

# Chapter 246-918 WAC

## PHYSICIAN ASSISTANTS—MEDICAL QUALITY ASSURANCE COMMISSION

### WAC

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Consultation—Exemptions for exigent and special circumstances. Consultation—Exemptions for the physician assistant. Pain management specialist. Physician assistants fees and renewal cycle.</p>	<p>246-918-009 246-918-010 246-918-020 246-918-040 246-918-060</p>	<p>278B), § 246-918-008, filed 6/3/92, effective 7/4/92.] Repealed by WSR 98-09-118, filed 4/22/98, effective 5/23/98. Statutory Authority: RCW 18.71.017.</p> <p>Adjudicative proceedings. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-009, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-009, filed 10/11/93, effective 11/11/93.] Repealed by WSR 98-09-118, filed 4/22/98, effective 5/23/98. Statutory Authority: RCW 18.71.017.</p> <p>Delegation of authority to initiate investigations. [Statutory Authority: RCW 18.71.017, 18.71A.020, 18.130-050(12), 18.130.080. WSR 07-03-150, § 246-918-010, filed 1/23/07, effective 2/23/07.] Repealed by WSR 10-20-138, filed 10/5/10, effective 11/5/10. Statutory Authority: RCW 18.130.050(1), 18.71.017.</p> <p>Physicians' assistants—Scope of jurisdiction. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-020, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.-020. WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-136, filed 3/14/78.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.</p> <p>Emergency narcotic administration. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-040, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 81-03-078 (Order PL 368), § 308-52-132, filed 1/21/81.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.</p> <p>Physician assistants—Program approval. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-060, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.-020. WSR 88-06-008 (Order PM 706), § 308-52-138, filed 2/23/88; WSR 85-03-083 (Order PL 507), § 308-52-138, filed 1/18/85; WSR 83-03-031 (Order PL 421), § 308-52-138, filed 1/14/83; WSR 81-03-078 (Order PL 368), § 308-52-138, filed 1/21/81; WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-138, filed 3/14/78.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.</p> <p>License renewal form. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-085, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.130.250. WSR 93-01-078 (Order 321B), § 246-918-085, filed 12/14/92, effective 1/14/93.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.</p> <p>Physician assistants—Responsibility of supervising physician. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-100, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 86-12-031 (Order PM 599), § 308-52-141, filed 5/29/86; WSR 81-03-078 (Order PL 368), § 308-52-141, filed 1/21/81; WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-141, filed 3/14/78.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.</p> <p>Physician assistant and certified physician assistant disciplinary actions. [Statutory Authority: RCW 18.71.-017. WSR 92-12-089 (Order 278B), § 246-918-160, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-160, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.-020. WSR 82-24-013 (Order PL 412), § 308-52-160, filed 11/19/82.] Repealed by WSR 98-09-119, filed</p>
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### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

<p>246-918-006</p> <p>246-918-008</p>	<p>Refunds. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-006, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-006, filed 6/3/92, effective 7/4/92.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.</p> <p>Brief adjudicative proceedings—Denials based on failure to meet education, experience, or examination prerequisites for licensure. [Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-008, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order</p>	<p>246-918-160</p>
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- 4/22/98, effective 5/23/98. Statutory Authority: RCW 18.71.017.
- 246-918-190 Categories of creditable continuing medical education activities. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-190, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 81-03-078 (Order PL 368), § 308-52-205, filed 1/21/81.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-200 Continuing medical education clock hour credit requirement. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-200, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 81-03-078 (Order PL 368), § 308-52-211, filed 1/21/81.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-210 Prior activity approval not required. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-210, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 81-03-078 (Order PL 368), § 308-52-215, filed 1/21/81.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-220 Certification of compliance. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-220, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 81-03-078 (Order PL 368), § 308-52-221, filed 1/21/81.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-240 Noncertified physician assistant—Surgical assistant. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-240, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-640, filed 6/8/89, effective 9/30/89.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-270 Major surgical procedures. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-270, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-20-023, § 308-52-680, filed 9/27/89, effective 10/28/89.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-280 Surgical assistant program requirements reconsideration. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-280, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-20-023, § 308-52-690, filed 9/27/89, effective 10/28/89.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-290 Acupuncture assistant education. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-290, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71.080 and 18.71A.020. WSR 85-23-043 (Order PL 565), § 308-52-500, filed 11/18/85. Statutory Authority: RCW 18.71A.020. WSR 83-07-014 (Order PL 428), § 308-52-500, filed 3/10/83; WSR 79-06-055 (Order PL 301), § 308-52-500, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-300 Acupuncture—Program approval. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-300, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 86-16-054 (Order PM 609), § 308-52-502, filed 8/1/86; WSR 83-07-014 (Order PL 428), § 308-52-502, filed 3/10/83.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-320 Acupuncture equivalency examination. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-320, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71.080 and 18.71A.020. WSR 85-23-043 (Order PL 565), § 308-52-510, filed 11/18/85. Statutory Authority: RCW 18.71A.020. WSR 79-06-055 (Order PL 301), § 308-52-510, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-330 Acupuncture examination review procedures. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-330, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.-020. WSR 86-16-054 (Order PM 609), § 308-52-515, filed 8/1/86.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-340 Investigation. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-340, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 79-06-055 (Order PL 301), § 308-52-530, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-350 English fluency. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-350, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 79-06-055 (Order PL 301), § 308-52-540, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-360 X-rays and laboratory tests. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-360, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 82-24-013 (Order PL 412), § 308-52-570, filed 11/19/82; WSR 79-06-055 (Order PL 301), § 308-52-570, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.
- 246-918-370 Ethical considerations. [Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-370, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 82-24-013 (Order PL 412), § 308-52-580, filed 11/19/82; WSR 79-06-055 (Order PL 301), § 308-52-580, filed 5/22/79.] Repealed by WSR 92-12-089, (Order 278B), filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71.017.

**WAC 246-918-005 Definitions.** The following terms used in this chapter shall have the meanings set forth in this section unless the context clearly indicates otherwise:

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

(2) "Physician assistant" means an individual who either:

(a) Successfully completed an accredited and commission approved physician assistant program, is eligible for the NCCPA examination and was licensed in Washington state prior to July 1, 1999;

(b) Qualified based on work experience and education and was licensed prior to July 1, 1989;

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

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

(3) "Physician assistant-surgical assistant" means an individual who was licensed as a physician assistant between September 30, 1989, and December 31, 1989, to function in a limited extent as authorized in WAC 246-918-230.

(4) "Licensee" means an individual credentialed as a certified physician assistant, physician assistant, or physician assistant-surgical assistant.

(5) "Commission approved program" means a physician assistant program accredited by the Committee on Allied Health Education and Accreditation (CAHEA); the Commission on Accreditation of Allied Health Education Programs (CAAHEP); the Accreditation Review Committee on Education for the Physician Assistant (ARC-PA); or any successive accrediting organizations.

(6) "Sponsoring physician" means the physician who is responsible for consulting with a certified physician assistant. An appropriate degree of supervision is involved.

(7) "Supervising physician" means the physician who is responsible for closely supervising, consulting, and reviewing the work of a physician assistant.

[Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-005, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-005, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-005, filed 10/11/93, effective 11/11/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-005, filed 6/3/92, effective 7/4/92.]

**WAC 246-918-007 Application withdrawals.** An application for a license or interim permit may not be withdrawn if grounds for denial exist.

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

**WAC 246-918-030 Prescriptions issued by physician assistants.** A physician assistant may issue written or oral prescriptions as provided herein when approved by the commission and assigned by the supervising physician(s).

(1) A physician assistant may not prescribe controlled substances unless specifically approved by the commission or its designee. A physician assistant may issue prescriptions for legend drugs for a patient who is under the care of the physician(s) responsible for the supervision of the physician assistant.

(a) Written prescriptions shall include the name, address, and telephone number of the physician or medical group; the name and address of the patient and the date on which the prescription was written.

(b) The physician assistant shall sign such a prescription using his or her own name followed by the letters "P.A."

(c) Written prescriptions for schedule two through five must include the physician assistant's D.E.A. registration number, or, if none, the supervising physician's D.E.A. registration number, followed by the letters "P.A." and the physician assistant's license number.

(2) A physician assistant employed or extended privileges by a hospital, nursing home or other health care institution may, if permissible under the bylaws, rules and regulations of the institution, order pharmaceutical agents for inpatients under the care of the physician(s) responsible for his or her supervision.

(3) The license of a physician assistant who issues a prescription in violation of these provisions shall be subject to revocation or suspension.

(9/18/12)

(4) Physician assistants may dispense medications the physician assistant has prescribed from office supplies. The physician assistant shall comply with the state laws concerning prescription labeling requirements.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-030, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-030, filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71A.020. WSR 91-08-007 (Order 153B), § 246-918-030, filed 3/26/91, effective 4/26/91. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-030, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 86-12-031 (Order PM 599), § 308-52-135, filed 5/29/86; WSR 83-07-014 (Order PL 428), § 308-52-135, filed 3/10/83; WSR 82-03-022 (Order PL 390), § 308-52-135, filed 1/14/82; WSR 79-10-041 (Order PL 317), § 308-52-135, filed 9/13/79; Order PL 264, § 308-52-135, filed 3/15/77.]

**WAC 246-918-035 Certified physician assistant prescriptions.** A certified physician assistant may issue written or oral prescriptions as provided herein when approved by the commission or its designee.

(1) Written prescriptions shall include the name, address, and telephone number of the physician or medical group; the name and address of the patient and the date on which the prescription was written.

(a) The certified physician assistant shall sign such a prescription using his or her own name followed by the letters "P.A.-C."

(b) The written prescriptions for schedule two through five must include the physician assistant's D.E.A. registration number, or, if none, the sponsoring physician's D.E.A. registration number, followed by the letters "P.A.-C" and the physician assistant's license number.

(2) A certified physician assistant employed or extended privileges by a hospital, nursing home or other health care institution may, if permissible under the bylaws, rules and regulations of the institution, order pharmaceutical agents for inpatients under the care of the sponsoring physician(s).

(3) The license of a certified physician assistant who issues a prescription in violation of these provisions shall be subject to revocation or suspension.

(4) Certified physician assistants may dispense medications the certified physician assistant has prescribed from office supplies. The certified physician assistant shall comply with the state laws concerning prescription labeling requirements.

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

**WAC 246-918-050 Physician assistant qualifications effective July 1, 1999.** Individuals applying to the commission under chapter 18.71A RCW after July 1, 1999, must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination: EXCEPT those applying for an interim permit under RCW 18.71A.020 (1) who will have one year from issuance of the interim permit to successfully complete the examination.

[Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-050, filed 9/5/01, effective 10/6/01. Statutory

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

**WAC 246-918-070 Credentialing of physician assistants.** All completed applications for licensure shall be reviewed by a member of the commission or a designee authorized in writing by the commission, prior to licensure.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-070, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-20-170 (Order 203B), § 246-918-070, filed 10/2/91, effective 11/2/91; WSR 91-06-030 (Order 147B), recodified as § 246-918-070, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 88-21-047 (Order PM 782), § 308-52-610, filed 10/13/88.]

**WAC 246-918-075 Background check—Temporary practice permit.** The medical quality assurance commission (MQAC) conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The MQAC may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

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

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

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

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

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

[Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-918-075, filed 2/9/10, effective 2/11/10.]

**WAC 246-918-080 Physician assistant—Licensure.** (1) Application procedure. Applications may be made jointly by the physician and the physician assistant on forms supplied by the commission. Applications and supporting documents must be on file in the commission office prior to consideration for a license or interim permit.

(2) No physician assistant or physician assistant-surgical assistant shall begin practice without commission approval of

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the practice plan of that working relationship. Practice plans must be submitted on forms provided by the commission.

(3) Changes or additions in supervision. In the event that a physician assistant or physician assistant-surgical assistant who is currently credentialed desires to become associated with another physician, he or she must submit a new practice plan. See WAC 246-918-110 regarding termination of working relationship.

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

**WAC 246-918-081 Expired license.** (1) If the license has expired for three years or less the practitioner must meet the requirements of chapter 246-12 WAC, Part 2.

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

- (a) Reapply for licensing under current requirements;
- (b) Meet the requirements of chapter 246-12 WAC, Part 2.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-081, filed 2/13/98, effective 3/16/98.]

**WAC 246-918-090 Physician assistant and certified physician assistant utilization.** No physician shall serve as primary supervisor or sponsor for more than three licensees without authorization by the commission.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-090, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-090, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-090, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-140, filed 2/23/88; WSR 86-10-054 (Order PM 609), § 308-52-140, filed 8/1/86; WSR 86-12-031 (Order PM 599), § 308-52-140, filed 5/29/86; WSR 83-07-014 (Order PL 428), § 308-52-140, filed 3/10/83; WSR 82-24-013 (Order PL 412), § 308-52-140, filed 11/19/82; WSR 82-03-022 (Order PL 390), § 308-52-140, filed 1/14/82; WSR 81-03-078 (Order PL 368), § 308-52-140, filed 1/21/81; WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-140, filed 3/14/78.]

**WAC 246-918-095 Scope of practice—Osteopathic alternate physician.** The physician assistant licensed under chapter 18.71A RCW practices under the practice plan and prescriptive authority approved by the commission whether the alternate sponsoring physician or alternate supervising physician is licensed under chapter 18.57 or 18.71 RCW.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-095, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-095, filed 7/19/94, effective 8/19/94.]

**WAC 246-918-105 Disciplinary action of sponsoring or supervising physician.** To the extent that the sponsoring

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or supervising physician's practice has been limited by disciplinary action under chapter 18.130 RCW, the physician assistant's practice is similarly limited while working under that physician's sponsorship or supervision.

[Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-105, filed 7/19/94, effective 8/19/94.]

**WAC 246-918-110 Termination of sponsorship or supervision.** Upon termination of the working relationship, the sponsoring or supervising physician and the licensee are each required to submit a letter to the commission indicating the relationship has been terminated and may summarize their observations of the working relationship. Exceptions to this requirement may be authorized by the commission or its designee.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-110, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-110, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-110, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 86-24-068 (Order PM 627), § 308-52-146, filed 12/3/86.]

**WAC 246-918-120 Remote site—Utilization—Limitations, geographic.** (1) No licensee shall be utilized in a remote site without approval by the commission or its designee. A remote site is defined as a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.

(2) Approval by the commission or its designee may be granted to utilize a licensee in a remote site if:

- (a) There is a demonstrated need for such utilization;
- (b) Adequate provision for timely communication between the primary or alternate physician and the licensee exists;

(c) The responsible sponsoring or supervising physician spends at least ten percent of the practice time of the licensee in the remote site. In the case of part time or unique practice settings, the physician may petition the commission to modify the on-site requirement providing the sponsoring physician demonstrates that adequate supervision is being maintained by an alternate method. The commission will consider each request on an individual basis;

(d) The names of the sponsoring or supervising physician and the licensee shall be prominently displayed at the entrance to the clinic or in the reception area.

(3) No physician assistant holding an interim permit shall be utilized in a remote site setting.

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

**WAC 246-918-125 Use of laser, light, radiofrequency, and plasma devices as applied to the skin.** (1) For the purposes of this rule, laser, light, radiofrequency, and

plasma devices (hereafter LLRP devices) are medical devices that:

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

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

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

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

#### PHYSICIAN ASSISTANT RESPONSIBILITIES

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

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

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

#### PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

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

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

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

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

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

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

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

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

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

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

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

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

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician assistant concerning specific decisions made. Documentation shall be recorded after each procedure, and may be performed on the patient's record or medical chart.

(f) The physician assistant is responsible for ensuring that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device.

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

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

**WAC 246-918-126 Nonsurgical medical cosmetic procedures.** (1) The purpose of this rule is to establish the duties and responsibilities of a physician assistant who injects medication or substances for cosmetic purposes or uses prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfigurement, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011.

(2) This section does not apply to:

(a) Surgery;

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

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

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

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

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

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

(c) "Physician assistant" means an individual licensed under chapter 18.71A RCW.

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

#### PHYSICIAN ASSISTANT RESPONSIBILITIES

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

(5) A physician assistant may not perform a nonsurgical cosmetic procedure unless his or her supervising or sponsoring physician is fully and appropriately trained to perform that same procedure.

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

(a) Techniques for each procedure;

(b) Cutaneous medicine;

(c) Indications and contraindications for each procedure;

(d) Preprocedural and postprocedural care;

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

(f) Infectious disease control involved with each treatment.

(7) The physician assistant must keep a record of his or her training in the office and available for review upon request by a patient or a representative of the commission.

(8) Prior to performing a nonsurgical medical cosmetic procedure, either the physician assistant or the delegating physician must:

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent including disclosing the credentials of the person who will perform the procedure;

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

(g) Prepare an appropriate medical record.

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

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

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

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

(d) A statement of the activities, decision criteria, and plan the physician assistant must follow if performing a procedure delegated by a physician pursuant to WAC 246-919-

606, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

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

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

(12) A physician assistant may perform a nonsurgical medical cosmetic procedure at a remote site. A physician assistant must comply with the established regulations governing physician assistants working in remote sites, including obtaining commission approval to work in a remote site under WAC 246-918-120.

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

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

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

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

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

**WAC 246-918-130 Physician assistants.** (1) A physician assistant may perform only those services as outlined in the standardized procedures reference and guidelines established by the commission. If said assistant is being trained to perform additional procedures beyond those established by the commission, the training must be carried out under the direct, personal supervision of the supervising physician or a qualified person mutually agreed upon by the supervising physician and the physician assistant. Requests for approval of newly acquired skills shall be submitted to the commission and may be granted by a reviewing commission member or at any regular meeting of the commission.

(2) The physician assistant may not practice in a remote site, or prescribe controlled substances unless specifically approved by the commission or its designee.

(3) A physician assistant may sign and attest to any document that might ordinarily be signed by a licensed physician, to include but not limited to such things as birth and death certificates.

(4) A physician assistant and supervising physician shall ensure that, with respect to each patient, all activities, functions, services and treatment measures are immediately and properly documented in written form by the physician assistant. Every written entry shall be reviewed and countersigned by the supervising physician within two working days unless a different time period is authorized by the commission.

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(5) It shall be the responsibility of the physician assistant and the supervising physician to ensure that adequate supervision and review of the work of the physician assistant are provided.

(6) In the temporary absence of the supervising physician, the supervisory and review mechanisms shall be provided by a designated alternate supervisor(s).

(7) The physician assistant, at all times when meeting or treating patients, must wear a badge identifying him or her as a physician assistant.

(8) No physician assistant may be presented in any manner which would tend to mislead the public as to his or her title.

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

**WAC 246-918-140 Certified physician assistants.** (1)

A certified physician assistant may perform only those services as outlined in the standardized procedures reference and guidelines established by the commission. If said assistant is being trained to perform additional procedures beyond those established by the commission, the training must be carried out under the direct, personal supervision of the sponsoring physician or a qualified person mutually agreed upon by the sponsoring physician and the certified physician assistant. Requests for approval of newly acquired skills shall be submitted to the commission and may be granted by a reviewing commission member or at any regular meeting of the commission.

(2) A certified physician assistant may sign and attest to any document that might ordinarily be signed by a licensed physician, to include, but not limited to such things as birth and death certificates.

(3) It shall be the responsibility of the certified physician assistant and the sponsoring physician to ensure that appropriate consultation and review of work are provided.

(4) In the temporary absence of the sponsoring physician, the consultation and review of work shall be provided by a designated alternate sponsor(s).

(5) The certified physician assistant must, at all times when meeting or treating patients, wear a badge identifying him or her as a certified physician assistant.

(6) No certified physician assistant may be presented in any manner which would tend to mislead the public as to his or her title.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-140, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-140, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-140, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-149, filed 2/23/88.]

**WAC 246-918-150 Assistance or consultation with other physicians.** (1) Physician sponsor. A physician assistant may assist or consult with a physician other than his or her sponsor or alternate concerning the care or treatment of the sponsor's patients, provided it is done with the knowledge and concurrence of the sponsor. The sponsor must maintain

on file a written statement which instructs the physician assistant as to who may be assisted or consulted and under what circumstances or if no list is possible, then the method to be used in determining who may be consulted or assisted. The sponsor retains primary responsibility for the performance of his or her physician assistant.

(2) Responsibility of a nonsponsoring physician. A nonsponsoring physician utilizing or advising a physician assistant as indicated in section (1) of this rule, shall assume responsibility for patient services provided by a physician assistant if the physician:

(a) Knowingly requests that patient services be rendered by the physician assistant; or

(b) Knowingly consults with the physician assistant concerning the rendering of patient services.

[Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-150, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 83-03-031 (Order PL 421), § 308-52-150, filed 1/14/83.]

**WAC 246-918-170 Physician assistant and certified physician assistant AIDS prevention and information education requirements.** Applicants must complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-170, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-170, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-170, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-170, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 70.24.270. WSR 89-08-063 (Order PM 831), § 308-52-190, filed 4/3/89.]

**WAC 246-918-171 Renewal and continuing medical education cycle revision.** Beginning January 1, 2000, the one-year renewal cycle for physician assistants will transition to a two-year cycle and two-year continuing medical education cycle. The renewal and continuing medical education will be as follows:

(1) Effective January 1, 2000, any physician assistant whose birth year is an even number will renew their credential for twenty-four months and every two years thereafter. Those physician assistants must obtain one hundred hours of continuing medical education within the twenty-four months following the date their first two-year license is issued and every two years thereafter.

(2) Effective January 1, 2001, any physician assistant whose birth year is an odd number will renew their credential for twenty-four months and every two years thereafter. Those physician assistants must obtain one hundred hours of continuing medical education within the twenty-four months following the date their first two-year license is issued and every two years thereafter.

[Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-918-171, filed 11/16/99, effective 1/1/00.]

**WAC 246-918-180 Continuing medical education requirements.** (1) Licensed physician assistants must complete one hundred hours of continuing education every two years as required in chapter 246-12 WAC, Part 7.

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(2) In lieu of one hundred hours of continuing medical education the commission will accept a current certification with the National Commission for the Certification of Physician Assistants and will consider approval of other programs as they are developed.

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

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

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

(5) It will not be necessary to inquire into the prior approval of any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these regulations and relies upon each licensee's integrity in complying with this requirement.

(6) Continuing medical education sponsors need not apply for nor expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to present continuing medical education for licensees that constitutes a meritorious learning experience.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-180, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-180, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-180, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-180, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 82-03-022 (Order PL 390), § 308-52-201, filed 1/14/82; WSR 81-03-078 (Order PL 368), § 308-52-201, filed 1/21/81.]

**WAC 246-918-230 Practice of medicine—Surgical procedures.** The following duties constitute the practice of medicine under chapters 18.71 and 18.71A RCW if performed by persons who are not registered, certified, or licensed by an agency of the state to perform these tasks when utilized by surgeons as assistants and are not otherwise exempted by RCW 18.71.030:

(1) Assisting surgeons in opening incisions by use of any surgical method including laser, scalpel, scissors, or cautery;

(2) Assisting surgeons in closing of incisions by use of suture material, staples, or other means;

(3) Controlling bleeding with direct tissue contact by the clamping and tying of blood vessels, cautery, and surgical clips;

(4) Suturing or stapling tissue; and

(5) Tying of closing sutures in any tissues.

[Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-230, filed 2/26/91, effective 3/29/91. Statutory



Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-630, filed 6/8/89, effective 9/30/89.]

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

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

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

(3) Not be allowed to perform any independent surgical procedures, even under direct supervision, and will be allowed to only assist the operating surgeon;

(4) Have no prescriptive authority; and

(5) Not write any progress notes or order(s) on hospitalized patients, except operative notes.

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

**WAC 246-918-260 Physician assistant-surgical assistant—Utilization and supervision.** (1) Responsibility of physician assistant-surgical assistant. The physician assistant-surgical assistant is responsible for performing only those tasks authorized by the supervising physician(s) and within the scope of physician assistant-surgical assistant practice described in WAC 246-918-250. The physician assistant-surgical assistant is responsible for ensuring his or her compliance with the rules regulating physician assistant-surgical assistant practice and failure to comply may constitute grounds for disciplinary action.

(2) Limitations, geographic. No physician assistant-surgical assistant shall be utilized in a place geographically separated from the institution in which the assistant and the supervising physician are authorized to practice.

(3) Responsibility of supervising physician(s). Each physician assistant-surgical assistant shall perform those tasks he or she is authorized to perform only under the supervision and control of the supervising physician(s), but such supervision and control shall not be construed to necessarily require the personal presence of the supervising physician at the place where the services are rendered. It shall be the responsibility of the supervising physician(s) to insure that:

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

(b) The physician assistant-surgical assistant shall wear a badge identifying him or her as a "physician assistant-surgical assistant" or "P.A.S.A." In all written documents and other communication modalities pertaining to his or her professional activities as a physician assistant-surgical assistant, the physician assistant-surgical assistant shall clearly denom-

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inate his or her profession as a "physician assistant-surgical assistant" or "P.A.S.A.";

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

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-260, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.130.250. WSR 93-11-008 (Order 360B), § 246-918-260, filed 5/5/93, effective 6/5/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-260, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-260, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-660, filed 6/8/89, effective 9/30/89.]

**WAC 246-918-310 Acupuncture—Definition.** (1) Acupuncture is a traditional system of medical theory, oriental diagnosis and treatment used to promote health and treat organic or functional disorders, by treating specific acupuncture points or meridians. Acupuncture includes the following techniques:

(a) Use of acupuncture needles to stimulate acupuncture points and meridians.

(b) Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians.

(c) Moxibustion.

(d) Acupressure.

(e) Cupping.

(f) Gwa hsa (dermal friction technique).

(g) Infrared.

(h) Sonopuncture.

(i) Laser puncture.

(j) Dietary advice.

(k) Manipulative therapies.

(l) Point injection therapy (aquapuncture).

These terms are to be understood within the context of the oriental medical art of acupuncture, and as the commission defines them.

[Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-310, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-310, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 83-07-014 (Order PL 428), § 308-52-504, filed 3/10/83; WSR 82-24-013 (Order PL 412), § 308-52-504, filed 11/19/82.]

**WAC 246-918-410 Sexual misconduct.** (1) Definitions:

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

(b) "Physician assistant" means a person licensed to practice as a physician assistant under chapter 18.71A RCW.

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

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

- (a) Sexual intercourse or genital to genital contact;
- (b) Oral to genital contact;
- (c) Genital to anal contact or oral to anal contact;
- (d) Kissing in a romantic or sexual manner;
- (e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

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

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

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

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

(j) Soliciting a date;

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

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

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

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

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

(a) Documentation of formal termination;

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

(c) The length of time that has passed;

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

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

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

(g) The degree of emotional dependence and vulnerability.

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

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

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

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-918-410, filed 1/9/06, effective 2/9/06.]

**WAC 246-918-420 Abuse.** (1) A physician assistant commits unprofessional conduct if the physician assistant

abuses a patient. A physician assistant abuses a patient when he or she:

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

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

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

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

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

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-918-420, filed 1/9/06, effective 2/9/06.]

## PAIN MANAGEMENT

**WAC 246-918-800 Pain management—Intent.** These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

Nothing in these rules in any way restricts the current scope of practice of physician assistants as set forth in chapters 18.71A and 18.57A RCW and the working agreements between the physician and physician assistant, which may include pain management.

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

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

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

relieved, and taking into account whether the treatment is appropriate for the diagnosis.

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

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

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

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

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

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner based on all the circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the approach was below the stan-

dard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken.

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-800, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-801 Exclusions.** The rules adopted under WAC 246-918-800 through 246-918-813 do not apply:

- (1) To the provision of palliative, hospice, or other end-of-life care; or
- (2) To the management of acute pain caused by an injury or surgical procedure.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-801, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-802 Definitions.** The definitions in this section apply in WAC 246-918-800 through 246-918-813 unless the context clearly requires otherwise.

(1) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited, often less than three months in duration, and usually less than six months.

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

- (a) Impaired control over drug use;
- (b) Craving;
- (c) Compulsive use; or
- (d) Continued use despite harm.

(3) "Chronic noncancer pain" means a state in which noncancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

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

(5) "Episodic care" means medical care provided by a practitioner other than the designated primary care practi-

tioner in the acute care setting, for example, urgent care or emergency department.

(6) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

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

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

(9) "Palliative" means care that improves the quality of life of patients and their families facing life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-802, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-803 Patient evaluation.** The physician assistant 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 the physician assistant.

(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 assistant; and

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-803, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-804 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 assistant should adjust drug therapy to the individual health needs of the patient. The physician assistant 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 assistant shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-804, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-805 Informed consent.** The physician assistant shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-805, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-806 Written agreement for treatment.** Chronic noncancer pain patients should receive all chronic

pain management prescriptions from one physician assistant 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 assistant 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 assistant;
- (2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
- (3) Reasons for which 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 assistant 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 assistant;
- (7) A written authorization that the physician assistant 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 assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-806, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-807 Periodic review.** The physician assistant 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 assistant 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

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

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-807, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-808 Long-acting opioids, including methadone.** Long-acting opioids, including methadone, should only be prescribed by a physician assistant who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. A physician assistant prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four continuing education hours relating to this topic.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-808, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-809 Episodic care.** (1) When evaluating patients for episodic care, such as emergency or urgent care, the physician assistant should review any available prescription monitoring program, emergency department-based information exchange, or other tracking system.

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

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

(4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under WAC 246-918-806(6) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-809, filed 5/24/11, effective 1/2/12.]

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**WAC 246-918-810 Consultation—Recommendations and requirements.** (1) The physician assistant 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 practitioner 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 246-918-813 is required, unless the consultation is exempted under WAC 246-918-811 or 246-918-812. 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 assistant;
- (iii) An electronic consultation between the pain management specialist and the physician assistant; or
- (iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the physician assistant or a licensed health care practitioner designated by the physician assistant or the pain management specialist.

(b) A physician assistant 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 assistant, the physician assistant 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 246-918-800 through 246-918-813, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-810, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-811 Consultation—Exemptions for exigent and special circumstances.** A physician assistant is not required to consult with a pain management specialist as described in WAC 246-918-813 when he or she has documented adherence to all standards of practice as defined in

WAC 246-918-800 through 246-918-813 when any one or more of the following conditions apply:

- (1) The patient is following a tapering schedule;
- (2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level;
- (3) The physician assistant documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or
- (4) The physician assistant documents that the patient's pain and function is stable and that the patient is on a nonescalating dosage of opioids.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-811, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-812 Consultation—Exemptions for the physician assistant.** The physician assistant is exempt from the consultation requirement in WAC 246-918-810 if one or more of the following qualifications are met:

- (1) The sponsoring physician is a pain management specialist under WAC 246-918-813; or
- (2) The sponsoring physician and the physician assistant has successfully completed, within the last two years, a minimum of twelve continuing education hours (Category 1 for physicians) on chronic pain management, with at least two of these hours dedicated to long-acting opioids; or
- (3) The physician assistant is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility.

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.-020. WSR 11-12-025, § 246-918-812, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-813 Pain management specialist.** A pain management specialist shall meet one or more of the following qualifications:

- (1) If a physician or osteopathic physician:
  - (a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or
  - (b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or
  - (c) Has a certification of added qualification in pain management by the AOA; or
  - (d) A minimum of three years of clinical experience in a chronic pain management care setting; and
  - (i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and
  - (ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians; and

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

(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.

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

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

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

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

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

(4) If a podiatric physician:

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

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

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

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

[Statutory Authority: RCW 18.71.450, 18.71A.100, 18.71.017, and 18.71A.020. WSR 11-12-025, § 246-918-813, filed 5/24/11, effective 1/2/12.]

**WAC 246-918-990 Physician assistants fees and renewal cycle.** (1) Licenses must be renewed every two years on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

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

Title of Fee	Fee
Physician assistants:	
Application (annual)*	\$116.00
Two-year renewal*	202.00
Expired license reissuance	50.00
Duplicate license	15.00

\* The application or renewal fee includes the Washington physician health program surcharge (RCW 18.71A.020(3)) assessed at \$50.00 per year, and the University of Washington (UW) HEAL-WA web portal access fee (RCW 43.70.110) assessed at \$16.00 per year.

[Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-19-088, § 246-918-990, filed 9/18/12, effective 11/1/12. Statutory Authority: RCW 43.70.250, 43.70.280, 18.31.310, 18.71A.020, 18.71.080, and 43.70.110. WSR 09-16-120, § 246-918-990, filed 8/4/09, effective 8/15/09. Statutory Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-918-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250. WSR 06-11-167, § 246-918-990, filed 5/24/06, effective 7/1/06. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-918-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 18.71.017, 18.71A.020 and 43.70.280. WSR 02-05-009, § 246-918-990, filed 2/8/02, effective 3/11/02. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-918-990, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 18.71.017 and 18.71A.020(3). WSR 99-13-087, § 246-918-990, filed 6/14/99, effective 7/15/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-990, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 43.70.040. WSR 91-06-027 (Order 131), § 246-918-990, filed 2/26/91, effective 3/29/91.]