RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
FILED

DATE: October 21, 2020
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WSR 20-22-003

Agency: Department of Health- Washington Medical Commission

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: WAC 246-919-010 through 246-919-770 (relating to allopathic physicians). The Washington Medical Commission (commission) adopted amendments to more closely align these sections with current industry standards and provide clearer rule language for licensed allopathic physicians (MDs). Changes include updating the name of the commission pursuant to SB 5764; updating definitions to reference new terminology or clarify their meaning; rescinding sections which are no longer relevant, utilized, or are referenced in other chapters; updating references to periodicals; updating physician licensing requirements to align with current standards; updating section titles to more clearly state the purpose of the section; incorporating language from commission interpretive statements; adding a new section on how a military spouse may obtain a temporary practice permit pursuant to RCW 18.340.020; adding a new section on the administration of deep sedation and general anesthesia by a physician in a dental office; and updating the timelines required for cooperating with an investigation.

Citation of rules affected by this order:

New: WAC 246-919-397, 246-919-602

Repealed: WAC 246-919-310, 246-919-710, 246-919-730, 246-919-740, 246-919-750, 246-919-760, 246-919-770

Amended: WAC 246-919-010, 246-919-020, 246-919-300, 246-919-320, 246-919-330, 246-919-340, 246-919-355, 246-919-360, 246-919-365, 246-919-370, 246-919-395, 246-919-396, 246-919-422, 246-919-435, 246-919-475, 246-919-480, 246-919-520, 246-919-601, 246-919-605, 246-919-606, 246-919-610, 246-919-620, 246-919-630, 246-919-700

Suspended: None

Statutory authority for adoption: RCW 18.71.017; and RCW 18.130.050

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 20-16-002 on 07/22/2020 (date).

Describe any changes other than editing from proposed to adopted version: There were no changes from the proposed to adopted version other than editing.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Amelia Boyd
Address: PO Box 47866, Olympia, WA 98504-7866
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Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	0	Amended	0	Repealed	0
Recently enacted state statutes:	New	2	Amended	24	Repealed	7

The number of sections adopted at the request of a nongovernmental entity:

	New	0	Amended	0	Repealed	0

The number of sections adopted in the agency's own initiative:

	New	0	Amended	0	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	0	Amended	0	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	2	Amended	24	Repealed	7

Date Adopted: 08/21/2020	**Signature:**
Name: Melanie de Leon	
Title: Executive Director	

Chapter 246-919 WAC
WASHINGTON MEDICAL ((~~QUALITY ASSURANCE~~)) COMMISSION

AMENDATORY SECTION (Amending WSR 11-05-025, filed 2/7/11, effective 3/10/11)

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

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

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

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

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

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

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

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

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

((~~(9)~~)) (7) "Unprofessional conduct" ((~~as used in these regulations shall~~)) means the conduct described ((~~in RCW 18.71.0193 for conduct occurring before June 11, 1986, and the conduct described~~)) in RCW 18.130.180 ((~~for conduct occurring on or after June 11, 1986~~)).

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

AMENDATORY SECTION (Amending WSR 04-04-067, filed 2/2/04, effective 3/4/04)

WAC 246-919-320 Approved United States and Canadian medical schools. For the purposes of ((~~the Medical Practice Act~~)) RCW 18.71.055, the commission approves ((~~those~~)) medical schools accredited by the Liaison Committee on Medical Education.

AMENDATORY SECTION (Amending WSR 05-07-024, filed 3/7/05, effective 4/7/05)

WAC 246-919-330 Postgraduate medical training ((~~defined~~)). (1) ((~~For the purposes of this chapter,~~)) Postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties ((~~and listed in the 2004 *Official ABMS Annual Report and Reference Handbook*, published March 18, 2004~~)) listed in the 2017-2018 ABMS Board Certification Report and new specialties or subspecialties approved by the commission.

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

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

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

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

(4) A physician must complete two consecutive years of postgraduate medical training in no more than two programs. The physician must acquire this training after completion of a formal course of undergraduate medical instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations.

AMENDATORY SECTION (Amending WSR 01-18-086, filed 9/5/01, effective 10/6/01)

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

(1) ((~~Been licensed~~)) Held a full and unrestricted license to practice medicine in another state prior to 1958;

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

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

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

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

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

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

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

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

~~(c) Be certified by the ECFMG if a graduate of an international medical school, or have successfully completed a fifth pathway program; and postgraduate training year in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education.~~)) Applicants must have passed all components of the USMLE within seven years after passing the first examination. The commission recognizes that an applicant with a combined degree may require an exception to the seven-year requirement. The commission will review exception requests on a case-by-case basis.

AMENDATORY SECTION (Amending WSR 06-18-042, filed 8/30/06, effective 9/30/06)

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

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

Table 1

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

WAC 246-919-365 FLEX examination standards. ((~~Reciprocity applicants who were licensed in another state by passing the FLEX examination will be eligible for a waiver of examination if the applicant received a FLEX weighted average score of at least 75. The score may~~

~~be obtained in a single setting of the three-day examination or by averaging the individual day scores from different examinations. The individual day scores will be averaged according to the following formula:~~

~~Day 1 equals 1/6.~~
~~Day 2 equals 2/6.~~
~~Day 3 equals 3/6.~~

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

(a) Resolved or pending malpractice suits;

(b) Pending action by another state licensing authority;

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

(d) Not having practiced for ((~~an interval of time~~)) the immediate two years prior to the application.

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

AMENDATORY SECTION (Amending WSR 17-18-098, filed 9/6/17, effective 10/7/17)

WAC 246-919-395 Substantially equivalent licensing standards—Temporary practice permit. (1) An applicant who holds an unrestricted, active license in another state with licensing standards substantially equivalent to those in Washington may apply for a temporary practice permit authorizing the applicant to practice as a physician in Washington.

(2) The commission will issue the physician a temporary practice permit if the following requirements are met:

(a) The applicant submits a completed application for a physician and surgeon license on a form provided by the commission on which the applicant indicates that he or she wishes to receive a temporary practice permit;

(b) The applicant submits payment of the application fee and temporary practice permit fee ((~~pursuant to~~)) under WAC 246-919-990;

(c) The commission receives the American Medical Association's physicians' data profile verifying states in which the applicant is or was licensed;

(d) The commission receives the practitioner profile from the Federation of State Medical Boards;

(e) The applicant requests and the commission receives written verification attesting that the applicant has a license in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment from all states which the applicant is or was licensed;

(f) The applicant is not subject to denial of a license or issuance of a conditional license under chapter 18.130 RCW; and

(g) The applicant is licensed in a state that has licensing standards substantially equivalent to Washington.

(3) The temporary practice permit allows the applicant to work in the state of Washington as a physician without restriction until the permit expires. The temporary practice permit is a license to practice medicine.

(4) The temporary practice permit shall expire upon the issuance of a license by the commission; initiation of an investigation by the commission of the applicant; or ninety days after the temporary practice permit is issued, whichever occurs first. The temporary permit will not be renewed, reissued, or extended.

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

AMENDATORY SECTION (Amending WSR 10-05-029, filed 2/9/10, effective 2/11/10)

WAC 246-919-396 Background check—Temporary practice permit. The ((~~medical quality assurance commission (MQAC)~~)) commission conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The ((~~MQAC~~)) 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 ((~~MQAC~~)) commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

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

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

(3) The ((~~MQAC~~)) 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 action is taken on the application because of the background check.

NEW SECTION

WAC 246-919-397 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 physicians.

(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 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.

(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 physicians;

(d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards for physicians 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) Documentation of a state registered domestic partnership.

(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.

AMENDATORY SECTION (Amending WSR 16-16-028, filed 7/22/16, effective 8/22/16)

WAC 246-919-422 Transition from post-graduate limited license to full license. In order to obtain full license status, ((~~individuals~~)) a physician with a post-graduate limited Washington license will pay the fee difference between the limited license application and the full license application. This license will expire on their second birth date after issuance and every two years thereafter.

AMENDATORY SECTION (Amending WSR 17-07-043, filed 3/8/17, effective 4/8/17)

WAC 246-919-435 Training in suicide assessment, treatment, and management. (1) A licensed physician, other than a resident holding a limited license issued under RCW 18.71.095(3), 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)~~)) (4) 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 246-919-460.

((~~(6)~~)) (5) The commission exempts any licensed physician from the training requirements of this section if the physician has only brief or limited patient contact, or no patient contact.

AMENDATORY SECTION (Amending WSR 01-03-115, filed 1/22/01, effective 2/22/01)

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

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

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

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

AMENDATORY SECTION (Amending WSR 11-05-025, filed 2/7/11, effective 3/10/11)

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

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

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

(4) A physician((~~s~~)) with a retired active license must renew every two years and must report one hundred hours of continuing medical education at every renewal. The commission will accept a maximum of forty hours of continuing medical education in Categories II through V, as defined in WAC 246-919-460, during each renewal period. There is no limit to the number of hours that may be accepted in Category I.

AMENDATORY SECTION (Amending WSR 97-21-053, filed 10/13/97, effective 11/13/97)

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

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

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

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

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

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

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

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

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

(a) Shall review the final order;

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

(c) May hear oral argument by the parties.

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

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

AMENDATORY SECTION (Amending WSR 17-18-032, filed 8/28/17, effective 9/28/17)

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

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

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

~~(b)~~)) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent air-

way, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

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

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

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

((~~(f)~~)) (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((~~, or both~~)).

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

((~~(h)~~)) (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.

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

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

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

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

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

surgical facility licensed under chapter 70.230 RCW, or a dental office under WAC 246-919-602.

(d) Administering deep sedation or general anesthesia to a patient in a dental office under WAC 246-919-602.

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

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

(ii) Complies with dental quality assurance commission regulations;

(iii) Holds a valid:

(A) Moderate sedation permit; or

(B) Moderate sedation with parenteral agents permit; or

(C) General anesthesia and deep sedation permit; and

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

(4) Application of rule.

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

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia.

(5) Accreditation or certification.

(a) A physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the commission.

(b) The commission may approve an accrediting entity that demonstrates to the satisfaction of the commission that it has all of the following:

(i) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the commission;

(ii) Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;

(iii) Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and

(iv) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

(c) A physician may perform procedures under this rule in a facility that is not accredited or certified, provided that the facility has submitted an application for accreditation by a commission-approved accrediting entity, and that the facility is appropriately equipped and maintained to ensure patient safety such that the facility meets the accreditation standards. If the facility is not accredited or certified within one year of the physician's performance of the first procedure under this rule, the physician must cease performing procedures under this rule until the facility is accredited or certified.

(d) If a facility loses its accreditation or certification and is no longer accredited or certified by at least one commission-approved entity, the physician shall immediately cease performing procedures under this rule in that facility.

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

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

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

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

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

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group ((~~(e.g., ACLS, PALS or APLS)~~)) must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility. Certification in advanced resuscitative techniques includes, but is not limited to, advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or advanced pediatric life support (APLS).

(9) Sedation assessment and management.

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

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

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

(10) Separation of surgical and monitoring functions.

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

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

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

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

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

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

(a) The medical record must include all of the following:

(i) Identity of the patient;

(ii) History and physical, diagnosis and plan;

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

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

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

(viii) Provision for continuity of postoperative care; and

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

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

(i) The type of sedation or anesthesia used;

(ii) ((~~Drugs (name and dose)~~)) Name, dose, and time of administration of drugs;

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

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

(vii) Estimated blood loss;

(viii) Duration of procedure; and

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

NEW SECTION

WAC 246-919-602 Administration of deep sedation and general anesthesia by physicians in dental offices. (1) Purpose. The purpose of this section is to govern the administration of deep sedation and general anesthesia by physicians in dental offices. The commission establishes these standards to promote effective perioperative communication and appropriately timed interventions, and mitigate adverse events and outcomes.

(2) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Administering physician" means an individual licensed under chapter 18.71 RCW who administers deep sedation or general anesthesia to a patient in a dental office.

(b) "Deep sedation" has the same meaning as in WAC 246-919-601.

(c) "Dental office" means any facility where dentistry is practiced, as defined in chapter 18.32 RCW, except a hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW.

(d) "General anesthesia" has the same meaning as in WAC 246-919-601.

(e) "Perioperative" includes the three phases of surgery: Preoperative, intraoperative, and postoperative.

(3) An administering physician is responsible for the perioperative anesthetic management and monitoring of a patient and must ensure patient care, recordkeeping, equipment, personnel, facilities, and other related matters are in accordance with acceptable and prevailing standards of care including, but not limited to, the following:

(a) Preoperative requirements. An administering physician shall ensure the patient has undergone a preoperative health evaluation and document review of the evaluation. The physician shall also conduct and document a risk assessment to determine whether a patient is an appropriate candidate for deep sedation or general anesthesia and discussion of the risks of deep sedation or general anesthesia with the patient. For a pediatric patient, this assessment must include:

(i) Whether the patient has specific risk factors that may warrant additional consultation before administration of deep sedation or general anesthesia, and how each patient meets criteria for deep sedation or general anesthesia in an outpatient environment. This must include a specific inquiry into whether the patient has signs and symptoms of sleep-disordered breathing or obstructive sleep apnea;

(ii) A discussion with a parent or guardian of a pediatric patient of the particular risks of deep sedation or general anesthesia for a patient who: (A) Is younger than six years old; (B) has special needs; (C) has airway abnormalities; or (D) has a chronic condition. This discussion must include reasoning why the pediatric patient can safely receive deep sedation or general anesthesia in an outpatient environment and any alternatives.

(b) Medical record. The anesthesia record must be complete, comprehensive, and accurate for each patient, including documentation at regular intervals of information from intraoperative and postoperative monitoring. The recordkeeping requirements under WAC 246-919-601 and 246-817-770 apply to an administering physician, including the elements of a separate anesthesia record. The anesthesia record must also include temperature measurement and a heart rate and rhythm measured by electrocardiogram. For a pediatric patient, the administering physician shall ensure vital signs are postoperatively recorded at least at five-minute intervals until the patient begins to awaken, then recording intervals may be increased to ten to fifteen minutes.

(c) Equipment. An administering physician shall ensure the requirements for equipment and emergency medications under WAC 246-817-724 and 246-817-770 are met, regardless of any delineated responsibility for furnishing of the equipment or medications in a contract between the physician and dental office. Additionally, for a pediatric patient, an administering physician shall ensure there is a complete selection of equipment for clinical application to the pediatric patient. The physician shall also ensure equipment is available in the recovery area to meet the requirements in this section for monitoring during the recovery period. The physician shall ensure all equipment and medications are checked and maintained on a scheduled basis.

(d) Recovery and discharge requirements. An administering physician shall ensure that:

(i) A physician licensed under chapter 18.71 RCW capable of managing complications, providing cardiopulmonary resuscitation, and currently certified in advanced cardiac life support measures appropriate for the patient age group is immediately available for a patient re-

covering from anesthesia. For a pediatric patient, the physician shall also be trained and experienced in pediatric perioperative care;

(ii) At least one licensed health care practitioner experienced in postanesthetic recovery care and currently certified in advanced cardiac life support measures appropriate for the patient age group visually monitors the patient, at all times, until the patient has met the criteria for discharge from the facility. Consideration for prolonged observation must be given to a pediatric patient with an anatomic airway abnormality, such as significant obstructive sleep apnea. A practitioner may not monitor more than two patients simultaneously, and any such simultaneous monitoring must take place in a single recovery room. If a practitioner is qualified to administer deep sedation or general anesthesia, the practitioner may not simultaneously administer deep sedation or general anesthesia and perform recovery period monitoring functions. The practitioner shall provide: (A) Continuous respiratory monitoring via pulse oximetry and cardiovascular monitoring via electrocardiography during the recovery period; and (B) monitoring, at regular intervals, during the recovery period of the patient for color of mucosa, skin, or blood, oxygen saturation, blood pressure, and level of consciousness; and (C) measurement of temperature at least once during the recovery period. If a patient's condition or other factor for the patient's health or safety preclude the frequency of monitoring during the recovery period required by this section, the practitioner must document the reason why such a departure from these requirements is medically necessary;

(iii) Emergency equipment, supplies, medications, and services comply with the provisions of WAC 246-817-770 and are immediately available in all areas where anesthesia is used and for a patient recovering from anesthesia. Resuscitative equipment and medications must be age and size-appropriate, including for care of a pediatric patient, pediatric defibrillator paddles, and vasoactive resuscitative medications and a muscle relaxant such as dantrolene sodium, which must be immediately available in appropriate pediatric concentrations, as well as a written pediatric dose schedule for these medications. The administering physician shall ensure that support personnel have knowledge of the emergency care inventory. All equipment and medications must be checked and maintained on a scheduled basis; and

(iv) Before discharge, the patient is awake, alert, and behaving appropriately for age and developmental status, normal patient vital signs, and if applicable, a capable parent or guardian present to assume care of the patient.

(e) Emergency care and transfer protocol. An administering physician shall monitor for, and be prepared to treat, complications involving compromise of the airway and depressed respiration, particularly with a pediatric patient. The physician shall ensure that in the event of a complication or emergency, his or her assistive personnel and all dental office clinical staff are well-versed in emergency recognition, rescue, and emergency protocols, and familiar with a written and documented plan to timely and safely transfer a patient to an appropriate hospital.

(4)(a) An administering physician shall submit to the commission a report of any patient death or serious perioperative complication, which is or may be the result of anesthesia administered by the physician.

(b) The physician shall notify the commission or the department of health, by telephone, email, or fax within seventy-two hours of discovery and shall submit a complete written report to the commission

within thirty days of the incident. The written report must include the following:

(i) Name, age, and address of the patient;

(ii) Name of the dentist and other personnel present during the incident;

(iii) Address of the facility or office where the incident took place;

(iv) Description of the type of anesthetic being utilized at the time of the incident;

(v) Dosages, if any, of any other drugs administered to the patient;

(vi) A narrative description of the incident including approximate times and evolution of symptoms;

(vii) Additional information which the commission may require or request.

AMENDATORY SECTION (Amending WSR 07-03-177, filed 1/24/07, effective 3/1/07)

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

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

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

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

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

PHYSICIAN RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

PHYSICIAN DELEGATION OF LLRP TREATMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The delegating physician ensures that the supervised professional uses the LLRP device only in accordance with the written office

protocol, and does not exercise independent medical judgment when using the device;

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

(h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating physician provided that there is a local back-up physician who satisfies the requirements of subsection (4) of this section. The local back-up physician must agree in writing to treat complications, provide consultation or resolve problems if medically indicated. The local back-up physician shall be reachable by phone and able to see the patient within sixty minutes. The delegating physician's absence from the site where the treatment occurs must be for brief and intermittent periods of time. The delegating physician's absence from the site where the treatment occurs cannot be an ongoing arrangement.

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

AMENDATORY SECTION (Amending WSR 10-11-001, filed 5/5/10, effective 6/5/10)

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

(2) This rule does not apply to:

(a) Surgery;

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

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

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

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

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

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

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

PHYSICIAN RESPONSIBILITIES

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

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

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent;

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

(g) Prepare an appropriate medical record.

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

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

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

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

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

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

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection ((~~(10)~~)) (11)(d) of this section and physician supervising practices; and

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

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

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

PHYSICIAN DELEGATION

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

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

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

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

(i) Techniques for each procedure;

(ii) Cutaneous medicine;

(iii) Indications and contraindications for each procedure;

(iv) Preprocedural and postprocedural care;

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

(vi) Infectious disease control involved with each treatment.

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

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

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

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

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

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

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

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

(12) If a physician delegates the performance of a procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, the physician must be on-site during the entire duration of the procedure.

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

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

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

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

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

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

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

WAC 246-919-620 Cooperation with investigation. (1) A ((~~licensee~~)) physician must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority ((~~pursuant to~~)) under RCW 18.130.050(2) ((~~by submitting~~)).

(a) The physician shall submit the requested items within ((~~fourteen~~)) twenty-one calendar days of receipt of the request by the ((~~licensee or the licensee's~~)) physician or the physician's attorney, whichever is first. If the ((~~licensee~~)) physician fails to comply with the request within ((~~fourteen~~)) twenty-one calendar days, the investigator shall contact the ((~~licensee or the licensee's~~)) physician or the physician's attorney by letter as a reminder.

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

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

(d) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.

(2) A ((~~licensee must~~)) physician shall comply with a request ((~~for~~)) from an investigator who is acting on behalf of the disciplin-

ing authority under RCW 18.130.050(2) for information, which may include, but is not limited to:

(a) Nonhealth care records or documents ((~~from an investigator who is acting on behalf of the commission pursuant to RCW 18.130.050(2) by submitting~~)) including, but not limited to:

(i) An explanation of the matter under investigation;

(ii) Curriculum vitae;

(iii) Continuing medical education credits;

(iv) Malpractice action summaries; or

(v) Hospital affiliations.

(b) The physician shall submit the requested items within ((~~fourteen~~)) twenty-one calendar days of receipt of the request by the ((~~licensee or the licensee's~~)) physician or the physician's attorney, whichever is first. If the ((~~licensee~~)) physician fails to comply with the request within ((~~fourteen~~)) twenty-one calendar days, the investigator shall contact the ((~~licensee~~)) physician or the licensee's attorney by letter as a reminder.

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

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

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

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

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

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

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

~~the commission for a decision on ratification and until ratified, the settlement is not final.~~))

(f) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.

AMENDATORY SECTION (Amending WSR 16-06-010, filed 2/18/16, effective 3/20/16)

WAC 246-919-630 Sexual misconduct. (1) The ((~~following~~)) definitions in this subsection 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-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

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

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

(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in any of 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 or masturbation by the physician while the patient is present;

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

(j) Soliciting a date; or

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

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

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

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

(4) 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 since the last health care services to the patient;

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

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

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

(g) The degree of emotional dependence and vulnerability of the patient.

(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~~)) constitutes grounds for disciplinary action.

AMENDATORY SECTION (Amending WSR 96-03-073, filed 1/17/96, effective 2/17/96)

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

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

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

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

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

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

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

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

~~(3) The mandatory reporting shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept for the confidential use of the commission as provided in the Uniform Disciplinary Act and shall not~~

~~be subject to subpoena or discovery proceedings in any civil action as provided in RCW 4.24.250, and shall be exempt from public disclosure pursuant to chapter 42.17 RCW except for review as provided in RCW 18.71.0195.~~)) The commission adopts the rules for mandatory reporting in chapter 246-16 WAC.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-919-310	Credentialing of physicians and surgeons.
WAC 246-919-710	Mandatory reporting requirement satisfied.
WAC 246-919-730	Medical associations or societies.
WAC 246-919-740	Health care service contractors and disability insurance carriers.
WAC 246-919-750	Courts.
WAC 246-919-760	State and federal agencies.
WAC 246-919-770	Professional standards review organizations.