STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Merle E. Janes, MD
Master Case No.:M2007-61746
Document: Statement of Charges

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

FILED
MAR 03 2016
Adjudicative Clerk Office

In the Matter of the License to Practice as a Physician and Surgeon of: **MERLE E. JANES, MD** License No. MD00026269 Respondent	**No. M2007-61746** **STATEMENT OF CHARGES**

The Executive Director of the Medical Quality Assurance Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file numbers 2006-48999, 2009-132034, 2009-141411, and 2011-156958. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On April 6, 1989, the State of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

1.2 Patient A presented as a 34-year-old woman in January 2005 and began treatment with Respondent who prescribed opioids for left ankle pain and other pain symptoms. Respondent treated Patient A from January 2005 through July 2006.

1.3 Patient B presented as a 29-year-old woman in December 2005 with pain relating to a neck fracture which had been surgically repaired in 2003. Patient B had a history of traumatic brain injury from a motor vehicle accident. Respondent treated Patient B from December 2005 to January 2007. Respondent maintained Patient B on opioid treatment for an extended period, at high doses, until she was discharged from his practice for forging prescriptions for opioid medications.

1.4 Patient C presented as a 25-year-old woman and was treated by Respondent between July 2006 and November 2008. She reported chronic pain symptoms including neck pain with "pins and needles" sensations in her right arm, distributed in a specific nerve region. Respondent prescribed Patient C long-term high-dose opioids for her pain symptoms.

1.5 Patient D presented as a 48-year-old woman being treated for chronic back pain. Respondent treated Patient D from July 2006 to January 2010. In

September 2007, Patient D underwent back surgery. Respondent maintained Patient D on opioid pain medications throughout his care.

1.6 Patient E presented as a 39- year-old male being treated for multiple sports-related injuries and injuries caused by a prior motor vehicle accident. Respondent maintained Patient E on opioid treatment throughout his care, which extended from June 2005 to February 2010.

1.7 Patient F presented as a 42-year-old man with chronic right shoulder, neck and arm pain from a work-related incident in 2001. He received care from Respondent from August 2007 through June 2011, and Respondent prescribed chronic opioid pain medications for him.

1.8 Patient G presented as a 34-year-old male who reported chronic back pain and was under Respondent's care from May 2006 to April 2008. In March 2008, Respondent wrote a letter to Patient G stating that he had decided to stop prescribing opioids on a chronic basis, effective April 30, 2008. Patient G's last visit with Respondent was April 15, 2008.

1.9 Patient H presented as a 50-year old woman whom Respondent treated with long-term opioids for chronic shoulder, back and posterior head pain from November 2003 through November of 2014.

1.10 Patient I presented as a 33-year-old woman who was treated for complaints of chronic back pain. Respondent treated Patient I from December 2010 through May 2014. Respondent prescribed Patient I with opioid pain medication for her complaints of chronic back pain.

1.11 Patient J presented as a 47-year-old woman who was treated for a crush injury to her right hand for which she sustained a 5th metacarpal fracture. Respondent treated Patient J with opioids for chronic pain symptoms, primarily located around the right elbow. Respondent treated Patient J from November 2007 to March 2014.

1.12 Patient K presented as 46-year-old woman who was treated by Respondent from June 2007 through August 2011 for multiple injuries, some work-related, resulting in chronic pain over most of the back side of her body, feet and hips as well as weakness with consequent recurrent falls. Patient K was taking medication for rheumatoid arthritis and had undergone a previous bypass surgery for coronary artery disease. Patient K reported depression due to limitations in her activity.

1.13 Patient L presented as a 20-year-old man who received treatment by Respondent from January 2010 through April 2014 for back pain and radicular symptoms caused by an on-the-job inquiry that occurred in March of 2008. He had undergone back surgery in 2001 and a subsequent micro discectomy for a herniated disc in 2008. Additionally, he suffered from chronic shoulder pain and underwent right shoulder surgery.

1.14 Patient M presented as a 39-year-old man, and was treated for chronic pain symptoms that he attributed to repetitive work injury from warehouse work. He also had a history of traumatic right radial nerve injury. He commonly complained of bilateral elbow, wrist and hand pain and numbness with tingling in the fourth and fifth finger bilaterally. Respondent treated Patient M from February 2010 through March 2014. The patient underwent carpal tunnel release surgery bilaterally, in 2005 and on the right in 2009.

1.15 Patient N presented as a 43-year-old woman who was treated with opioids for injuries relating to a motor vehicle accident that occurred in November of 2001 in which she was a restrained passenger. Patient N was under the care of Respondent from November of 2001 until November of 2014.

1.16 Patient O presented as a 21-year-old male, and was treated for his complaints of mild to severe hip and low back pain since lifting a heavy tractor battery on April 8, 2010. Patient O received treatment through July of 2013 from Respondent.

1.17 Patient P presented as a 41- year-old male who was treated for a traumatic work related injury that occurred in April of 2008. He sustained dental and left shoulder trauma that resulted in chronic neck and shoulder pain as well as hand numbness. Respondent cared for Patient P from October 2008 to August 2014.

1.18 Patient Q presented as a 41-year-old man who was treated for his complaints of a two to three year history of fibromyalgia, sciatica and "deep joint and back pain". Respondent cared for Patient Q from January 2008 to October 2014.

1.19 Patient R presented as a 55 year old woman who Respondent treated from January 2007 to November 2014. Patient R had complained of pain in various locations and was given trigger-point injections during almost every visit. Respondent prescribed opioids and testosterone to Patient R, to whom he is related, and for whom he ethically should not have prescribed controlled substances.

1.20 As further specified below, Respondent's treatment of Patients A – R did not meet the standard of care and placed the patients at significant risk of harm. Even prior to the 2011 Pain Management Guideline, providers were well aware of the potential harm of opiate treatment and prescribed opiates only in a cautious and intentional fashion. Early refills were not routinely provided, opiate fills were tracked in an organized fashion and providers remained alert for possible misuse of scheduled medications.

Though pain medication prescribing was more liberal in the years prior to 2011, Respondent's practice of opioid prescribing fell well outside the standard practice that was followed by reasonable and prudent providers during those years. Despite updated pain management guidelines, Respondent continued to prescribe opiates in a remarkably dangerous fashion.

1.21 Respondent did not do standard histories and physicals, often omitted exams which would have been indicated, provided inadequate continuity of care, and failed to obtain the medical records of his patients' previous and/or current medical care providers. When other physicians forwarded records to Respondent, he did not respond appropriately, (Patients A, B, C, F, G, H, I, L, K, N, O, P, Q, and R). For example:

- When Patient C overdosed on opioids in a possible suicide attempt and required inpatient psychiatric treatment, Respondent did not request or review records from the hospitalization, and continued to prescribe scheduled medications for her.
- When Patient K's orthopedist forwarded Patient K's urine toxicology results and a diagnosis of "amphetamine and other psychostimulant dependence," Respondent prescribed Patient K 300 tablets of 15mg oxycodone, maintained Patient K on opioids, never ordered drug screening, did not establish a pain contract, and never discussed the orthopedist's report with Patient K.
- Respondent did not perform a standard and indicated history and physical to evaluate Patient O's report of left buttock pain, and his legs having given way on two occasions, which could have indicated a radiculopathy

caused by spinal cord or nerve compression after Patient O had lifted a heavy tractor battery.

- Although Patient Q's initial pain diagram indicated neck and elbow pain and numbness in his hands, Respondent did not evaluate him for possible cervical neuropathy and did not perform the indicated upper extremity neurological exam.

1.22 Respondent prescribed opioids to patients based on a self-report history written by the patients, which included their medications. Respondent did not corroborate the self-report with prior providers or medical records of the patients, (Patients A, B, C, D, F, G, H, I, J, K, L, M, N, O, P, Q, and R).

1.23 Respondent prescribed opioids without determining if his patients had a history of substance use disorder, cognitive deficits, or mental health issues that might have placed the patient at higher risk of misuse or harm. Respondent prescribed opioids even when he was aware that a patient had a history of suicide attempts, opioid dependency, and/or reported opioid abuse while under Respondent's care. Respondent prescribed opioids to patients who had significant depression while under his care, without asking about suicidal ideation or history of suicide attempts, and did not document any consideration that the opioids he was prescribing were contributing to the patients' depression, (Patients B, C, D, F, G, H, J, K, I, L, M, N, O, P, and Q).

1.24 Respondent prescribed benzodiazepines, Soma, and/or sedatives in conjunction with opioids and rarely counseled his patients concerning the risk of taking these medications while taking opioids, (Patients C, D, E, F, H, P, and Q).

1.25 Respondent prescribed extremely high doses of opioids, dangerous incremental dose increases of controlled substances, and inappropriate variable doses, (Patients A, B, C, D, E, F, G, H, I, J, K, M, N, O, P, Q, and R). For example, Respondent prescribed Patient Q doses up to 1920 mg per day of oxycodone (2880 Morphine Equivalent Dose (MED)), and Patient B up to 1000 MED per day. He prescribed apparently opioid-naïve Patients R and C, initial doses of oxycodone of 120 mg per day (180 MED), putting the patients at risk for overdose.

1.26 Respondent prescribed early refills of opioids, failed to track the number of pills prescribed or the dates he prescribed them, and prescribed varying numbers of pills from refill to refill. Because Respondent prescribed variable quantities of opioids,

his ability to readily track appropriate medication usage by his patients was limited. The Patients were at risk of overuse, stockpiling or diversion of their medications, (Patients C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, and R).

1.27 Respondent continued to prescribe opioids despite patients' aberrant behavior or documentation of abuse of controlled substances, (Patient B, C, D, E, F, G, J, K, L, M, N, O, P, and Q). For example:

- Patient E, who had a history of opioid dependency, reported that he cut open his delayed-release fentanyl patches and put them in Coca Cola to get the "full dose" of the medication.
- Respondent continued to prescribe opioids to Patient P even after he received a report that Patient P had lied to another physician and told the physician that he was not taking opioids.

1.28 Respondent continued to prescribe opioids without obtaining pain contracts, without conducting urine toxicology screens when indicated, and without providing counseling or considering the potential adverse effects of the medications he prescribed, including over-sedation, (Patients A, B, C, D, E, F, G, H, J, K, M, N, O, P, and Q). For example:

- Respondent failed to counsel Patient B, a female of child-bearing age, of the risk of harm to a developing fetus, and did not discuss birth control with her.
- Patient C was found to be 13 weeks pregnant while taking high-dose opioids prescribed by Respondent. Although she reported being a "stay-at-home" mother, who likely transported her children by car, there was no discussion about the potential for over-sedation and the risks of driving while over-sedated. Patient C was in a car wreck during her treatment with Respondent.
- Despite documentation of falls, Respondent continued to prescribe high-dose opiate treatment to Patient H and Patient R despite a lack of symptom benefit.

- Patient H was at notably greater risk of harm from opiate-induced respiratory suppression due to her limited respiratory reserve from severe oxygen-dependent COPD.
- Patient D was reported to fall asleep at work and Patient K was reported by her daughter to fall asleep while eating, during conversations, and while smoking.

1.29 Respondent continued to prescribe opioids to patients who other providers had recommended be tapered off of opioids, who an independent medical examination had determined had no ratable impairment, or who themselves expressed a desire to decrease their use of or stop taking opioid medications, (Patients B, C, D, E, F, G, H, I, J, L, K, M, N, O, and P).

1.30 Respondent's medical records copied the same information for his patients over many notes, sometime spanning many years. The sole purpose of many visits as documented was to deliver a prescription for an opioid to the patient, without any inquiry, assessment, examination, testing, counseling, or updates. Respondent failed to document opioid prescriptions he issued and did not document visits or rationale for the prescriptions, (Patients O and R). For example, Respondent issued prescriptions for 900 tablets of oxycodone 15 mg to Patient O without any documentation by Respondent in Patient O's records that he saw Patient O or issued these prescriptions, and rather elaborately documented that he was not prescribing opioids to Patient O due to Patient O's recent suicide attempt and inpatient psychiatric admission. The medical charting for these patients was so inaccurate and misleading that it misrepresented the patient consultations and evaluations and even the patient's medical conditions on the dates of service. The lack of complete and accurate documentation and the conflicting and confusing chart notes would compromise any continuity of care or delivery of quality care to the patient, (Patients A-R).

1.31 Respondent continued to prescribe opioids to patients even when the patients' pain was unresponsive, functionality was not improved, and/or they exhibited significant functional decline, (Patients A, B, C, D, E, F, H, I, J, K, L, M, N, O, P, and Q).

1.32 Respondent failed to address non-pain-related medical issues for his patients who clearly were not being followed by another medical care provider or who

presented with a complaint that indicated immediate attention, (Patients C, D, E, I, K, and P). For example:

- Even after Patient I had excision of an accessory spleen, Respondent failed to monitor her platelet counts.
- Respondent failed to refer Patient K to a rheumatologist in spite of her diagnosis of seropositive rheumatoid arthritis.
- When Patient P reported shortness of breath, Respondent failed to check Patient P's oxygenation or examine his lungs; the next day Patient P was diagnosed with pulmonary emboli.

1.33 Respondent failed to make appropriate referrals to specialists, follow up on referrals he did make, recommend changes in patients' activities, or make sufficient use of therapies other than opioids to address his patients' pain, (Patient B, C, D, E, F, I, J, K, M, N, P and R). For example, Respondent did not order cervical spine X-rays for Patient B, to identify if her post-surgery neck pain was the result of hardware complications. Respondent committed Patient R to long-term opioid treatment without a trial of non-opioid medications.

1.34 Respondent exhibited a lack of professionalism in his communication with colleagues and others regarding his patients' care, and to his patients concerning other health care professionals, (Patients D, I, J, K, M, N, O, and P). For example:

- Respondent told a pharmacist that another physician, who had discharged Patient D for being dishonest and for filling opioid prescriptions from multiple providers clearly didn't understand chronic pain or pain management.
- Respondent wrote about an independent medical examiner who had examined Patient L: "Is the guy blind? Or is he just stupid?"
- Respondent referred to Patient M's orthopedist as an "arrogant coward" who "bided his snake's time."
- Although Patient N's surgeon reported to Respondent that Patient N did not have a hernia, Respondent wrote to Patient N's primary care provider that Patient N had a large abdominal midline hernia and that the surgeon simply wasn't interested in performing the surgical correction.

1.35 Respondent regularly engaged in non-standard treatments that lack evidence of efficacy and may be outside his trained scope of practice. (Patients M, I, N, O, Q and R). In addition, Respondent provided non-standard treatment practices without utilizing basic and standard treatment. For example:

- Respondent treated Patients M, I, and N with HCG for weight loss. He also provided non-standard treatment to Patient M for an infection including intravenous vitamin C infusions, hyperbaric oxygen and laser treatment to lymph nodes.
- Respondent initiated thyroid medication for Patient I for weight loss without checking a Thyroid Stimulating Hormone (TSH) level before or after initiation of this treatment and when Patient I's Body Mass Index (BMI) was last noted to be 27.8. Respondent did not pair his obesity treatment with an intentional exercise regimen or a referral to a nutritionist.
- Respondent provided prolotherapy/Lyftogt treatment for Patients N and Q with injection of a dextrose/water solution and laser treatment. (Prolotherapy is injection of any substance that promotes growth of normal cells, or tissues.)
- For Patient N, Respondent suggested injecting platelet –rich plasma into ligaments or periosteal insertion zones. In addition, Respondent either provided or planned in detail for "Auriculotherapy" for Patient N. (Auriculotherapy is the stimulation of the auricle of the external ear for the diagnosis and treatment of health conditions in other parts of the body.) One site he charted, as a focus for the treatment was the adrenal gland, which would not have been indicated by the patient's presenting symptomatology.
- Throughout Patient O's care Respondent determined that he had "slipped clutch syndrome", a diagnosis not accepted in medicine, and despite the MRI evidence of nerve compression.
- Respondent prescribed testosterone for Patient R without documented medical justification.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (4), (7), and WAC 246-919-852, 853, 854,855, 856, 857, 858, and 860 which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
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> ...
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> **(4)** Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
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> ...
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> **(7)** Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
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> ...
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> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
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> ...
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> **WAC 246-919-853**
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> **Patient evaluation.**
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> The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.
> (1) The patient's health history shall include:
> (a) Current and past treatments for pain;
> (b) Comorbidities; and
> (c) Any substance abuse.
> (2) The patient's health history should include:
> (a) A review of any available prescription monitoring program or emergency department-based information exchange; and
> (b) Any relevant information from a pharmacist provided to a physician.
> (3) The initial patient evaluation shall include:
> (a) Physical examination;
> (b) The nature and intensity of the pain;
> (c) The effect of the pain on physical and psychological function;
> (d) Medications including indication(s), date, type, dosage, and quantity prescribed;
> (e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:
> (i) History of addiction;
> (ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;
(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;
(v) Poorly controlled depression or anxiety;
(vi) Evidence or risk of significant adverse events, including falls or fractures;
(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;
(viii) Repeated visits to emergency departments seeking opioids;
(ix) History of sleep apnea or other respiratory risk factors;
(x) Possible or current pregnancy; and
(xi) History of allergies or intolerances.
(4) The initial patient evaluation should include:
(a) Any available diagnostic, therapeutic, and laboratory results; and
(b) Any available consultations.
(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:
(a) The diagnosis, treatment plan, and objectives;
(b) Documentation of the presence of one or more recognized indications for the use of pain medication;
(c) Documentation of any medication prescribed;
(d) Results of periodic reviews;
(e) Any written agreements for treatment between the patient and the physician; and
(f) The physician's instructions to the patient.

WAC 246-919-854

Treatment plan.

(1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:
(a) Any change in pain relief;
(b) Any change in physical and psychosocial function; and
(c) Additional diagnostic evaluations or other planned treatments.

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

(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.
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WAC 246-919-855

Informed consent.

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

WAC 246-919-856

Written agreement for treatment.

Chronic noncancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing physician shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

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

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
(3) Reasons for which drug therapy may be discontinued (e.g., violation of agreement);

(4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;
(5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
(6) A written authorization for:

(a) The physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and
(b) Other practitioners to report violations of the agreement back to the physician;

(7) A written authorization that the physician may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;
(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;
(9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(10) Acknowledgment that if the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.
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WAC 246-919-857

Periodic review.

The physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.
(1) During the periodic review, the physician shall determine:
(a) Patient's compliance with any medication treatment plan;

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

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

(2) The physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The physician shall consider tapering, changing, or discontinuing treatment when:
(a) Function or pain does not improve after a trial period;
(b) There is evidence of significant adverse effects;
(c) Other treatment modalities are indicated; or
(d) There is evidence of misuse, addiction, or diversion.

(3) The physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.
(4) The physician should periodically review any relevant information from a pharmacist provided to the physician.

WAC 246-919-858

Long-acting opioids, including methadone.

Long-acting opioids, including methadone, should only be prescribed by a physician who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The physician prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic
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WAC 246-919-860

Consultation—Recommendations and requirements.

(1) The physician shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-919-863 is required, unless the consultation is exempted under WAC 246-919-861 or 246-919-862. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.
(a) The mandatory consultation shall consist of at least one of the following:
(i) An office visit with the patient and the pain management specialist;
(ii) A telephone consultation between the pain management specialist and the physician;
(iii) An electronic consultation between the pain management specialist and the physician; or

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

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

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-919-850 through 246-919-863, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.
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2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety, and welfare. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: March 3, 2016.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE
COMMISSION

Melanie de Leon
MELANIE DE LEON
EXECUTIVE DIRECTOR

Kristin G. Brewer
KRISTIN G. BREWER, WSBA #38494
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A: [redacted]

Patient B:

Patient C:

Patient D:

Patient E:

Patient F:

Patient G:

Patient H:

Patient I:

Patient J:

Patient K:

Patient L:

Patient M:

Patient N:

Patient O:

Patient P:

Patient Q:

Patient R: