



WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Rules Workshop

Physician Assistants

April 7, 2021 – 2 pm to 4 pm

GoToWebinar

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Rule Workshop Notice



WASHINGTON
**Medical
Commission**
Licensing. Accountability. Leadership.

Rulemaking

The Washington Medical Commission (Commission) has officially filed a [CR-101](#) with the Office of the Code Reviser on November 19, 2020. The WSR# is 20-24-015.

The Commission is considering updating the physician assistant (PA) chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of [Substitute House Bill 2378](#) (SHB 2378) Concerning physician assistants. The Commission is considering adding new sections in accordance with SHB 2378. This bill combines the physician assistant (PA) licensing under the Washington Medical Commission effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the Commission to consult with the Board of Osteopathic Medicine and Surgery when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the Commission to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

Proposed Physician Assistant Rules Workshop Meeting

In response to the filing, the Commission will conduct an open public rules workshop on Wednesday, April 7, 2021, from 2:00 pm to 4:00 pm via GoToWebinar.

Please register for Chapter 246-918 WAC - Physician Assistants - Rulemaking
Workshop on Apr 7, 2021 2:00 PM PDT at:

<https://attendee.gotowebinar.com/register/4818941074673818384>

After registering, you will receive a confirmation email containing information about joining the webinar.

This meeting will be open to the public.

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

The purpose of the rules workshop will be to:

- Invite committee members and members of the public to present draft rule language; and
- Consider possible dates, times, and locations of proposed rules workshops or hearings to be scheduled.

Interested parties and the general public are invited to participate in the rules workshops or provide comments on draft rules. For continued updates on rule development, interested parties are encouraged to join the [Commission's rules GovDelivery](#).

For more information, please contact Amelia Boyd, Program Manager, Washington Medical Commission at (360) 236-2727 or by email at amelia.boyd@wmc.wa.gov.

*CR means Code Reviser

Rules Workshop Agenda



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In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for this meeting. A virtual public meeting, without a physical meeting space, will be held instead. The registration link can be found below.

Wednesday, April 7, 2021 – 2:00 pm to 4:00 pm

Physician Assistants Pre-Proposal Rules

- Housekeeping
- Open workshop
- Discuss draft language
 - WAC 246-918-055 Practice agreements
- Comments from interested parties
- Next steps
- Close workshop

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.



PREPROPOSAL STATEMENT OF INQUIRY

CR-101 (October 2017)

(Implements RCW 34.05.310)

Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 19, 2020

TIME: 2:34 PM

WSR 20-24-015

Agency: Department of Health- Washington Medical Commission

Subject of possible rule making: Chapter 246-918 WAC Physician Assistants--Washington Medical Commission (commission). Revising physician assistant (PA) rules pursuant to Substitute House Bill (SHB) 2378 (Chapter 80, Laws of 2020) and updating PA rules to incorporate current, national standards and best practices.

Statutes authorizing the agency to adopt rules on this subject: RCW 18.71A.150, RCW 18.130.050, chapter 18.71A RCW, and SHB 2378.

Reasons why rules on this subject may be needed and what they might accomplish: The commission is considering updating the PA chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of SHB 2378 Concerning physician assistants. The commission is considering adding new sections in accordance with SHB 2378. This bill combines the physician assistant (PA) licensing under the Washington Medical Commission effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the commission to consult with the Board of Osteopathic Medicine and Surgery (BOMS) when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the commission to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies: None

Process for developing new rule (check all that apply):

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe) Collaborative rulemaking

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting:

Name: Amelia Boyd, Program Manager
Address: PO Box 47866, Olympia, WA 98504-7866
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Web site: wmc.wa.gov
Other:

(If necessary)

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Additional comments: To join the interested parties email list, please visit:
https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153

Date: November 19, 2020	Signature: Signature on file
Name: Melanie de Leon	
Title: Executive Director	

Chapter 246-918 WAC

PHYSICIAN ASSISTANTS—WASHINGTON MEDICAL COMMISSION

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

Last Update: 3/26/20

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

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

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

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

(43) "NCCPA" means National Commission on Certification of Physician Assistants.

(54) "Osteopathic physician" means an individual licensed under chapter 18.57 RCW.

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

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

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

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

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

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

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

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

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

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

~~_(9) "Remote site" means a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

prior to successfully passing the commission approved licensing examination.

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

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

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

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

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

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

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

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

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

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

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

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

(3) It must be noted in the practice agreement that a physician assistant delivering general anesthesia or intrathecal anesthesia has had training that is consistent with the certified anesthesiologist assistant training.

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

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

See page 108 in this packet for more information on this comment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 246-918-075 Background check—Temporary practice

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

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

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

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

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

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

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

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

WAC 246-918-076 How to obtain a temporary practice permit—

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

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

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

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

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

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

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

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

(a) The license is granted;

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

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

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

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

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

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

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

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

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

(ii) A marriage license; or

(iii) A state registered domestic partnership; and

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

(5) For the purposes of this section:

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

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

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

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

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

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

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

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

~~(de)~~ Other information required by the commission.

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

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

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

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

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

See page 106 in this packet for more information on this comment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 246-918-105 Practice limitations due to disciplinary

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

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

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

~~WAC 246-918-120 Remote site. (1) A physician assistant~~

~~may not work in a remote site without approval of the commission or its designee. A physician may not supervise more than three physician assistants who are working in remote sites, or more physician assistants than the physician can adequately supervise.~~

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

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

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

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

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

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

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

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

WAC 246-918-125 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this rule, laser, light, radiofrequency, and plasma devices (hereafter LLRP devices) are medical devices that:

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

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

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

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

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) A physician assistant must be appropriately trained in the physics, safety and techniques of using LLRP devices prior

to using such a device, and must remain competent for as long as the device is used.

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

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

PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

(7) A physician assistant who meets the above requirements may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice

allow the use of an LLRP device provided all the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 246-918-126 Nonsurgical medical cosmetic procedures.

(1) The purpose of this rule is to establish the duties and responsibilities of a physician assistant who injects medication or substances for cosmetic purposes or uses prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation

and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011.

(2) This section does not apply to:

(a) Surgery;

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

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

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

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

(a) "Nonsurgical medical cosmetic procedure" means a procedure or treatment that involves the injection of a medication or substance for cosmetic purposes, or the use of a prescription device for cosmetic purposes. Laser, light, radiofrequency and plasma devices that are used to topically penetrate the skin are devices used for cosmetic purposes, but

are excluded under subsection (2)(b) of this section, and are covered by WAC 246-919-605 and 246-918-125.

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

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

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

(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.

(143) 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.

(145) 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.

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-171, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-918-171, filed 11/16/99, effective 1/1/00.]

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

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

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

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

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

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

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

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

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

WAC 246-918-180 Continuing medical education requirements.

(1) A physician assistant must complete one hundred hours of continuing education every two years as required in chapter 246-

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

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

(a) Current certification with the NCCPA; or

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

(c) Other programs approved by the commission.

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

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

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

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

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

(6) A continuing medical education sponsor does not need to apply for or expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to present continuing medical education for the physician assistant that constitutes a meritorious learning experience.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Have no prescriptive authority; and

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

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

WAC 246-918-260 Physician assistant-surgical assistant

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited

to, spouses, partners, parents, siblings, children, guardians and proxies.

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

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;

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

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

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

(j) Soliciting a date;

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

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

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

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

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

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

(a) Documentation of formal termination;

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

(c) The length of time that has passed;

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

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

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

(g) The degree of emotional dependence and vulnerability.

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

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

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

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

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

WAC 246-918-420 Abuse. (1) A physician assistant commits unprofessional conduct if the physician assistant abuses a patient. A physician assistant abuses a patient when he or she:

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

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

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

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

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

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

OPIOID PRESCRIBING—GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

The commission will judge the validity of the physician assistant's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the

patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist physician assistants in providing appropriate medical care for patients.

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

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

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

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

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

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

- (1) The treatment of patients with cancer-related pain;
- (2) The provision of palliative, hospice, or other end-of-life care;
- (3) The treatment of inpatient hospital patients who are patients who have been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural medications.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

between fifty to ninety milligram morphine equivalent doses per day.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Emergent care;

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

(c) Procedures involving the administration of anesthesia;

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

or

(e) MAT for substance use disorders.

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

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

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

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

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

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

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

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

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

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

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

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE

PERIOPERATIVE PAIN

WAC 246-918-830 Patient evaluation and patient record—

Acute nonoperative pain. Prior to issuing an opioid prescription for acute nonoperative pain or acute perioperative pain, the physician assistant shall:

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

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

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

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

WAC 246-918-835 Treatment plan—Acute nonoperative pain.

The physician assistant shall comply with the requirements in this section when prescribing opioids for acute nonoperative pain.

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

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

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

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

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

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and
- (d) Additional indicated diagnostic evaluations.

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

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

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

(9) If the physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the physician assistant shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-918-845 and 246-918-850 shall apply.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-835, filed 11/16/18, effective 1/1/19.]

WAC 246-918-840 Treatment plan—Acute perioperative pain.

The physician assistant shall comply with the requirements in this section when prescribing opioids for perioperative pain.

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

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

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

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

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

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and
- (d) Additional indicated diagnostic evaluations or other treatments.

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

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

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

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

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

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

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-918-845 Patient evaluation and patient record—

Subacute pain. The physician assistant shall comply with the requirements in this section when prescribing opioids for subacute pain.

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

(a) Conduct an appropriate history and physical examination;

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

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

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

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

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

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

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

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

(c) Pertinent concerns discovered in the PMP;

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

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

(f) Results of psychosocial screening or consultation;

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

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

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

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional indicated diagnostic evaluations or other treatments.

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

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

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

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

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

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

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

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

WAC 246-918-855 Patient evaluation and patient record—

Chronic pain. When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician assistant shall include in the patient's record:

- (1) An appropriate history including:

(a) The nature and intensity of the pain;

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

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

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

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

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

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

(c) Pertinent consultations; and

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

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

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

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

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

(d) Pertinent concerns discovered in the PMP.

(5) Treatment plan as provided in WAC 246-918-860.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-855, filed 11/16/18, effective 1/1/19.]

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

(1) Treatment plan and objectives including:

(a) Documentation of any medication prescribed;

(b) Biologic specimen testing ordered;

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

(d) Other planned treatments; and

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

(2) The physician assistant shall complete patient notification in accordance with the provisions of WAC 246-918-815 or provide this information in the written agreement.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-860, filed 11/16/18, effective 1/1/19.]

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

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

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

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

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

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

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

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

(8) The patient's responsibility to safeguard all medications and keep them in a secure location.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-865, filed 11/16/18, effective 1/1/19.]

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

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

- (a) For a high-risk patient, at least quarterly;
- (b) For a moderate-risk patient, at least semiannually;
- (c) For a low-risk patient, at least annually;
- (d) Immediately upon indication of concerning aberrant behavior; and

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

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

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

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

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

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

(3) Periodic patient evaluations must also include:

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

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

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

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

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

WAC 246-918-875 Long-acting opioids—Chronic pain. Long-acting opioids should only be prescribed by a physician assistant who is familiar with its risks and use, and who is

prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The physician assistant prescribing long-acting opioids should have a one-time completion of at least four hours of continuing education relating to this topic.

[Statutory Authority: RCW 18.71.017, 18.71.800, 18.71A.800 and 2017 c 297. WSR 18-23-061, § 246-918-875, filed 11/16/18, effective 1/1/19.]

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

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

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

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

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

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

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

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

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

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

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

(1) The patient is following a tapering schedule;

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

(3) The physician assistant documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or

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

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

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

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

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

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

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

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

WAC 246-918-895 Pain management specialist—Chronic pain.

A pain management specialist shall meet one or more of the following qualifications:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The patient requests;

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

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

(4) Other treatment modalities are indicated;

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

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

(7) There is unauthorized escalation of doses; or

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

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

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

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

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

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

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

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

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

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

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

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-918-910 Special populations—Children or adolescent patients, pregnant patients, and aging populations. (1)

Children or adolescent patients. In the treatment of pain for children or adolescent patients, the physician assistant shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

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

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

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

WAC 246-918-915 Episodic care of chronic opioid patients.

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

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

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

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

OPIOID PRESCRIBING—COPRESCRIBING

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

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Nonbenzodiazepine hypnotics.

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

the new prescription shall consult with the other prescriber to establish a patient care plan surrounding these medications.

This provision does not apply to emergency care.

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

WAC 246-918-925 Coprescribing of opioids for patients

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

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

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

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

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

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FEES

WAC 246-918-990 Physician assistants fees and renewal cycle. (1) Licenses must be renewed every two years on the

practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

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

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

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

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

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

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

From: [Amy Brackenbury](#)
To: [WMC Medical Rules](#)
Subject: Proposed language for Physician Assistants practicing anesthesiology
Date: Friday, March 26, 2021 11:06:25 AM

External Email

Good Morning,

On behalf of the Washington State Society of Anesthesiology, I respectfully submit the following language for your consideration as you contemplate rule making to implement Section 5(3) of SHB 2378 (2020):

Physician assistant—Requirements for licensure.

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

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

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

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

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

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

(e) Other information required by the commission.

~~(3) To perform general or intrathecal anesthesia services, a physician assistant must submit to the commission, in addition to the requirements of subsection (2), proof of current certification by the National Commission for the Certification of Anesthesiologist Assistants.~~

~~(3)~~ (4) The commission will only consider complete applications with all supporting documents for licensure.

~~(4)~~ (5) A physician assistant may not begin practicing without written commission approval of a delegation agreement.

Amy Brackenbury

WSSA

Amy Brackenbury | 360.239.1013



March 29, 2021

John Maldon, Chair
Washington Medical Commission

Via email

Dear Chair Maldon:

On behalf of the Washington Association of Nurse Anesthetists (WANA), thank you for the opportunity to provide comments to the proposed rules amending Chapter 246-918 WAC pursuant to SHB 2378. Specifically, I am providing comments on the section of the rules allowing physician assistants to administer general and intrathecal anesthesia. **WANA requests that the Medical Commission's rules include a requirement that any physician assistant who is delivering general or intrathecal anesthesia show evidence of the same level of education as a nurse anesthetist or physician anesthesiologist.**

As you know, SHB 2378 passed the Legislature and was signed into law by Governor Inslee last year. Initially, WANA testified with concerns on this legislation, as the original bill would have allowed the physician assistant to practice in any area of medicine as long as the practice is not beyond the scope or expertise of the participating physician.

This meant that for the administration of anesthesia, the original bill would have allowed a physician assistant to have a practice agreement with an anesthesiologist and perform anesthesia services, as anesthesia is not beyond the scope or expertise of the participating anesthesiologist. There was no requirement in the original bill for the physician assistant to show any evidence of adequate education and training in the administration of anesthesia.

However, WANA worked with the proponents and the bill sponsor to amend the bill. EHB 2378, as passed by the Legislature, requires that a physician assistant who is "delivering general anesthesia or intrathecal anesthesia pursuant to a practice agreement with a physician shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement." **The Medical Commission should define "adequate education and training" as the same level of education that a nurse anesthetist or a physician anesthesiologist is required to have.** This level of education is necessary to ensure patient safety, as administering anesthesia is not a core competency included in physician assistant education and training programs. Here is WANA's suggested rule language:

A physician assistant delivering general anesthesia or intrathecal anesthesia pursuant to a practice agreement with a physician shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on

his or her practice agreement. Adequate education and training will meet, at minimum, the education and training required for anesthesia providers licensed to perform anesthesia in the state, which are certified registered nurse anesthetists and physician anesthesiologists.

It is important to know the level of education nurse anesthetists have in order to safely administer anesthesia. For example, the Doctor of Nurse Anesthesia Practice is a three-year program, with 88 credits and over 3300 clinical hours. Applicants must have a baccalaureate or graduate degree in nursing or other appropriate major from an accredited university. They must also have an RN or ARNP license, with at least one year of full-time work experience as an RN in a critical care setting at the time of application.

General anesthesia results in the patient becoming unconscious, unable to breathe on their own, and creates great variants in their cardiovascular and pulmonary systems. This type of anesthesia comes with great risks. Each patient has unique and individual risk factors that must be taken into consideration when conducting general anesthesia. The significant changes within each major organ system requires an in-depth understanding of not only those systems, but the effects that anesthesia has on these systems. The anesthesia provider must be able to react quickly and instantaneously to any complication arising from the surgical procedure or anesthetic. This requires a comprehensive knowledge of physiology, pharmacology and the specifics of anesthesia. Negative outcomes or complications that may arise include heart attack, stroke, kidney failure, pneumonia and significant blood loss.

Because physician assistants are allowed to practice unsupervised, it is imperative that they have the same level of education in administering anesthesia as nurse anesthetists and anesthesiologists do to ensure the safety of the patient.

Therefore, WANA requests that the Medical Commission's rules implementing SHB 2378 require any physician assistant who is delivering general or intrathecal anesthesia to show evidence of the same level of education as a nurse anesthetist or an anesthesiologist.

Thank you for the opportunity to provide comments on behalf of WANA.

Ellen Kraus-Schaeffer

Ellen Kraus-Schaeffer, RN, ARNP, CRNA
President