

Chapter 246-854 WAC
OSTEOPATHIC PHYSICIANS' ASSISTANTS

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WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-854-020 Osteopathic physician assistant program. [Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-020, filed 11/22/93, effective 12/23/93; WSR 91-20-120 (Order 199B), § 246-854-020, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-854-020, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2). WSR 89-22-065 (Order PM 863), § 308-138A-020, filed 10/31/89, effective

12/1/89. Statutory Authority: RCW 18.57.005(2), 18.57A.020 and 18.130.050(1). WSR 88-14-113 (Order 745), § 308-138A-020, filed 7/6/88. Statutory Authority: RCW 18.57A.020, 18.57.005 and 18.130.050. WSR 88-09-030 (Order PM 723), § 308-138A-020, filed 4/15/88. Statutory Authority: RCW 18.57A.020. WSR 87-20-099 (Order PM 671), § 308-138A-020, filed 10/7/87. Statutory Authority: RCW 18.57.005. WSR 87-13-004 (Order PM 655), § 308-138A-020, filed 6/4/87. Statutory Authority: RCW 18.57A.020. WSR 83-16-024 (Order PL 440), § 308-138A-020, filed 7/27/83. Statutory Authority: RCW 18.57.005 and 18.57A.020. WSR 82-17-005 (Order PL 402), § 308-138A-020, filed 8/5/82. Formerly WAC 308-138-020.] Repealed by WSR 07-11-057, filed 5/11/07, effective 6/11/07. Statutory Authority: RCW 18.57.005, 18.57A.020.

- 246-854-040 Osteopathic physician assistant use of drugs or autotransfusion to enhance athletic ability. [Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-040, filed 11/22/93, effective 12/23/93; WSR 90-24-055 (Order 100B), recodified as § 246-854-040, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2), 18.57A.020 and 18.130.050(1). WSR 88-21-081 (Order PM 780), § 308-138A-030, filed 10/19/88.] Repealed by WSR 15-03-013, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203.
- 246-854-050 AIDS education and training. [Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-854-050, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-050, filed 11/22/93, effective 12/23/93; WSR 91-20-120 (Order 199B), § 246-854-050, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-854-050, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138A-040, filed 11/23/88.] Repealed by WSR 15-03-013, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203.
- 246-854-060 Application for licensure. [Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-060, filed 11/22/93, effective 12/23/93; WSR 91-20-120 (Order 199B), § 246-854-060, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-854-060, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138A-050, filed 11/23/88.] Repealed by WSR 15-03-013, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203.
- 246-854-070 Registration renewal requirement. [Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-854-070, filed 12/3/90, effective 1/31/91. Statutory Authority: 1988 c 206 § 604. WSR 88-23-124 (Order PM 801), § 308-138A-060, filed 11/23/88.] Repealed by WSR 91-20-120 (Order 199B), filed 9/30/91, effective 10/31/91. Statutory Authority: RCW 18.57.005.
- 246-854-090 Osteopathic physician assistant practice plan. [Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-090, filed 11/22/93, effective 12/23/93; WSR 90-24-055 (Order 100B), recodified as § 246-854-090, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2). WSR 89-22-065 (Order PM 863), § 308-138A-080, filed 10/31/89, effective 12/1/89.] Repealed by WSR 07-11-057, filed 5/11/07, effective 6/11/07. Statutory Authority: RCW 18.57.005, 18.57A.020.
- 246-854-100 Osteopathic physicians' assistants reregistration. [Statutory Authority: RCW 18.57.005. WSR 90-24-055 (Order 100B), recodified as § 246-854-100, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2). WSR 89-22-065 (Order PM 863), § 308-138A-090, filed 10/31/89, effective 12/1/89.] Repealed by WSR 93-24-028, filed 11/22/93, effective 12/23/93. Statutory Authority: RCW 18.57.005.
- 246-854-120 Use of controlled substances for pain control. [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-854-120, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-068, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.
- 246-854-130 What specific guidance should an osteopathic physician assistant follow? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-854-130, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-068, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.
- 246-854-140 What knowledge should an osteopathic physician assistant who elects to treat chronic pain patient possess? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-854-140, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-068, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.
- 246-854-150 How will the board evaluate prescribing for pain? [Statutory Authority: RCW 18.57.005, 18.130.050, and chapters 18.57, 18.18.57A [18.57A] RCW. WSR 07-11-058, § 246-854-150, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-068, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020.
- 246-854-243 Patient evaluation. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-243, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.
- 246-854-244 Treatment plan. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-244, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.
- 246-854-245 Informed consent. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-245, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.
- 246-854-246 Written agreement for treatment. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-246, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-247 Periodic review. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-247, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-248 Long-acting opioids, including methadone. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-248, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-249 Episodic care. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-249, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-250 Consultation—Recommendations and requirements. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-250, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-251 Consultation—Exemptions for exigent and special circumstances. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-251, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-252 Consultation—Exemptions for the osteopathic physician assistant. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-252, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

246-854-253 Pain management specialist. [Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-253, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-087, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297.

WAC 246-854-005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Board" means the Washington state board of osteopathic medicine and surgery.

(2) "Delegation agreement" means a mutually agreed upon plan, as detailed in WAC 246-854-021, between a sponsoring osteopathic physician and an osteopathic physician assistant, which describes the manner and extent to which the osteopathic physician assistant will practice and be supervised.

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

(4) "Osteopathic physician assistant" means a person who is licensed under chapter 18.57A RCW by the board to practice medicine to a limited extent only under the supervision of a physician as detailed in a delegation agreement approved by the board.

(5) "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 osteopathic physician assistant.

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

(a) "Sponsoring physician" means any osteopathic physician licensed under chapter 18.57 RCW and identified in a delegation agreement as providing primary clinical and administrative oversight for a physician assistant.

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

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-005, filed 1/8/15, effective 2/8/15.]

WAC 246-854-007 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 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-007, filed 1/8/15, effective 2/8/15.]

WAC 246-854-010 Approved training and additional skills or procedures. (1) "Board approved program" means a physician assistant program accredited by:

- (a) The committee on allied health education and accreditation (CAHEA);
- (b) The commission on accreditation of allied health education programs (CAAHEP);
- (c) The accreditation review committee on education for the physician assistant (ARC-PA); or
- (d) Other substantially equivalent organization(s) approved by the board.

(2) An individual enrolled in a board approved program for physician assistants may function only in direct association with his or her precepting physician or a delegated alternate physician in the immediate clinical setting. A trainee may not function in a remote site or in the absence of the preceptor.

(3) If an osteopathic physician assistant is being trained to perform additional skills or procedures beyond those established by the board, the training must be carried out under the direct, personal supervision of the supervising osteopathic physician or other qualified physician familiar with the delegation agreement of the osteopathic physician assistant. The training arrangement must be mutually agreed upon by the supervising osteopathic physician and the osteopathic physician assistant.

(4) To become approved to perform newly acquired skills or procedures an osteopathic physician assistant shall submit a request in writing to the board. The request must include a certificate by the program director or other acceptable evidence showing that he or she was trained in the additional skill or procedure for which authorization is requested. The board will review the evidence to determine whether the applicant has adequate knowledge to perform the additional skill or procedure.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-010, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-010, filed 5/11/07, effective 6/11/07.]

WAC 246-854-015 Use and supervision of an osteopathic physician assistant. (1) Unless otherwise stated, for the purposes of this section reference to "osteopathic physician assistant" means an osteopathic physician assistant or interim permit holder.

(2) A licensed osteopathic physician assistant may not practice until the board approves a delegation agreement jointly submitted by the osteopathic physician assistant and sponsoring physician or physi-

cian group under whose supervision the osteopathic physician assistant will practice.

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

(a) More than three physician assistants who are working in remote sites as provided in WAC 246-854-025; or

(b) More physician assistants than the osteopathic physician can adequately supervise. The board may consider petitions to supervise more than five osteopathic physician assistants based on the individual qualifications and experience of the osteopathic physician and osteopathic physician assistant, community need, and review mechanisms identified in the proposed delegation agreement.

(4) The osteopathic physician assistant shall practice only in the locations designated in the delegation agreement.

(5) The osteopathic physician assistant and supervising osteopathic physician shall ensure that the supervising osteopathic physician provides adequate supervision and review of the osteopathic physician assistant's practice.

(6) An osteopathic physician assistant must clearly identify himself or herself as an osteopathic physician assistant and must appropriately display on his or her person identification as an osteopathic physician assistant.

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

(8) In the event that an osteopathic physician assistant desires to become sponsored by another osteopathic physician, he or she must submit a new delegation agreement. Board approval of the new relationship is required before the osteopathic physician assistant may begin practice under the new sponsoring physician.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-015, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-015, filed 5/11/07, effective 6/11/07.]

WAC 246-854-021 Delegation agreements. (1) The osteopathic physician assistant and sponsoring physician must submit a joint delegation agreement on forms provided by the board. An osteopathic physician assistant may not begin practicing without written board approval of a delegation agreement.

(2) The delegation agreement must specify:

(a) The names and Washington state license number 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 osteopathic physician assistant;

(c) A description of the supervision process for the practice, including chart review; and

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

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

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

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

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

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

(a) More than three physician assistants who are working in remote sites as provided in WAC 246-854-025; or

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

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

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

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-021, filed 1/8/15, effective 2/8/15.]

WAC 246-854-025 Remote site. (1) An osteopathic physician assistant may not work in a remote site without the approval by the board or its designee. An osteopathic physician may not supervise more than three physician assistants who are working in remote sites; or more physician assistants than the osteopathic physician can adequately supervise.

(2) The board or its designee may approve the use of an osteopathic physician assistant in a remote site if:

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

(b) There are adequate means for timely communication between the supervising physician and the osteopathic physician assistant;

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

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

(3) An osteopathic physician assistant holding an interim permit may not work in a remote site.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-025, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-025, filed 5/11/07, effective 6/11/07.]

WAC 246-854-030 Prescriptions. (1) An osteopathic 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 agreement provided:

(a) The osteopathic 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 osteopathic physician assistant will be similarly limited in his or her prescribing privileges, unless otherwise authorized in writing by the board.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-030, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57A.020. WSR 07-08-052, § 246-854-030, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-030, filed 11/22/93, effective 12/23/93; WSR 91-20-120 (Order 199B), § 246-854-030, filed 9/30/91, effective 10/31/91; WSR 90-24-055 (Order 100B), recodified as § 246-854-030, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57A.020, 18.57.005 and 18.130.050. WSR 89-23-067 (Order 018), § 308-138A-025, filed 11/15/89, effective 12/16/89; WSR 88-09-030 (Order PM 723), § 308-138A-025, filed 4/15/88. Statutory Authority: RCW 18.57A.020. WSR 87-20-099 (Order PM 671), § 308-138A-025, filed 10/7/87. Statutory Authority: RCW 18.57.005, 18.57A.020 and 18.57A.070. WSR 84-05-011 (Order PL 457), § 308-138A-025, filed 2/7/84. Statutory Authority: RCW 18.57A.020. WSR 83-16-024 (Order PL 440), § 308-138A-025, filed 7/27/83. Statutory Authority: RCW 18.57.005 and 18.57A.020. WSR 82-17-005 (Order PL 402), § 308-138A-025, filed 8/5/82. Formerly WAC 308-138-025.]

WAC 246-854-035 Osteopathic physician assistant—Scope of practice. (1) For the purpose of this section, reference to "osteopathic physician assistant" means a licensed osteopathic physician assistant or interim permit holder.

(2) The osteopathic physician assistant may perform services for which they have been trained and approved in a delegation agreement by the board. Those services may be performed by the osteopathic physician assistant unless limited in the approved delegation agreement.

(3) An osteopathic physician assistant may sign and attest to any document that might ordinarily be signed by a licensed osteopathic

physician, to include, but not be limited to, such things as birth and death certificates.

(4) An osteopathic physician assistant may prescribe legend drugs and controlled substances as permitted in WAC 246-854-030.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-035, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-035, filed 5/11/07, effective 6/11/07.]

WAC 246-854-075 Background check—Temporary practice permit.

The board 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 board 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 board 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 board.

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

(3) The board 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 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-075, filed 1/8/15, effective 2/8/15.]

WAC 246-854-080 Osteopathic physician assistant—Requirements for licensure.

(1) Individuals applying to the board for licensure as an osteopathic physician assistant must have graduated from an accredited board approved physician assistant program and successfully passed the NCCPA examination.

(2) An applicant for licensure as an osteopathic physician assistant must submit to the board:

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

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

- (c) All applicable fees as specified in WAC 246-853-990;
 - (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 board.
- (3) The board will only consider complete applications with all supporting documents for licensure.
- (4) An osteopathic physician assistant may not begin practicing without written board approval of the delegation agreement.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-080, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-080, filed 5/11/07, effective 6/11/07. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-854-080, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005 and 18.130.050. WSR 94-15-068, § 246-854-080, filed 7/19/94, effective 8/19/94. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-080, filed 11/22/93, effective 12/23/93; WSR 90-24-055 (Order 100B), recodified as § 246-854-080, filed 12/3/90, effective 1/31/91. Statutory Authority: RCW 18.57.005(2). WSR 89-22-065 (Order PM 863), § 308-138A-070, filed 10/31/89, effective 12/1/89.]

WAC 246-854-081 How to return to active status when a license has expired. To return to active status the osteopathic physician assistant must meet the requirements of chapter 246-12 WAC, Part 2, which includes paying the applicable fees under WAC 246-853-990 and meeting the continuing medical education requirements under WAC 246-854-115.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-081, filed 1/8/15, effective 2/8/15.]

WAC 246-854-082 Requirements for obtaining an osteopathic physician assistant license for those who hold an active allopathic physician assistant license. A person who holds a full, active, unrestricted physician assistant license that is in good standing issued by the Washington state medical quality assurance commission and meets current licensing requirements may apply for licensure as an osteopathic physician assistant through an abbreviated application process.

- (1) An applicant for an osteopathic physician assistant license must:
- (a) Hold an active, unrestricted license as a physician assistant issued by the Washington state medical quality assurance commission;
 - (b) Submit a completed application on forms provided by the board; and
 - (c) Submit any fees required under WAC 246-853-990.
- (2) A physician assistant may not begin practice without written board approval of the delegation agreement.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-082, filed 1/8/15, effective 2/8/15.]

WAC 246-854-085 Osteopathic physician assistant interim permit—Qualifications and requirements. An interim permit is a limited license. The permit allows an individual who has graduated from a board approved program within the previous twelve months to practice prior to successfully passing the board approved licensing examination.

(1) An individual applying to the board for an interim permit under RCW 18.57A.020(1) must have graduated from an accredited board approved physician assistant program.

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

(3) An applicant for an osteopathic physician assistant interim permit must submit to the board:

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

(b) Applicable fees as specified in WAC 246-853-990; and

(c) Requirements as specified in WAC 246-854-080.

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

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-085, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020. WSR 07-11-057, § 246-854-085, filed 5/11/07, effective 6/11/07.]

WAC 246-854-095 Scope of practice—Allopathic alternate physician. The osteopathic physician assistant licensed under chapter 18.57A RCW shall practice under the delegation agreement and prescriptive authority approved by the board 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.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-095, filed 1/8/15, effective 2/8/15.]

WAC 246-854-105 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 board.

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

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-105, filed 1/8/15, effective 2/8/15.]

WAC 246-854-110 Osteopathic physician assistant renewal and continuing medical education cycle. (1) Under WAC 246-12-020, an initial

credential issued within ninety days of the osteopathic physician assistant's birthday does not expire until the osteopathic physician assistant's next birthday.

(2) An osteopathic physician assistant must renew his or her license every year on his or her birthday. Renewal fees are accepted no sooner than ninety days prior to the expiration date.

(3) Each osteopathic physician assistant will have one year to meet the continuing medical education requirements in WAC 246-854-115. The review period begins on the first birthday after receiving the initial license.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-110, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-854-110, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-110, filed 11/22/93, effective 12/23/93.]

WAC 246-854-112 Retired active license. (1) To obtain a retired active license an osteopathic physician assistant must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) An osteopathic physician assistant with a retired active license must have a delegation agreement approved by the board 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.

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

(4) An osteopathic 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 non-permanent basis.

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

(6) An osteopathic physician assistant with a retired active license shall report fifty hours of continuing education at every renewal.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-112, filed 1/8/15, effective 2/8/15.]

WAC 246-854-115 Continuing medical education requirements. (1) An osteopathic physician assistant must complete fifty hours of continuing education every year as required in chapter 246-12 WAC, Part 7, which may be audited for compliance at the discretion of the board.

(2) In lieu of the continuing medical education requirements, the board 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 board.

(3) The board approves the following categories of creditable continuing medical education. A minimum of thirty 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 board 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) An osteopathic physician assistant does not need prior approval of any continuing medical education. The board will accept any continuing medical education that reasonably falls within the requirements of this section and relies upon each osteopathic 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 board 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 board relies upon the integrity of the program sponsors to present continuing medical education for the osteopathic physician assistant that constitutes a meritorious learning experience.

(7) In the case of a permanent retirement or illness, the board may grant an indefinite waiver of continuing education as a requirement for licensure, provided that an affidavit is received indicating that the osteopathic physician assistant is not providing osteopathic medical services to consumers. If such permanent retirement or illness status is changed or osteopathic medical services are resumed, it is incumbent upon the licensee to immediately notify the board and show proof of practice competency as determined necessary by the board.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-115, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005. WSR 93-24-028, § 246-854-115, filed 11/22/93, effective 12/23/93.]

WAC 246-854-116 Mandatory one-time training in suicide assessment, treatment, and management. A licensed osteopathic physician assistant must complete a board-approved one-time training that is at least six hours long in suicide assessment, treatment, and management. This training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or the first full continuing education reporting period after initial licensure, whichever is later.

(1) Until July 1, 2017, a board-approved training must be an empirically supported training in suicide assessment, including screening and referral, suicide treatment, and suicide management, and meet any other requirement in RCW 43.70.442.

(2) Beginning July 1, 2017, training accepted by the board must be on the department's model list developed in accordance with rules adopted by the department that establish minimum standards for training programs. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.

(3) A board-approved training must be at least six hours in length and may be provided in one or more sessions.

(4) The hours spent completing the training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education requirements.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.130.050, and 43.70.442. WSR 17-12-103, § 246-854-116, filed 6/6/17, effective 7/7/17.]

WAC 246-854-200 Sexual misconduct. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise:

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the osteopathic 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 osteopathic 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) "Osteopathic physician assistant" means a person licensed to practice osteopathic medicine and surgery under chapter 18.57A 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) An osteopathic physician assistant shall not engage in sexual misconduct with a current patient or a key third party. An osteopathic physician assistant engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

- (a) Sexual intercourse or genital to genital contact;
- (b) Oral to genital contact;
- (c) Genital to anal contact or oral to anal contact;
- (d) Kissing in a romantic or sexual manner;
- (e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;
- (f) Examination or touching of genitals without using gloves;
- (g) Not allowing a patient the privacy to dress or undress;
- (h) Encouraging the patient to masturbate in the presence of the osteopathic physician assistant or masturbation by the osteopathic physician assistant while the patient is present;
- (i) Offering to provide practice-related services, such as medication, in exchange for sexual favors;
- (j) Soliciting a date;
- (k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the osteopathic physician assistant.

(3) 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.

(4) An osteopathic 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 osteopathic 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 osteopathic physician assistant's personal or sexual needs.

(5) To determine whether a patient is a current patient or a former patient, the board 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 osteopathic 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 18.57.005, 18.57A.020, 18.130.050, 18.130.062, and Executive Order 06-03. WSR 17-01-043, § 246-854-200, filed 12/13/16, effective 1/13/17. Statutory Authority: RCW 18.57.005, 18.130.050 and chapters 18.57, 18.57A RCW. WSR 07-12-091, § 246-854-200, filed 6/6/07, effective 7/7/07.]

WAC 246-854-210 Abuse. (1) An osteopathic physician assistant commits unprofessional conduct if the osteopathic physician assistant abuses a patient or key third party. "Osteopathic physician assistant," "patient" and "key third party" are defined in WAC 246-854-200. An osteopathic 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 18.57.005, 18.130.050 and chapters 18.57, 18.57A RCW. WSR 07-12-091, § 246-854-210, filed 6/6/07, effective 7/7/07.]

WAC 246-854-220 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this section,

laser, light, radiofrequency, and plasma (LLRP) devices are medical devices that:

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

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

(2) Because an LLRP device is used to treat disease, injuries, deformities and other physical conditions of human beings, the use of an LLRP device is the practice of osteopathic medicine under RCW 18.57.001. 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 those in subsection (1) of this section constitutes surgery and is outside the scope of this section.

OSTEOPATHIC PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) An osteopathic physician assistant may use an LLRP device with the consent of the sponsoring or supervising osteopathic physician who meets the requirements under WAC 246-853-630, is in compliance with the delegation agreement approved by the board, and in accordance with standard medical practice.

(5) An osteopathic 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.

(6) Prior to authorizing treatment with an LLRP device, an osteopathic 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.

OSTEOPATHIC PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

(7) An osteopathic 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 allows the use of a prescriptive LLRP medical 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 including, but not limited to:

(i) Application techniques of each LLRP device;

(ii) Cutaneous medicine;

(iii) Indications and contraindications for such procedures;

(iv) Preprocedural and postprocedural care;

(v) Potential complications; and

(vi) Infectious disease control involved with each treatment;

(e) The delegating osteopathic 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 osteopathic 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 osteopathic physician assistant concerning specific decisions made. Documentation shall be recorded after each procedure on the patient's record or medical chart;

(f) The osteopathic 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 osteopathic 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 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-220, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020, 18.130.050. WSR 08-20-125, § 246-854-220, filed 10/1/08, effective 11/1/08.]

WAC 246-854-230 Nonsurgical medical cosmetic procedures. (1)

The purpose of this rule is to establish the duties and responsibilities of an osteopathic 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 18.57.001.

(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 246-853-630 and 246-854-220;

(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.

(b) "Physician" means an individual licensed under chapter 18.57 RCW.

(c) "Physician assistant" means an individual licensed under chapter 18.57A RCW.

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

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) An osteopathic physician assistant may perform a nonsurgical medical cosmetic procedure only after the board approves a delegation agreement permitting the osteopathic physician assistant to perform such procedures. An osteopathic physician assistant must ensure that the supervising or sponsoring osteopathic physician is in full compliance with WAC 246-853-640.

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

(6) Prior to performing a nonsurgical medical cosmetic procedure, an osteopathic 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 osteopathic 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 board.

(8) Prior to performing a nonsurgical medical cosmetic procedure, either the osteopathic physician assistant or the delegating osteopathic 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 osteopathic 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 osteopathic 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 osteopathic physician assistant must follow if performing a procedure delegated by an osteopathic physician pursuant to WAC 246-853-640, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

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

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

(12) An osteopathic physician assistant must ensure that each treatment is documented in the patient's medical record.

(13) An osteopathic 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.

(14) An osteopathic 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.

(15) An osteopathic physician assistant must participate in a quality assurance program required of the supervising or sponsoring physician under WAC 246-853-640.

[Statutory Authority: RCW 18.57.005, 18.57A.020, 18.57A.040, 18.130.050, and 2013 c 203. WSR 15-03-013, § 246-854-230, filed 1/8/15, effective 2/8/15. Statutory Authority: RCW 18.57.005, 18.57A.020, and 18.130.050(4). WSR 11-08-024, § 246-854-230, filed 3/31/11, effective 5/1/11.]

PAIN MANAGEMENT

WAC 246-854-240 Intent and scope. WAC 246-854-240 through 246-854-370 govern the prescribing of opioids in the treatment of pain. Nothing in these rules in any way restricts the current scope of practice of osteopathic physician assistants as set forth in chapters 18.57 and 18.57A RCW and the working agreements between the osteopathic physician and the osteopathic physician assistant, which may include pain management.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-240, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-240, filed 5/2/11, effective 7/1/11.]

WAC 246-854-241 Exclusions. WAC 246-854-240 through 246-854-370 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. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or
- (4) The provision of procedural premedications.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-241, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-241, filed 5/2/11, effective 7/1/11.]

WAC 246-854-242 Definitions. The definitions in this section apply to WAC 246-854-240 through 246-854-370 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(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 considered to be 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 resulting from cancer in a patient who is less than two years postcompletion of curative anti-cancer treatment with current evidence of disease.

(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 may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anti-cancer treatment with no current evidence of disease.

(6) "High-dose" means ninety milligrams, MED, or more per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

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

(9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, abnormality, or from any other condition for which obstetrical,

medical, or surgical services would be appropriate for care or diagnosis.

(10) "Low-risk" means 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.

(11) "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.

(12) "Moderate-risk" means a category of patient at a 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 and ninety milligram morphine equivalent doses.

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

(14) "Multidisciplinary pain clinic" means a facility that provides comprehensive pain management and includes care provided by multiple available disciplines, practitioners, or treatment modalities.

(15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

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

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "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.

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

(23) "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 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-242, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.57.285, 18.57A.090, 18.57.005, 18.57A.020. WSR 11-10-062, § 246-854-242, filed 5/2/11, effective 7/1/11.]

WAC 246-854-255 Patient notification, secure storage, and disposal. (1) The osteopathic physician assistant shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician assistant shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

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

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-255, filed 10/1/18, effective 11/1/18.]

WAC 246-854-260 Use of alternative modalities for pain treatment. The osteopathic physician assistant shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician assistant may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-260, filed 10/1/18, effective 11/1/18.]

WAC 246-854-265 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic 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 continuing education required under this section counts toward meeting any applicable continuing education requirements.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-265, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

WAC 246-854-270 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic 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, including date, type, dosage, and quantity prescribed.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-270, filed 10/1/18, effective 11/1/18.]

WAC 246-854-275 Treatment plan—Acute nonoperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.

(2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in a quantity greater than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a seven-day supply will rarely be needed.

(c) The osteopathic 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 osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall 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 includes, at a minimum:

- (a) Change in pain level;
- (b) Change in physical function;
- (c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician assistant need to prescribe a long-acting opioid for acute pain, the osteopathic physician assistant must document the reason in the patient record.

(7) An osteopathic physician assistant shall not discontinue medication assistant treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-854-360.

(8) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic 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 246-854-285 and 246-854-290 shall apply.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-275, filed 10/1/18, effective 11/1/18.]

WAC 246-854-280 Treatment plan—Acute perioperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.

(2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic 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. For more specific best practices, the osteopathic physician assistant may refer to clinical practice guidelines.

(4) The osteopathic physician assistant shall reevaluate a patient who does not follow the expected course of recovery. If signifi-

cant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall 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 includes, at a minimum:

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

(6) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant must prescribe in accordance with WAC 246-854-355.

(7) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-854-285 and 246-854-290 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-280, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—SUBACUTE PAIN

WAC 246-854-285 Patient evaluation and patient record. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician assistant shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

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

(c) Inquire regarding other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician assistant determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician assistant treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are 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 significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The results of any queries of the PMP and any concerns the osteopathic physician assistant has;

(d) All medications the patient is known to be prescribed or taking;

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

(f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

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

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

(j) All other required components of the patient record, as established in statute or rule.

(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 planned diagnostic evaluations or other treatments.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-285, filed 10/1/18, effective 11/1/18.]

WAC 246-854-290 Treatment plan—Subacute pain. (1) The osteopathic physician assistant shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician assistant shall

make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The osteopathic physician assistant shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant shall prescribe in accordance with WAC 246-854-355.

(5) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic 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 in WAC 246-854-295 through 246-854-340, shall apply.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-290, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

WAC 246-854-295 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician assistant shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

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

(iii) Current and past treatments for pain, including medications and their efficacy;

(iv) Review of any significant comorbidities;

(v) Any current or historical substance use disorder;

(vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and

(vii) Medication allergies.

(b) Evaluation. The patient evaluation prior to opioid prescribing must include:

(i) Appropriate physical examination;

(ii) Consideration of the risks and benefits of chronic pain treatment for the patient;

(iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;

(iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-854-370;

(v) Any available diagnostic, therapeutic, and laboratory results;

(vi) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low-risk category. The osteopathic physician assistant should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;

(vii) Any available consultations, particularly as related to the patient's pain;

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

(ix) Treatment plan and objectives including:

(A) Documentation of any medication prescribed;

(B) Biologic specimen testing ordered; and

(C) Any labs or imaging ordered.

(x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician assistant; and

(xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-295, filed 10/1/18, effective 11/1/18.]

WAC 246-854-300 Treatment plan. (1) When the patient enters the chronic pain phase, the osteopathic physician assistant shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include, at a minimum:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the osteopathic physician assistant shall adjust drug therapy to the individual health needs of the patient.

(4) The osteopathic physician assistant shall complete patient notification in accordance with the provisions of WAC 246-854-255.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-300, filed 10/1/18, effective 11/1/18.]

WAC 246-854-305 Written agreement for treatment. The osteopathic physician assistant shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

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

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

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

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician assistant to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The osteopathic physician assistant to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician assistant treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

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

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-854-240 through 246-854-370, refills are subject to the same limitations and requirements as initial prescriptions.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-305, filed 10/1/18, effective 11/1/18.]

WAC 246-854-310 Periodic review. (1) The osteopathic physician assistant shall periodically review the course of treatment for chronic pain. The osteopathic physician assistant shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-854-370 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 or aberrant behavior; and

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

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

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

- (b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and
 - (c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician assistant's evaluation of progress towards treatment objectives.
- (3) Periodic patient evaluations must also include:
- (a) History and physical exam related to the pain;
 - (b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and
 - (c) Review the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-854-370 and subsection (1) of this section.
- (4) The osteopathic physician assistant shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician assistant shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-854-335.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-310, filed 10/1/18, effective 11/1/18.]

WAC 246-854-315 Consultation—Recommendations and requirements.

- (1) The osteopathic 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. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.
- (2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-854-320 or 246-854-325, an osteopathic physician assistant who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-854-330. 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 consultation between the pain management specialist and the osteopathic physician assistant;
 - (c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the osteopathic physician assistant or with a licensed health care practitioner designated by the osteopathic physician assistant or the pain management specialist; or
 - (d) Other chronic pain evaluation services as approved by the board.
- (3) The osteopathic physician assistant shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the con-

sultation to the osteopathic physician assistant, the osteopathic physician assistant shall maintain it as part of the patient record.

(4) The osteopathic physician assistant shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-315, filed 10/1/18, effective 11/1/18.]

WAC 246-854-320 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician assistant is not required to consult with a pain management specialist as defined in WAC 246-854-330 when the osteopathic physician assistant has documented adherence to all standards of practice as defined in WAC 246-854-295 through 246-854-340, 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 expected return to their baseline dosage level or below;

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

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-320, filed 10/1/18, effective 11/1/18.]

WAC 246-854-325 Consultation—Exemptions for the osteopathic physician assistant. An osteopathic physician assistant is exempt from the consultation requirement in WAC 246-854-315 if one or more of the following qualifications are met:

(1) The osteopathic physician assistant is a pain management specialist under WAC 246-854-330;

(2) The osteopathic physician assistant has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

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

(4) The osteopathic physician assistant has a minimum of three years 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-325, filed 10/1/18, effective 11/1/18.]

WAC 246-854-330 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) An osteopathic physician assistant shall have a delegation agreement with a physician pain management specialist and meet all of the following educational requirements and practice requirements:

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

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

(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 osteopathic physician assistant's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) An osteopathic physician shall meet requirements in WAC 246-853-750.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-330, filed 10/1/18, effective 11/1/18.]

WAC 246-854-335 Tapering requirements. (1) The osteopathic physician assistant shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician assistant shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests;

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

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

(d) Other treatment modalities are indicated;

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

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

(g) There is unauthorized escalation or doses; or

(h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-335, filed 10/1/18, effective 11/1/18.]

WAC 246-854-340 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a

new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician assistant's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-854-315 and the tapering requirements of WAC 246-854-335 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams 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 demonstrated history in their record of compliance with treatment plans and written agreements as 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 dose in excess of one hundred twenty milligrams MED.

(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 246-854-315 and 246-854-335 shall apply.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-340, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-854-345 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician assistant shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician assistant shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician assistant shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic 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 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-345, filed 10/1/18, effective 11/1/18.]

WAC 246-854-350 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain,

such as for emergency or urgent care, the osteopathic physician assistant shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician assistant providing episodic care to a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician assistant shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician assistant providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician assistant providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician assistant providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-350, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-854-355 Coprescribing of opioids with certain medications. (1) The osteopathic physician assistant must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician assistant prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-355, filed 10/1/18, effective 11/1/18.]

WAC 246-854-360 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic

physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-360, filed 10/1/18, effective 11/1/18.]

WAC 246-854-365 Coprescribing of naloxone. (1) The osteopathic physician assistant shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed.

(2) The osteopathic physician assistant should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-365, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-854-370 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician assistant shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician assistant may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician assistant shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or a benzodiazepine.

(4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician assistant or their authorized designee due to a temporary technical or electrical failure.

(5) In cases of technical or electrical failure, the osteopathic physician assistant shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

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

[Statutory Authority: RCW 18.57.800, 18.57A.800 and 2017 c 297. WSR 18-20-087, § 246-854-370, filed 10/1/18, effective 11/1/18.]