar | Thompson, Robert, MD | M2021-553 | TBD |
| 30-Mar **through** 31-Mar | Brecht, Kristine, MD | M2022-564 | TBD |
| **2023 April** | | | |
| 3-Apr **through** 7-Apr | Wilkinson, Richard, MD | M2022-196 | TBD |
| **2023 May** | | | |
| 8-May | Kimura, Irene, MD | M2020-930 | TBD |
| 24-May **through** 26-May | Eggleston, Richard, MD | M2022-204 | TBD |
| **2023 June** | | | |
| 15-June **through** 16-June | Wingfield, Guito, MD | M2022-502 | TBD |
| **2023 July** | | | |
| 28-Jul | Pothini, Gouri, MD | M2022-852 | TBD |

| Hearing | Respondent | Case No. | Location |
|---|---|---|---|
| **2023 August** | | | |
| 3-Aug **through** 4-Aug | Pugh, Steven, MD | M2022-611 | TBD |
| 18-Aug | Alhafez, Fadi, MD | M2021-656 | TBD |
| 22-Aug **through** 23-Aug | Aljumaili, Wisam, MD | M2021-444 | TBD |
| 31-Aug | Riyaz, Farhaad, MD | M2022-716 | TBD |

# Commission Meeting Agenda
# March 2-3, 2023 – 1st Revised

WASHINGTON Medical Commission
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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 (WMC) meetings. This agenda is subject to change. The Policy Committee Meeting will begin at 4:00 pm on March 2, 2023 until all agenda items are complete. The WMC will take public comment at the Policy Committee Meeting. The Business Meeting will begin at 8:00 am on March 3, 2023 until all agenda items are complete. The WMC 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.

*The Washington Medical Commission (WMC) is providing a virtual option for members of the public for several of the open sessions in this agenda. This is to promote social distancing and the safety of the citizens of Washington State. Registration links can be found below.*

**Capital Event Center (ESD 113), 6005 Tyee Drive SW, Tumwater, WA 98512**

## Time — Thursday – March 2, 2023

### Closed Sessions

| | | |
|---|---|---|
| 8:00 am | Case Reviews – Panel A | Pacific |
| 8:00 am | Case Reviews – Panel B | Grays Harbor |

### Open Session

**12:30 pm — Lunch & Learn — Thurston**

To attend virtually, please **register** at: https://attendee.gotowebinar.com/register/7208049016337142357
After registering, you will receive an email containing a link that is unique to you to join the webinar.

**Washington Physicians Health Program Annual Report**
*Chris Bundy, Executive Medical Director*

### Closed Sessions

| | | |
|---|---|---|
| 1:30 pm | Case Reviews – Panel A | Pacific |
| 1:30 pm | Case Reviews – Panel B | Grays Harbor |

### Open Session

**4:00 pm — Policy Committee Meeting — Grays Harbor**

To attend virtually, **register** at: https://attendee.gotowebinar.com/register/3997828571946827 16
After registering, you will receive an email containing a link that is unique to you to join the webinar.

| Agenda Items | Presented By: | Page(s) |
|---|---|---|
| **Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants**<br>*Routine review, discussion, and possible revisions to interpretive statement.* | Mike Farrell | 15-19 |
| **Interpretive Statement: Opioid Prescribing & Monitoring for Patients**<br>*Routine review, discussion, and possible revisions to interpretive statement.* | Mike Farrell | 20-23 |
| **Guidance Document: Treating Partners of Patients with Sexually Transmitted Chlamydia and Gonorrhea**<br>*Routine review, discussion, and possible revisions to guidance document.* | Mike Farrell | 24-25 |
| **Interpretive Statement: Physician Assistants' Use of DEA Waiver for Buprenorphine**<br>*Consider rescinding interpretive statement.* | Mike Farrell | 26-34 |



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| Policy Committee Meeting Agenda continued | | |
|---|---|---|
| **Agenda Items** | **Presented By:** | **Page(s)** |
| **Proposed Interpretive Statement: Application of the Office-based Surgery Rule, WAC 246-919-601, to the Use of Nitrous Oxide** | Mike Farrell | 35-36 |
| **Report: High Reliability Organizations Workgroup** | Mike Farrell | NA |

## Time — Friday – March 3, 2023

## Open Session

## 8:00 am — Business Meeting — Thurston

To attend virtually, **register** for this meeting at: https://attendee.gotowebinar.com/rt/5660356123841895 28
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 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.***

### 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 January 13, 2023 Business Meeting minutes. — Pages 9-11

4.2 Agenda – Approval of the March 3, 2023 Business Meeting agenda. — Pages 6-8

### 5.0 New Business

5.1 **Outstanding Performance Awards**

Melanie de Leon, Executive Director; Rick Glein, Director of Legal Services; and Freda Pace, Director of Investigations, will present the Outstanding Performance Awards to WMC staff.

### 6.0 Old Business

6.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 12

See page 13 for a list of committees and workgroups.

6.2 **Nominating Committee** — Update

Announcement of committee members. The election of leadership will take place at the May 26, 2023, Business Meeting.

6.3 **Rulemaking Activities** — Update

Rules Progress Report provided on page 14.



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## 7.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on March 2, 2023. See the Policy Committee agenda on page 1 of this agenda for the list of items to be presented.

Report/Action Begins on page 15

## 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 on pages 37-46

## 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 | Page 47 | Pacific |
| 9:45 am | Personal Appearances – Panel B | Page 48 | Grays Harbor |

## Closed Session

| | | |
|---|---|---|
| Noon to 1:00 pm | High Reliability Organizations Workgroup Meeting | Grays Harbor |



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# Business Meeting Minutes
# January 13, 2023

WASHINGTON Medical Commission
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Link to recording: https://youtu.be/T_bvSdpGGzU

## Commission Members

Mabel Bongmba, MD
Michael Bailey, Public Member – Absent
Christine Blake, Public Member
Toni Borlas, Public Member – Absent
Po-Shen Chang, MD
Jimmy Chung, MD, Chair
Diana Currie, MD
Karen Domino, MD, Chair Elect
Arlene Dorrough, PA-C
Anjali D'Souza, MD
Harlan Gallinger, MD
April Jaeger, MD – Absent
Ed Lopez, PA-C
Sarah Lyle, MD – Absent
Terry Murphy, MD, Vice Chair
Elisha Mvundura, MD
Robert Pullen, Public Member
Scott Rodgers, JD, Public Member
Claire Trescott, MD – Absent
Richard Wohns, MD
Yanling Yu, PhD, Public Member

## WMC Staff in Attendance

Morgan Barrett, Director of Compliance
Amelia Boyd, Program Manager
Kayla Bryson, Executive Assistant
Melanie de Leon, Executive Director
Joel DeFazio, Staff Attorney
Kelly Elder, Staff Attorney
Mike Farrell, Policy Development Manager
Rick Glein, Director of Legal Services
Ken Imes, Information Liaison
Kyle Karinen, Staff Attorney
Pam Kohlmeier, MD, JD, Attorney
Fatima Mirza, Program Case Manager

## Others in Attendance

Heather Carter, Assistant Attorney General

## 1.0 Call to Order

Jimmy Chung, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 8:00 a.m. on January 13, 2023.

## 2.0 Public Comment

No member of the public was signed up to speak therefore no public comment was given.

## 3.0 Chair Report

Jimmy Chung, MD, Chair, welcomed new Commissioner, Dr. Mabel Bongmba and asked that she tell her a bit about herself. Dr. Bongmba introduced herself and gave a bit of her background.

Dr. Chung then asked the other members to introduce themselves and give a bit of a background about themselves.

## 4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

**4.1** Minutes from the November 18, 2022 Business Meeting
**4.2** Agenda for January 13, 2023.





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

## 5.0 Old Business

### 5.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet. There were no additional reports.

### 5.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. There were no additional reports.

## 8.0 Policy Committee Report

Christine Blake, Public Member, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on January 12, 2023:

**Proposed Interpretive Statement: Physician Assistants Performing Disability Evaluations**
Ms. Blake presented the document and stated that the Committee recommended approving the document as provided in the meeting packet.

> ***Motion:*** The Chair made a motion to approve the document as presented for review by the Secretary's office. The motion was approved unanimously.

**Interpretive Statement: Physician Assistants Ordering Patient Restraint and Seclusion**
Ms. Blake presented the document and stated that the Committee recommended approving the document as provided in the meeting packet.

> ***Motion:*** The Chair made a motion to reaffirm the document as presented. The motion was approved unanimously.

**Policy Request**
Ms. Blake provided an overview of the request and stated that the Committee felt this request was not under the jurisdiction of the WMC. Ms. Blake then asked that Mike Farrell, Policy Development Manager, provide more information on this request. Mr. Farrell explained that there are already policies and rules in place that address the request.

> ***Motion:*** The Chair made a motion to deny the request. The motion was approved unanimously.

## 9.0 Member Reports

Yanling Yu, PhD, Public Member, wanted to call the Commissioners' attention to an article that had been published recently in the New England Journal of Medicine about The Safety of Inpatient Health Care: The Safety of Inpatient Health Care | NEJM

Terry Murphy, MD, stated there was a campaign in the state of Washington to address a critical blood bank shortage. She asked that those that are able to donate to seek out their nearest blood bank.

## 10.0 Staff Reports

The reports below are in addition to the written reports that were included in the meeting packet.



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Melanie de Leon, Executive Director, announced she will be retiring September 1, 2023. She went on to explain the recruitment and interviewing process that will be used to fill this vacancy.

## 11.0 AAG Report

Heather Carter, AAG, had nothing to report.

## 12.0 Adjournment

The Chair called the meeting adjourned at 8:32 am.

Submitted by

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Amelia Boyd, Program Manager

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Jimmy Chung, MD, Chair Elect
Washington Medical Commission

Approved March 3, 2023

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# Committee/Workgroup Reports: March 2023

| High Reliability Organizations Workgroup – Chair: Dr. Chung<br>Staff: Mike Farrell |
|---|
| The workgroup met in January and will meet again in March with the investigators to discuss communication between investigators and RCMs, and communication between investigators and respondents. |

| Healthcare Disparities Workgroup – Chair: Dr. Currie<br>Staff: Melanie de Leon |
|---|
| No updates to report. |

# Committees & Workgroups

WASHINGTON Medical Commission
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| Executive Committee |
|---|
| Chair: Dr. Chung |
| Chair Elect: Dr. Domino |
| Vice Chair: Dr. Murphy |
| Policy Chair: Christine Blake, PM |
| Immediate Past Chair: John Maldon, PM |
| Melanie de Leon |
| Micah Matthews |
| Heather Carter, AAG |

| Policy Committee |
|---|
| Christine Blake, PM, Chair (B) |
| Dr. Domino (B) |
| Dr. Trescott (B) |
| Scott Rodgers, PM (A) |
| Ed Lopez, PA-C (B) |
| 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. Chung, Chair |
| John Maldon, PM. Pro Tem Commissioner |
| Christine Blake, PM |
| Dr. Wohns |
| Melanie de Leon |
| Micah Matthews |

| Healthcare Disparities Workgroup |
|---|
| Dr. Currie, Chair |
| Dr. Browne |
| Dr. Jaeger |
| Christine Blake, PM |
| Melanie de Leon |

| Panel L |
|---|
| Dr. Chung, Chair |
| Christine Blake, PM |
| Dr. Browne, Pro Tem |
| Dr. Chung |
| Arlene Dorrough, PA-C |
| Dr. Lyle |
| Dr. Wohns |
| John Maldon, PM, Pro Tem |
| Dr. Roberts, Pro Tem |
| Dr. Trescott |
| Dr. Barrett, Medical Consultant |
| Marisa Courtney, Licensing Supervisor |
| Pam Kohlmeier, MD, JD, Staff Attorney |
| Micah Matthews |

| Finance Workgroup |
|---|
| Dr. Chung, WMC Chair, Workgroup Chair |
| Dr. Domino, WMC Chair Elect |
| Melanie de Leon |
| Micah Matthews |
| Jimi Bush |

| High Reliability Workgroup |
|---|
| Dr. Domino, Chair |
| Dr. Chung |
| Christine Blake, PM |
| Dr. Jaeger |
| Scott Rodgers, PM |
| Dr. Chang |
| Ed Lopez, PA-C |
| Dr. Roberts, Pro Tem |
| John Maldon, PM, Pro Tem |
| Melanie de Leon |
| Mike Farrell |

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

PM = Public Member



Updated: January 19, 2023

| WMC Rules Progress Report | | | | | | | | Projected filing dates | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Rule** | **Status** | **Date** | **Next step** | **Complete By** | **Notes** | **Submitted in RMS** | **SBEIS Check** | **CR-101** | **CR-102** | **CR-103** |
| Collaborative Drug Therapy Agreements (CDTA) | CR-101 filed | 7/22/2020 | Workshops | TBD | | | | Complete | TBD | TBD |
| SB 5229 - Health Equity CE | CR-101 filed | 2/10/2023 | Workshops | August 2023 | | | | Complete | TBD | TBD |

Updated: 2/22/2023

# Interpretive Statement

WASHINGTON Medical Commission
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| | | |
|---|---|---|
| Title: | Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants | INS2019-01 |
| References: | RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-990 | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Effective Date: | March 8, 2019 | |
| Approved By: | Alden Roberts, MD, Chair (signature on file) | |

## Description of the Issue

The Washington Medical Commission (Commission) is aware of concerns by practitioners that the Commission's opioid prescribing rules are inflexible and do not allow for variation based on patient presentation. The Commission is also aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids.

## Interpretive Statement

WAC 246-919-850—Intent and scope, and its corresponding Washington Administrative Code for allopathic physician assistants (WAC 246-918-800), states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission in WAC 246-919-850 and WAC 246-918-800 encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

It is important to note that the rules are not inflexible and recognize the importance of sound clinical judgment. Those concerned about the use of the word "shall" within the rules are encouraged to consider the Intent Section. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire opioid prescribing ruleset by the Commission. The intent provision explicitly states that the rules are not inflexible and repeatedly recognizes the importance of clinical judgment.

## Background

**The Commission established rules for managing chronic, noncancer pain in 2011 to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. In** 2017, Engrossed Substitute House Bill 1427 required the Commission to ~~create new rules regarding~~cover opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids. In addition to developing new opioid prescribing rules pursuant to ESHB 1427, ~~T~~rhe Commission made minor modifications to the ~~current~~existing rules for managing chronic pain rules in 2018 ~~as well~~ resulting in comprehensive opioid prescribing rules for all phases of pain are effective January 1, 2019.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a physician to inform a patient that the patient has the right to refuse an opioid prescription for any reason.[1] In 2022, the Commission modified the rules to exempt from the requirements of the rules the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities from the rules, and residential habilitation centers.[2]

## Analysis

The ~~new~~ opioid prescribing rules describe the Commission's intent and scope of the rules as follows:

"The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, 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 physicians to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All [practitioners] 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. …

… Appropriate pain management is the treating physician's responsibility As such, the commission will consider the inappropriate treatment of pain to be a departure from standards

[1] RCW 18.71.810.
[2] WAC 246-919-851.

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.

These rules are designed to assist [practitioners] 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 [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care."

## Commonly Asked Questions

### *1. What is episodic care and how does it apply to my practice?*

For the purpose of these rules, episodic care usually includes patients seen in an emergency department or urgent care facility for chronic pain when complete medical records are not available. Additionally, patients seen in an ambulatory care setting with complaints associated with chronic pain whose complete medical records are not available would also be covered by this rule. However, some healthcare systems and clinics may have an associated urgent care facility with complete availability of medical records. These facilities would be excluded from the definition of episodic care for the purposes of these rules.

### *2. Does the rule define the entire standard of care for the management of pain?*

No. The contents of the rules do address some important elements of the standard of care for pain management, but they do not define the entire standard of care. The rules are not exhaustive. The standard of care (current practice guidelines articulated by expert review) will continue to control circumstances and issues not addressed by the rule.

### *3. Is the 120 mg. (MED) "consultation threshold" a maximum dose under the rules?*

No. The 120 mg. (MED) threshold is a triggering dose, intended to alert the practitioner to the fact that prescribing at this dose or higher significantly increases the potential for morbidity and mortality, and requires a consultation with a pain specialist unless the practitioner or circumstances are exempted under the rules. The articulation of this dose in the rules is consistent with the legislature's requirement in ~~ESHB 2876~~RCW 18.71.450[3] to adopt rules that contain a dosage amount that must not be exceeded without pain specialist consultation.

[3] ESHB 2876, effective June, 10, 2010.

Some have referred to the 120 mg. (MED) threshold (or "triggering") dose as a "maximum dose". The rules do not provide a maximum dose. They simply require, absent an exemption, that the practitioner obtain a pain specialist consultation before continuing on to prescribe opioids at a level that is associated with significant increases in opioid-related overdoses and deaths.

### *4. Is the 120 mg. (MED) "consultation threshold" the minimum dosage at which a consultation should be obtained under the rules?*

No. A physician or physician assistant should obtain a consultation when warranted. In WAC 246-919-860(2) and WAC 246-918-810(2), the threshold for mandatory consultation is set at 120 mg. (MED) for adult patients. However, WAC 246-919-860(1) and WAC 246-918-810(1) reference, more generally, additional evaluation that *may* be needed to meet treatment objectives. This provision makes specific reference to evaluation of patients under age 18 who are at risk, as well as patients with co-morbidity psychiatric disorders. However, other circumstances may call for a consultation with a pain management specialist for patients who have not yet met the threshold dose.

## Specific Guidance from the Rules

WAC 246-919-955 and 246-918-905 provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- New patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:
    - The patient was previously being treated for the same conditions;
    - The dose is stable and nonescalating;
    - There is a history of compliance with written agreements and treatment plans; and
    - There is documented function improvements or stability at the presenting dose.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- Evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- Unauthorized escalation of doses;
- An authorized escalation of dose with no improvement in pain or function.

A patient on a stable, non-escalating dose with positive impact on function would be exempt from any need for additional consultation with a pain specialist regarding treatment. Additionally, there is no upper MED limit in Washington State or federal law. The Centers for Disease Control (CDC) has a 90 MED descriptor in their guidelines, which, while a valid indication for consultation, does not have the force of law in Washington. The Commission's opioid prescribing rules represent the only

legal requirement and cite a 120 MED consultation threshold for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. For those practitioners not considered pain management specialists treating patients over the 120 MED consultation threshold, there are several options to satisfy the exemption consultation requirement, including but not limited to:

- Receive a peer-to-peer consult with a pain management specialist;
- Participate in an electronic (audio/video) case consult such as the University of Washington (UW) Telepain or the Washington Health Care Authority (HCA) Opioid Hotline;
- Chart note documenting the attempt to get a consult but lack of success in attaining one;
- For a full list of options to satisfy the exemption consultation requirement, please see the rules.

For all of these options, documenting the outcomes or reasoning in the patient medical record satisfies the consultation exemption and would be part of the normal course of medical practice to do so.

# Interpretive Statement

WASHINGTON Medical Commission
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| | | |
|---|---|---|
| Title: | Opioid Prescribing & Monitoring for Patients | INS2019-02 |
| References: | RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-990 | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 | E-mail: medical.commission@wmc.wa.gov |
| Effective Date: | January 18, 2019 | |
| Approved By: | Alden Roberts, MD, Chair (signature on file) | |

## Description of the Issue

The Washington Medical Commission (Commission) is aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids. To help underscore and clarify the need for patient access and the rights of patients for treatment, the Commission issues this interpretive statement for patient and practitioner use.

## Interpretive Statement

The opioid prescribing rule states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission, in WAC 246-919-850 and WAC 246-918-800 encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments. The intent provision explicitly states that the rules are not inflexible and repeatedly recognizes the importance of clinical judgment.

The Commission interprets WAC 246-919-850 to 246-919-985 and corresponding physician assistant Washington Administrative Code (WAC 246-918-800 to WAC 246-918-935) as encouragement to practitioners to not exclude, undertreat, or dismiss a patient from a practice solely because the patient has used or is using opioids in the course of normal medical care. While in most circumstances a practitioner is not legally required to treat a particular patient, the refusal to see or continue to treat a patient merely because the patient has taken or is currently using opioids is contrary to the clear intent of the Commission's rules governing opioid prescribing. Ending opioid therapy or initiating a forced tapering of opioids to a particular MED level for reasons outside of clinical efficacy or improvement in quality of life and/or function or abuse would violate the intent of the rules.

## Background

The Commission established rules for managing chronic, noncancer pain in 2011 to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. In 2017, Engrossed Substitute House Bill (ESHB) 1427 required the Commission to cover opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids. In addition to developing new opioid prescribing rules pursuant to ESHB 1427, the Commission made minor modifications to the current chronic pain rules in 2018 resulting in comprehensive opioid prescribing rules for all phases of pain, effective January 1, 2019.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a physician to inform a patient that the patient has the right to refuse an opioid prescription for any reason.[1] In 2022, the Commission modified the rules to exempt from the requirements of the rules the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities from the rules, and residential habilitation centers.[2]

## Analysis

The new rule, WAC 246-919-850, and its corresponding physician assistant rule (WAC 246-918-800), describe the Commission's intent and scope of the rules as follows:

> "The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, 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.
> …
> 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 [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care."

## Examples

### Existing Patient

A patient with a longstanding history in a medical practice develops an injury or condition that becomes a pain condition requiring chronic opioid therapy. A practitioner who refuses to treat

[1] RCW 18.71.810.
[2] WAC 246-919-851.

the condition properly, including the appropriate utilization of opioids when opioids are clearly indicated, would be practicing below the standard of care. Similarly, if the practitioner referred the patient to a pain management specialist as defined by Commission rule, but refused to continue or support the pain management treatment designed by the specialist while responding to all other aspects of patient care, would likely be practicing below the standard of care. Finally, electing to terminate the patient from the practice, because their regular care involves pain management or opioid therapy, would be considered practice below the standard of care.

### New Patient

The Commission's opioid prescribing rules provide incentives for practitioners to take new patients into their practice who are on existing opioid therapy regimens.

WAC 246-919-955 and 246-918-905, and the corresponding physician assistant rules, provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- Be aware that new patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:
    - The patient was previously being treated for the same condition(s);
    - The dose is stable and nonescalating;
    - There is a history of compliance with written agreements and treatment plans; and
    - There is documented function improvements or stability at the presenting dose.

### Tapering

A patient on opioid therapy, chronic or otherwise, is on a stable non-escalating dose. The practitioner has observed the patient's function and quality of life to be positive. Citing reasons related to state or federal law or desire to have the patient below a certain morphine equivalent dose (MED) per day, the practitioner initiates a tapering schedule without consent of the patient or consideration of function or quality of life. This would be a clear violation of the Commission opioid prescribing rules.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when one or more of the following occurs:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- Evidence of misuse, abuse, substance use disorder, or diversion;

- The patient experiences a severe adverse event or overdose;
- Unauthorized escalation of doses; or
- An authorized escalation of dose with no improvement in pain or function.

A patient on a stable non-escalating dose with positive impact on function would be exempt from any need for additional consultation with a pain specialist regarding treatment. Additionally, there is no upper MED limit in Washington State or federal law. The Centers for Disease Control (CDC) has a 90 MED descriptor in their guidelines, which, while a valid indication for consultation, does not have the force of law in Washington. The Commission's opioid prescribing rules represent the only legal requirement for licensed allopathic physicians and physician assistants in Washington state, and cite a 120 MED consultation threshold for practitioners who are not considered pain management specialists under the rule.

# Guideline

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

# Treating Partners of Patients with Sexually Transmitted Chlamydia and Gonorrhea

## Introduction

The Washington Medical Commission (Commission) recognizes that when sexually transmitted chlamydia and gonorrhea are identified in a patient, the adequate treatment and prevention of recurrence in the patient often depends on the treatment of the partner or partners who may not be available or agreeable to direct examination.

The Commission recognizes that it is a common practice for health care practitioners to provide antibiotics for the partner(s) without prior examination. While this is not ideal for the diagnosis and control of sexually transmitted diseases, this is often the only reasonable way to gain access to and to treat the partner(s) and impact the personal and public health risks of continued or additional chlamydial and gonorrheal infections.

## Guideline

The Commission recommends that when treating partners of patients with sexually transmitted chlamydia and gonorrhea, physicians and physician assistants follow the current "Sexually Transmitted Diseases Treatment Guidelines" issued by the Centers for Disease Control and Prevention.[1] The Commission urges physicians and physician assistants to use all reasonable efforts to assure that appropriate information and advice is made available to the partner(s) of a patient with chlamydia and gonorrhea.

In order to assure widespread access to patient delivered partner therapy (PDPT), the Commission recognizes that clinical providers and public health agencies will need to allow staff to provide PDPT according to a special prescribing protocol. Physicians and physician assistants should review and approve all prescriptions within seven days. Public health staff providing PDPT should undergo training to be defined by the local health officer.

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Number: MD2015-13

Date of Adoption: November 6, 2015

Reaffirmed: August 23, 2019

Supersedes: Treating Partners of Patients with Sexually Transmitted Chlamydia and Gonorrhea, MD2008-03

[1] http://www.cdc.gov/std/tg2015/tg-2015-print.pdf

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

*Olympia, Washington 98504*

# NOTICE OF ADOPTION INTERPRETIVE STATEMENT

**Title of Interpretive Statement:** Physician Assistants' Use of DEA Waiver for Buprenorphine | INS2022-01

**Issuing Entity:** Washington Medical Commission

**Subject Matter:** Physician assistants may treat opioid addiction with buprenorphine while under a waiver from the DEA even when the supervising physician does not have a waiver.

**Effective Date:** July 15, 2022

**Contact Person**: Michael Farrell, JD
Policy Development Manager
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Spokane Valley, WA 99203
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OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 09, 2022
TIME: 12:59 PM

WSR 22-19-015

# Interpretive Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

| | | |
|---|---|---|
| Title: | Physician Assistants' Use of DEA Waiver for Buprenorphine | INS2022-01 |
| References: | RCW 18.71A.030; WAC 246-918-055; 21 U.S.C. § 823(g) | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 E-mail: medical.commission@wmc.wa.gov | |
| Effective Date: | July 15, 2022 | |
| Supersedes: | INS2018-01, effective March 2, 2018 | |
| Approved By: | Jimmy Chung, MD, Chair (signature on file) | |

The Washington Medical Commission (Commission) interprets RCW 18.71A.030 and 21 U.S.C. § 823(g) to permit a physician assistant who has received a waiver from the federal Drug Enforcement Administration (DEA) to provide buprenorphine for the treatment of opioid addiction even if the supervising physician has not received a waiver, provided that the physician assistant is supervised by a qualifying physician and the practice agreement between the physician and the physician assistant complies with Washington law. Under 21 U.S.C. § 823(g), a qualifying physician is a physician who is an addiction specialist or who has taken the appropriate training, as defined in the federal statute.

In 2000, the United States Congress passed the Drug Addiction Treatment Act of 2000 to allow qualified physicians to apply for waivers to enable them to dispense or prescribe narcotic drugs approved by the FDA, including buprenorphine, to individuals for maintenance treatment or detoxification treatment for opioid use disorder (formerly known in the DSM-IV as opioid dependence) in settings other than approved opioid treatment programs. In 2016, the United States Congress passed the Comprehensive Addiction and Recovery Act (CARA), amending the prior law to permit physician assistants and nurse practitioners to apply for waivers to enable them to dispense or prescribe narcotic drugs, including buprenorphine, to individuals for maintenance or detoxification treatment if certain conditions are met. CARA provided that this exception expires in 2021. In 2018, Congress extended the expiration until October 1, 2023, with the passage of the Support for Patients and Communities Act.

In Washington, the scope of practice of a physician assistant is limited only by the education, training and experience of the physician assistant, the expertise and scope of practice of the supervising physician, and the practice agreement between the physician assistant and the supervising physician. The Commission does not require the physician assistant's practice to be

the same as the supervising physician, but it cannot exceed the supervising physician's expertise and practice.

RCW 18.71A.030 provides in part:

> **Limitations on practice—Scope of practice.**
>
> (1) A physician assistant may practice medicine in this state to the extent permitted by the practice agreement. A physician assistant shall be subject to discipline under chapter 18.130 RCW.
>
> (2) Physician assistants may provide services that they are competent to perform based on their education, training, and experience and that are consistent with their practice agreement. The supervising physician and the physician assistant shall determine which procedures may be performed and the supervision under which the procedure is performed. Physician assistants may practice in any area of medicine or surgery as long as the practice is not beyond the supervising physician's own scope of expertise and clinical practice and the practice agreement.
>
> ….

RCW 18.71A.120 provides in part:

> **Practice agreement—Elements—Amendment—Disciplinary action.**
>
> (1) Prior to commencing practice, a physician assistant licensed in Washington state must enter into a practice agreement with a physician or group of physicians, at least one of whom must be working in a supervisory capacity. …
>
> (2) A practice agreement must include all of the following:
>
> (a) The duties and responsibilities of the physician assistant, the supervising physician, and alternate physicians. The practice agreement must describe supervision requirements for specified procedures or areas of practice. The practice agreement may only include acts, tasks, or functions that the physician assistant and supervising physician or alternate physicians are qualified to perform by education, training, or experience and that are within the scope of expertise and clinical practice of both the physician assistant and the supervising physician or alternate physicians, unless otherwise authorized by law, rule, or the commission;
>
> ….

21 U.S.C. § 823(g) provides in part:

> **(g)** PRACTITIONERS DISPENSING NARCOTIC DRUGS FOR NARCOTIC TREATMENT; ANNUAL REGISTRATION; SEPARATE REGISTRATION; QUALIFICATIONS; WAIVER

**(1)** Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose.

**…**

**(2)**

**(A)** Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

**(B)** For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a practitioner are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, the practitioner submit to the Secretary a notification of the intent of the practitioner to begin dispensing the drugs or combinations for such purpose, and that the notification contain the following certifications by the practitioner:

**(i)** The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

**(ii)** With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary—

**(I)** all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention; and

**(II)** appropriate counseling and other appropriate ancillary services.

**(iii)**

**(I)** The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclause (II), the applicable number is 30.

**(II)** The applicable number is—

**(aa)** 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients;

**(bb)** 100 if the practitioner holds additional credentialing, as defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations);

**(cc)** 100 if the practitioner provides medication-assisted treatment (MAT) using covered medications (as such terms are defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations)) in a qualified practice setting (as described in section 8.615 of title 42, Code of Federal Regulations (or successor regulations)); or

**(dd)** 275 if the practitioner meets the requirements specified in sections 8.610 through 8.655 of title 42, Code of Federal Regulations (or successor regulations).

**(III)** The Secretary may by regulation change such applicable number.

**(IV)** The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.

…

**(G)** For purposes of this paragraph:

…

**(ii)** The term "qualifying physician" means a physician who is licensed under State law and who meets one or more of the following conditions:

**(I)** The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.

**(II**) The physician holds an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine.

**(III**) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

**(IV)** The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction

Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall include—

**(aa)** opioid maintenance and detoxification;

**(bb)** appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

**(cc)** initial and periodic patient assessments (including substance use monitoring);

**(dd)** individualized treatment planning, overdose reversal, and relapse prevention;

**(ee)** counseling and recovery support services;

**(ff)** staffing roles and considerations;

**(gg)** diversion control; and

**(hh)** other best practices, as identified by the Secretary.

**(V)** The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

**(VI)** The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

**(VII)** The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

**(VIII)** The physician graduated in good standing from an accredited school of allopathic medicine or osteopathic medicine in the United States during the 5-year period immediately preceding the date on which the physician submits to the Secretary a written notification under subparagraph (B) and successfully completed a comprehensive allopathic or osteopathic medicine curriculum or accredited medical residency that—

**(aa)** included not less than 8 hours of training on treating and managing opioid-dependent patients; and

**(bb)** included, at a minimum—

**(AA)** the training described in items (aa) through (gg) of subclause (IV); and

**(BB)** training with respect to any other best practice the Secretary determines should be included in the curriculum, which may include training on pain management, including assessment and appropriate use of opioid and non-opioid alternatives.

**(iii)** The term "qualifying practitioner" means—

(I) a qualifying physician, as defined in clause (ii);

(II) a qualifying other practitioner, as defined in clause (iv), who is a nurse practitioner or physician assistant; or

(III) for the period beginning on October 1, 2018, and ending on October 1, 2023, a qualifying other practitioner, as defined in clause (iv), who is a clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife.

**(iv)** The term "qualifying other practitioner" means a nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant who satisfies each of the following:

**(I)** The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

**(II)** The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant has—

**(aa)** completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or

otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or

**(bb)** has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant to treat and manage opiate-dependent patients.

**(III)** The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has informed the Washington State Department of Health that the supervising physician is not required to obtain a waiver before a physician assistant may obtain a waiver, so long as the supervising physician and the physician assistant otherwise meet the requirements as set forth above. SAMHSA explained that each state may impose such a requirement, or impose any other restriction or limitation on the scope of a physician assistant's practice.

The Commission interprets RCW 18.71A.120 and 21 U.S.C. § 823(g) to permit a physician assistant who has received a waiver from the DEA to provide buprenorphine for the treatment of opioid addiction even if the supervising physician has not received a waiver, provided that the physician assistant is supervised by a qualifying physician and the practice agreement between the physician and the physician assistant complies with Washington law. Since a qualifying physician is an addiction specialist or has taken training in treating and managing opiate-dependent patients, the qualifying physician does not need a DEA waiver to supervise a physician assistant who provides buprenorphine to opiate-dependent patients through a DEA waiver.

Meeting the challenges of the ongoing opioid epidemic will require increased access to addiction treatment, and recognizing a physician assistant's ability to obtain a DEA waiver is one method to attempt to meet the needs of Washington citizens suffering from opioid use disorder. When applying for a waiver, practitioners are strongly encouraged to let their practice address be publicly listed to facilitate access to treatment of opioid use disorder.

**U.S. Department of Justice**
Drug Enforcement Administration

*Office of the Administrator* *Springfield, VA 22152*

January 12, 2023

Dear Registrants:

On December 29, 2022, with the signing of the Consolidated Appropriations Act of 2023 (the Act), Congress eliminated the "DATA-Waiver Program."

DEA fully supports this significant policy reform. In this moment, when the United States is suffering tens of thousands of opioid-related drug poisoning deaths every year, the DEA's top priority is doing everything in our power to save lives. Medication for opioid use disorder helps those who are fighting to overcome opioid use disorder by sustaining recovery and preventing overdoses. At DEA, our goal is simple: we want medication for opioid use disorder to be readily and safely available to anyone in the country who needs it. The elimination of the X-Waiver will increase access to buprenorphine for those in need.

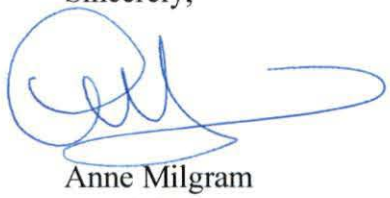
All DEA registrants should be aware of the following:

- A DATA-Waiver registration is no longer required to treat patients with buprenorphine for opioid use disorder.
- Going forward, all prescriptions for buprenorphine only require a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
- There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- The Act does not impact existing state laws or regulations that may be applicable.

Separately, the Act also introduced new training requirements for all prescribers. These requirements will not go into effect until June 21, 2023. The DEA and SAMHSA are actively

working to provide further guidance and DEA will follow up with additional information on these requirements shortly. Importantly, these new requirements do not impact the changes related to elimination of the DATA-Waiver Program described above.

Sincerely,



Anne Milgram
Administrator

*For information regarding DEA's Diversion Control Division, please visit https://www.DEAdiversion.usdoj.gov. Please contact the Diversion Control Division Policy Section at ODLP@dea.gov if you seek additional assistance regarding this or any other matter.*

# Interpretive Statement

WASHINGTON Medical Commission
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| | | |
|---|---|---|
| Title: | Application of the Office-based Surgery Rule, WAC 246-919-601, to the Use of Nitrous Oxide | INS2023-0x |
| References: | WAC 246-919-601 | |
| Contact: | Washington Medical Commission | |
| Phone: | (360) 236-2750 E-mail: medical.commission@wmc.wa.gov | |
| Supersedes: | None | |
| Effective Date: | | |
| Approved By: | Jimmy Chung, MD, Chair (signature on file) | |

The Washington Medical Commission (WMC) interprets WAC 246-919-601, which regulates analgesia, anesthesia, and sedation in office-based settings, to apply to the use of nitrous oxide. The use of nitrous oxide, a systemic analgesic, is not considered "minimal sedation" and, therefore, an a~~ll~~opathic physician who uses nitrous oxide in an office-based setting must comply with the requirements of WAC 246-919-601.

The WMC adopted WAC 246-919-601 in 2010 to promote patient safety by establishing consistent standards and competency for procedures requiring analgesia, anesthesia, or sedation performed in an office-based setting. The rule was designed to complement new legislation requiring the licensing of ambulatory surgical facilities.

The rule contains certain requirements to ensure that patients are safe when undergoing procedures in a physician's office. These requirements include accreditation or certification of the facility where the procedures take place; competency; separation of surgical and monitoring functions; written emergency care and transfer protocols; the ability to rescue a patient who enters a deeper level of sedation than intended; and having a licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group present or immediately available.

WAC 246-919-601 provides in relevant part:

> (2) Definitions. The following terms used in this subsection apply throughout this section unless the context clearly indicates otherwise:
> ...
> (e) "Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral, intranasal, or intramuscular medications.
> ...

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

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

When the WMC adopted WAC 246-919-601 in 2010, and when the WMC made a minor definition amendment a decade later, the WMC did not intend for nitrous oxide to qualify for the above rule exemptions. WAC 246-919-601(3)(a) specifically exempts from the rule requirements procedures that require only minimal sedation. WAC 246-919-601(2)(e) clarifies that minimal sedation is limited to oral, intranasal, or intramuscular medications. The WMC revised the rule in 2020 to add the term "intranasal" to the definition of minimal sedation to permit the use of midazolam when sprayed into the nose. The addition of the term "intranasal" was not meant to include the use of inhaled anesthetic agents such as nitrous oxide. Since its inception, WAC 246-919-601 was not intended to include, nor does it include, an exemption to the rule for nitrous oxide in an office-based setting.

Based on the language of the rule and the intent behind the revision in 2020, the WMC interprets WAC 246-919-601 to apply to the use of nitrous oxide. The use of nitrous oxide is not considered "minimal sedation," and, therefore, an allopathic physician who uses nitrous oxide in an office-based setting must comply with the requirements of WAC 246-919-601.

# Staff Reports: March 3, 2023

## Melanie de Leon, Executive Director

**Awards:** Marisa Courtney was selected by FSMB for their Award of Merit for her exemplary work through the pandemic to further the field of medical licensure. She rebuilt the Licensing Unit and changed its culture to empower each member to make decisions using their skill, training, and experience. As a result of all their hard work, licensing time decreased from 20 weeks to 3.4 weeks while simultaneously eliminating Intake backlog. Their responsiveness ensures our applicants have the best experience possible. She will be honored at FSMB's annual meeting in May.

**CLEAR International Congress:** Jimi Bush was selected to participate on a panel at CLEAR's International Congress in Dublin, Ireland, to share WMC's DEI initiatives along with Staci Mason, Director, AMCAS Operations, Association of American Medical Colleges.

**Executive Director recruitment:** Based on my announced retirement date of September 1, 2023, I am working with DOH HR to finalize a timeline to have a 1-month overlap in August to help the new ED transition smoothly into this role. The recruitment announcement will be posted on or about March 10th and close the end of May. Interviews by both a commissioner panel and a staff leadership panel will occur in June, with an offer by 1 Jul and start date of 1 August to allow the successful candidate to provide notice and tend to any relocation needs.

## Micah Matthews, Deputy Executive Director

**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 Department of Health policy, requests submitted after the cutoff cannot be paid out.

### Other

Our own Ms. Jimi Bush was awarded the FSMB Journal of Medical Regulation Award for Distinguished Scholarship for the paper she submitted on medical recidivism. A huge congratulations to Jimi for this national recognition. Thanks for the work of Sarah Chenvert in her work on the data portion of the article and helping make it a success. Read the article here: An Evaluation of Clinicians with Subsequent Disciplinary Actions: Washington Medical Commission | Journal of Medical Regulation (allenpress.com)

### Budget

The WMC overall budget outlook is positive. Regular budget reporting for January 2023:

- The WMC revenue collections are slightly under expectations but remain reasonable when observing three-month trends and reduced spending versus allotments.

## Micah Matthews, Deputy Executive Director continued

- Collections in FY 1 of the current biennium completed at 95% of projections resulting in a revenue deficit of $730,000. As we are entering the licensing busy season, we expect to make up some of this collection deficit.
- Our expenditures being less than our allotments results in an overall projected outlook of the WMC finishing the biennium with a 3.7 percent underspend ($730,000). Variables in this equation are what the service unit charges and indirect charges from the department, both of which we don't control, will look like as the biennium concludes. Currently, the service unit charges are at 102 percent of total allotment ($1.8 million) and their indirect charges are 88 percent of total allotment ($5.3 million). As a reminder, any unspent allotment funds revert to our reserve and must be re-appropriated to us by the Legislature through the normal budget process.
- Finally, we have had one HELMS (regulatory database replacement project) expenditure of $723,000 in July 2022. There is an additional estimated "contribution" scheduled in June 2023 of $669,000. These expenditures come from our fund balance directly and not from our allotment and as such will not impact our projected underspend for the biennium.

We are waiting for the House and Senate to mark up their respective budget bills to know if our request is going to be included in their proposals.

### Legislative Session

Overall outlook for WMC on legislation is neutral. We reached the first policy cutoff on February 17, which is closely followed by a fiscal cutoff (February 24) and house of origin cutoff (March 8). This is the process of reducing what bills and proposals move forward for consideration and passage. As things are constantly moving until more cutoffs occur, I refer you to my update emails sent to all commissioners and staff for more up to date information.

### Audit

We await the technical review from the contracted auditor. I do not have a timeframe for when this will be delivered. Based on current timing, we will not have an audit presentation for this legislative session that will allow any form of policy or budgetary action based on the results. Overall preliminary results appear to be positive for the WMC.

### Joint Operating Agreement

WMC and DOH staff have come to agreement on the changes in the section of the proposed JOA relating to public disclosure. In process is a final WMC management staff level review and comment followed by a coordination meeting with the Nursing and Chiropractic Commission leadership staff. The JOA will then be submitted to the Office of the Secretary for final consideration and signature.

## Morgan Barrett, MD, Medical Consultant, Director of Compliance

Since its inception, the Physician Support Program has received 93 referrals.

## Amelia Boyd, Program Manager

### Recruitment

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

- Urology
- Radiology
- Neurosurgery
- General surgeon
- Psychiatry

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.

We began our recruitment for the vacancies we will have on July 1, 2023. We are recruiting for the following positions:

- One physician representing Congressional District 2
  - Dr. Lyle's position – eligible for reappointment
- One physician representing Congressional District 4
  - Dr. Murphy's position – eligible for reappointment
- One physician representing Congressional District 10
  - Dr. Wohns' position – eligible for reappointment
- One Physician-at-Large
  - Dr. Currie's position – eligible for reappointment
- Two Public Members
  - Michael Bailey – eligible for reappointment
  - Scott Rodgers – eligible for reappointment

All the above Commissioners have been notified that their first term is ending June 30, 2023, they are eligible for reappointment, and they must submit a new application to be considered for reappointment. The application deadline is March 24, 2023. The recruitment notice is available on our website.

The following positions expired as of June 30, 2022, and we are awaiting word from the Governor's office staff on the new appointees:

- Public Member – Toni Borlas – not eligible for reappointment
- Public Member – Yanling Yu, PhD – not eligible for reappointment

## Mike Hively, Director of Operations and Informatics

Operations & Informatics has begun testing its newly developed litigation hold program and is currently processing three hold notices as well as conducting a fourth electronic records search. We've received valuable feedback relating to the program and will implement relevant changes moving forward. We also completed one compulsory request for the AAG's Criminal Protection Division and are working on another for the Office of Inspector General.

## Mike Hively, Director of Operations and Informatics continued

**Unit Accomplishments Include:**

Digital Archiving:

- 166 Complaints closed BT – folder is current
- 590 Active MD licensing applications
- 531 Active PA licensing applications
- Approximately 2,132 demographic census forms

Data Requests/Changes:

- Approximately 739 open/closed inquiries (individual requests may contain requests)
- Approximately 516 address changes

Demographics:

- Entered approximately 2,132 census forms into the IRLS database and conducted quality checks
- Conducts 730 secondary census contacts via email
- Created quarterly demographic report
- Created graph based on demographic data relating to practice settings
- Completed quality checks on census data

Ops & Info continues to sort, scan, and distributed WMC mail as well as, respond to Scope of Practice inquiries and support staff and commission I.T. issues as needed via, email, chat, phone, and remote access. Information Liaison Ken Imes restructured the WMC call center combing the complaints and investigation into one consumer option and updated all announcements to reflect needed changes.

Lastly, we verified our ability to scan & toss digitally imaged paper-based records with the Washington State Archives and submitted two additional boxes of paper-based applications for destruction.

## Rick Glein, Director of Legal Services

**Legal Staff Update:**

The Legal Unit welcomed our newest staff attorney, Lisa Krynicki, to our team on February 16. After graduating from Willamette University College of Law in 2001, Lisa spent nearly twenty years practicing law in Alaska before "retiring" due to the pandemic in 2021. For fifteen of those years, Lisa specialized in medical malpractice and professional licensing defense. In addition to Lisa's law degree, she also has a Masters in Library and Information Sciences from Kent State University. Lisa is moving to Washington from Bend, Oregon, with her husband and two sons.

**Summary Actions:**

*In re Balamurali K. Ambati, MD,* Case No. M2022-354. On January 6, 2023, the Commission issued an Ex Parte Order of Summary Restriction which ordered Dr. Ambati restricted from

performing all types of eye surgery (including laser, intraocular injections, and any type of surgery involving cutting), performing any experimental and/or off-label procedures, and using non-FDA approved materials pending further disciplinary proceedings by the Commission. The Statement of Charges (SOC) alleges Dr. Ambati practiced experimental medicine that poses a grave risk to patient safety and did so without proper consent. Dr. Ambati filed a timely Answer to the SOC* and initially requested a show cause hearing. Dr. Ambati subsequently withdrew his request for a show cause hearing, and this matter will be scheduled for hearing on the merits of the SOC.

*The license holder must file a request for hearing with the disciplining authority within twenty days after being served the statement of charges. RCW 18.130.090

**Orders Resulting from SOCs**:
*In re Dara Parvin, MD,* Case No. M2021-376. Final Order.** In March 2022, the Commission filed a SOC alleging Dr. Parvin entered into a Settlement Agreement with the Iowa Board of Medicine which placed her license to practice in the state of Iowa on probation for a period of two years upon her return to practice in that state. The underlying conduct alleged in the Iowa Settlement Agreement included making inappropriate advances on and sending suggestive messages to subordinate co-workers and a colleague. In September 2022, the HLJ granted the Commission's Motion for Partial Summary Judgment, finding that there is no genuine dispute as to any material fact and limited the issue at hearing to sanctions only. The Commission held a virtual hearing on October 21, 2022. A Final Order was issued on January 12, 2023. The Commission reprimanded Dr. Parvin for the underlying conduct that resulted in his license restriction in Iowa and ordered compliance with the terms and conditions of the Iowa Agreement and an Ohio Order which requires Dr. Parvin complete a Professional Ethics and Physician/Patient Boundaries course. Dr. Parvin's Washington state medical license is currently expired. Before applying for reactivation of his license, Dr. Parvin shall obtain an assessment from the Washington Physicians Health Program (WPHP).

*In re John C. Lucke, MD,* Case No. M2021-908. Agreed Order. On September 2, 2022, the Commission served a SOC and Ex Parte Order of Summary Suspension which suspended Dr. Lucke's medical license based on allegations that Dr. Lucke entered into an Order with the Board of Registration in Medicine for the Commonwealth of Massachusetts in which Dr. Lucke voluntarily surrendered his medical license. The conduct underlying the Massachusetts Order was a restriction of Dr. Lucke's Oregon medical license prohibiting him from performing cardiac procedures in the state of Oregon based on a finding that he performed below the standard of care. On January 12, 2023, the Commission approved an Agreed Order in which Dr. Lucke agreed to voluntarily surrender his Washington medical license.

*In re Chester C. Hu, MD,* Case No. M2022-359. Agreed Order. On May 31, 2022, the Commission served a SOC alleging Dr. Hu entered into a Consent Agreement with the Alaska State Medical Board (Alaska Consent Agreement) for administering fentanyl to a patient with a known fentanyl allergy without the patient's consent. The Alaska Consent Agreement placed Dr. Hu's license on probation for a period of three years, required Dr. Hu pay a fine, complete continuing medical education, undergo chart audits, and submit quarterly reports.

## Rick Glein, Director of Legal Services continued

On January 12, 2023, the Commission approved an Agreed Order in which Dr. Hu agreed to restrict his practice by treating a patient only in a hospital-based setting with a post-anesthesia care unit (PACU). This restriction permits treatment where a patient is discharged on the same day as surgery or anesthesia administration. Additionally, Dr. Hu may not treat patients in an ambulatory surgical facility (ASF), a hospital-affiliated ASF, or in a non-hospital-based outpatient setting. Dr. Hu must permit compliance audits at his practice on a periodic basis, appear personally before the Commission, and pay a $2,500 fine. Dr. Hu may petition to terminate the Agreed Order three years from its effective date.

**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).

**Virtual Hearing**:
*In re Rajninder Jutla, MD,* Case No. M2022-438. On July 15, 2022, the Commission served a Statement of Charges (SOC) and Ex Parte Order of Summary Suspension which suspended Dr. Juta's medical license based on allegations that Dr. Jutla is not safe to practice medicine with reasonable skill and safety. The Commission held a virtual hearing January 19-20, 2023. A Final Order is expected to be issued by the end of April 2023.***

***The HLJ has 90 days after the conclusion of the hearing to issue a decision. RCW 34.05.461.

**Items of Interest:**
On February 1, Rick and Trisha participated in the Oregon US Department of Justice Health Care Fraud Task Force (made up of governmental agency representatives and insurers) to discuss cases and licensees of mutual interest.

On February 2, Rick met with members of the newly created State Office of Behavioral Health Consumer Advocacy. Leaders from the Nursing Commission, DOH's Health Professions & Facilities, Community Health, Behavioral Health Inspections, and the Secretary's Office also attended. The group discussed a Working Agreement between the agencies, and how to handle complaints and investigations referred by the new Office. The WMC was included since complaints could potentially come in from the new Office involving our psychiatrist licensees. The Working Agreement is still in the draft stage.

## Mike Farrell, Policy Development Manager

Nothing to report that isn't in the policy or legal unit report.

## Freda Pace, Director of Investigations

**Reviewing Commissioner Member Notification (RCM Notification) process:**
As a reminder, the RCM Notification process allows you (the RCM) and the assigned investigator an opportunity to collaborate in building the foundation for a thorough investigation. Please make sure to monitor your WMC email inbox regularly and respond timely to request for specific feedback which will help with a speedy and thorough investigation.

**CMT Sign-up for 2023**
Our CMT sign up slots for 2023 is ready and awaiting your name! Please take some time to check out the CMT calendar to find a vacant slot – there are plenty. We appreciate your continued participation in this very important process. We could not be able to do this work without you and your support!

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman (chris.waterman@wmc.wa.gov). This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs.

January Case Trends provided by Chris Waterman, Complaint Intake Manager:

| | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|
| New Cases | 114 | | 121 | | 118 | |
| Authorized | 31 | 27.2% | 27 | 22.3% | 38 | 32.2% |
| Closed | 83 | 72.8% | 94 | 77.7% | 80 | 67.8% |

## Jimi Bush, Director of Quality and Engagement

**Engagement**

**Patient Safety Awareness Week**

We are planning to strengthen the WMC presence during the 2023 Patient Safety Awareness Week (PSAW). We have a variety of webinars and "fun facts" that will be shared on social media throughout the week of March 12 –18. On Sunday we are going to be releasing a pre-recorded video on social media where we have short testimonials from staff and commissioners about what patient safety means to them, how the work of the WMC protects patient safety and/or a story where you (or a coworker or health care provider) went above and beyond to correct a potential issue before it affected the safety of yourself or a patient. **I encourage you to submit a short video (no more than 90 seconds) sharing your thoughts or experience.** I am here to help with any wordsmithing or technical assistance you may need – please share your video with me no later than March 7th. Here are the other events we have planned:

- Tuesday 14th- 5 Steps to Filing a Complaint

- Wednesday 15th- How Discrimination Affects Patient Safety
- Thursday 16th- Strengthening RN/MD Communication - This is a collaboration with the NCQAC

**Coffee with the Commission**
We have 2 upcoming Coffee with the Commission. On March 21 at 11 am we will be joining Dr. Chris Bundy with WPHP to discuss the changes that have been made to our initial licensing application with regards to personal data questions surrounding mental and physical health. And on March 23rd Stephanie and Micah will provide a Legislative Update.

**More information on each event and registration can be found on our Webinar Page and Event Calendar.** Please share this information with your circles.

**Speaking Engagements**
Dr. Currie and Kyle Karinen will be presenting to the Washington Academy of Family Physicians regarding the Abuse of a Patient on March 24th. This was a special request by the academy after reaching the Fall 2022 newsletter articles.

**JMR Award**
The Journal of Medical Regulation Editorial Board recently selected our article, "An Evaluation of Clinicians with Subsequent Disciplinary Actions" to receive the JMR Award for Distinguished Scholarship for articles published in 2022. This award will be presented at the Annual Conference in Minneapolis in May.

**Performance**

| Metric | 2021 | 2022 |
|---|---|---|
| Applications received | 4,370 | 4,243 |
| New Credentials issued | 4,462 | 4,271 |
| Renewals processed | 18,005 | 18,624 |
| Percent of credentials processed within 14 days of required information | 99.3% | 99.8% |
| Cases Reviewed at CMT | 1,830 | 1,704 |
| COVID Related Complaints | 99 | 14 |
| % of complaints authorized for investigation | 48% | 27% |
| % of investigations closed within 170 days | 83% | 79% |
| Average Days to Complete an Investigation | 153.4 | 163.6 |
| Cases reviewed by Panel A | 326 | 351 |
| Cases Reviewed by Panel B | 436 | 498 |
| % of cases closed within 140 days of entering case disposition status | 82% | 85% |
| Average number of days to close a case out of case disposition | 91.7 | 80.1 |

Jimi Bush, Director of Quality and Engagement continued

| Outcomes | 2021 | 2022 |
|---|---|---|
| Cases closed with no action (A closure) | 386 | 343 |
| STIDs Finalized | 66 | 34 |
| SOCs Served | 24 | 27 |
| Agreed Order | 10 | 9 |
| Final Order | 11 | 5 |
| Hearings completed | 10 | 4 |
| Summary Suspension Action | 8 | 15 |
| Revocation | 1 | 0 |
| BT Reconsiderations Received / Authorized | 59 Received/ 11 Authorized | 39 Received/ 7 Authorized |
| A Reconsiderations Received / Authorized | 11 Received/ 0 Authorized | 17 Received/ 3 Authorized |
| Practitioners actively in compliance | 152 | 181 |
| Practitioners released from compliance | 40 | 35 |

**Quality**

To date – we have formally created 68 unique processes and their associated maps. All formalized processes are available on our SharePoint site in their respective folders (I.e. processes that are associated with a legal process can be found in the legal folder) Processes that are in progress can be found in the LEAN folder.

In 2022, we updated 45 processes. The largest number of updates were made to the Investigation Unit's processes (16 processes), followed by the Licensing Unit (12 processes). We also created 21 new processes in 2022.

The Lean Facilitator's group was created under the direction of the Strategic Plan and has been meeting monthly. This group is composed of non-supervisory employees across all the WMC Units. The group discusses how we can work better together across Units and identifies opportunities for Lean process improvements.

## Marisa Courtney, Licensing Manager

Total licenses issued from 01/01/2023- 02/21/2023= 451

| Credential Type | Total Workflow Count |
|---|---|
| Physician And Surgeon Clinical Experience License | 2 |
| 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 | 243 |
| Physician and Surgeon License Interstate Medical Licensure Compact | 133 |
| Physician And Surgeon Residency License | 0 |
| Physician And Surgeon Teaching Research License | 2 |
| Physician And Surgeon Temporary Permit | 4 |
| Physician Assistant Interim Permit | 1 |
| Physician Assistant License | 65 |
| Physician Assistant Temporary Permit | 1 |
| **Totals:** | **406** |

**Information on Renewals: January Renewals- 74.08% online renewals**

| Credential Type | # of Online Renewals | # of Manual Renewals | Total # of Renewals |
|---|---|---|---|
| IMLC | 0 | 59 | 59 |
| MD | 975 | 310 | 1285 |
| MDTR | 3 | 0 | 3 |
| PA | 191 | 40 | 231 |
| | **74.08%** | **25.92%** | **100.00%** |

WASHINGTON Medical Commission
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# Panel A
# Personal Appearance Agenda

Friday, March 3, 2023

| | | | | |
|---|---|---|---|---|
| Panel Members: | Sarah Lyle, MD, Panel Chair | Mabel Bongmba, MD | Jimmy Chung, MD | Arlene Dorrough, PA-C |
| | Anjali D'Souza, MD | Harlan Gallinger, MD | Elisha Mvundura, MD | Robert Pullen, Public Member |
| | Scott Rodgers, Public Member | Richard Wohns, MD | Yanling Yu, PhD, Public Member | |
| | Janet Barrall, MD, Pro-Tem | Alan Brown, MD, Pro-Tem | Mary Curtis, MD, Pro-Tem | Charlie Browne, MD |
| | Robert Golden, MD | | | |

Compliance Officer: Anthony Elders

| | | |
|---|---|---|
| **9:45 a.m.** | **David W. Janeway, MD**<br>Attorney: Timothy E. Allen | M2021-747 (2021-3373)<br>RCM: Sarah Lyle, MD<br>SA: Colleen Balatbat |
| **10:30 a.m.** | **Carol E. Flaugher, PA-C**<br>Attorney: Pro Se | M2022-197 (2021-197)<br>RCM: Richard Wohns, MD<br>SA: Mike Farrell |
| **11:15 a.m.** | **Vladimir B. Fiks, MD**<br>Attorney: Pro Se | M2021-906 (2021-9950)<br>RCM: Jimmy Chung, MD<br>SA: Trisha Wolf |

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WASHINGTON Medical Commission
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# Panel B

# Personal Appearance Agenda

Friday, March 3, 2023

| | | | | |
|---|---|---|---|---|
| Panel Members: | Chair: Terry Murphy, MD | Michael Bailey, Public Member | Christine Blake, Public Member | Toni Borlas, Public Member |
| | Po-Shen Chang, MD | Diana Currie, MD | Karen Domino, MD | April Jaeger, MD |
| | Ed Lopez, PA-C | Claire Trescott, MD | | |
| | Theresa Schimmels, PA-C, Pro-Tem | Daniel Flugstad, MD, Pro-Tem | Alden Roberts, MD, Pro-Tem | John Maldon, Public Member, Pro-Tem |
| | | | | |

Compliance Officer: Mike Kramer

| | | |
|---|---|---|
| **9:45 a.m.** | **Randi G. Carter, MD-Virtual Appearance**<br>Attorney: William Etter | M2021-653 (2021-2053)<br>RCM: Ed Lopez, PA-C<br>SA: Joel Defazio |
| **10:30 a.m.** | **Garrett E. Soames, PA-C**<br>Attorney: Kenneth S. Kagan | M2021-753 (2021-2094)<br>RCM: Toni Borlas, Public Member<br>SA: Rick Glein |
| **11:15 a.m.** | **Jesse P. McClelland, MD**<br>Attorneys: Amy Magnano,<br>Carol Sue Janes | M2018-709 (2020-17586 et al.)<br>RCM: Claire Trescott, MD<br>SA: Rick Glein |

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