ARTICLE 2.2. PHYSICIAN ASSISTANTS

Rule 1. Definitions (Repealed)

(Repealed by Medical Licensing Board of Indiana; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA)

Rule 1.1. Definitions

844 IAC 2.2-1.1-1 Applicability

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 1. The definitions in this rule apply throughout this title. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-1; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-2 "Anesthesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 2. For purposes of IC 25-27.5, "anesthesia" includes the following:
(1) Moderate sedation/analgesia.
(2) Deep sedation/analgesia.
(3) General anesthesia.
(4) Regional anesthesia.
(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-2; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-1.1-3 "Board" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 3. "Board" refers to the medical licensing board of Indiana. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-3; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-4 "Committee" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1; IC 25-27.5-3-1

Sec. 4. "Committee" refers to the physician assistant committee established by IC 25-27.5-3-1. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-4; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-5 "Contact hour" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 5. "Contact hour" includes fifty (50) to sixty (60) minutes of instruction in pharmacology in either an institutional setting or Category I continuing medical education. One (1) credit hour obtained through an educational institution approved by the committee is equal to ten (10) contact hours. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-5; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-6 "Deep sedation/analgesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 6. (a) For purposes of IC 25-27.5, "deep sedation/analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. For purposes of this rule, reflex withdrawal from a painful stimulus is not considered a purposeful response.

(b) The following are conditions that a patient under deep sedation/analgesia may experience:

(1) The ability to independently maintain ventilatory function may be impaired.

(2) Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate.

(3) Cardiovascular function is usually maintained.

(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-6; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-1.1-7 "Drug classification" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 7. "Drug classification" means the broad general category of drug products defined by their primary clinical role, for example, antihypertensive or antibiotic. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-7; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-8 "General anesthesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 8. (a) For purposes of IC 25-27.5, "general anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by pain stimulation.

(b) The following are conditions that a patient under general anesthesia may experience:

(1) The ability to independently maintain ventilatory function is often impaired.

(2) Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required due to depressed spontaneous ventilation or drug-induced depression of neuromuscular function.

(3) Cardiovascular function may be impaired.

(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-8; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-1.1-9 "Local anesthesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 9. For purposes of IC 25-27.5, "local anesthesia" means a transient and reversible loss of sensation in a circumscribed portion of the body produced by a local anesthetic agent or by cooling a circumscribed area of the skin. The term includes subcutaneous infiltration of an agent. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-9; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-10 "Minimal sedation/anxiolysis" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 10. For purposes of IC 25-27.5, "minimal sedation/anxiolysis" means a drug-induced state during which a patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are usually not affected. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-10; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-11 "Moderate sedation/analgesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 11. (a) For purposes of IC 25-27.5, "moderate sedation/analgesia" (also referred to as "conscious sedation") means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.

(b) The following are conditions that a patient under moderate sedation/analgesia may experience:

(1) No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate.

(2) Cardiovascular function is usually maintained.

(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-11; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-1.1-12 "NCCPA" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 12. "NCCPA" refers to the National Commission on Certification of Physician Assistants. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-12; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-13 "Physician assistant" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 13. "Physician assistant" means an individual who has:

(1) graduated from an approved physician assistant or surgeon assistant program; and

(2) passed the certifying examination and maintains certification by the NCCPA.

(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-13; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-1.1-14 "Protocol" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1

Sec. 14. "Protocol" means general directions under standard practice for prescribing a drug or medical device. The term includes clinical practice guidelines and reference texts or other sources. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-14; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-15 "Regional anesthesia" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5; IC 25-27.5

Sec. 15. (a) For purposes of IC 25-27.5, "regional anesthesia" means the administration of anesthetic agents to a patient to interrupt nerve impulses without the loss of consciousness and includes the following:

(1) Major conduction blocks, such as:

(A) epidural;

(B) spinal; and

(C) caudal;

blocks.

(2) Peripheral nerve blocks, such as:

(A) brachial;

(B) lumbar plexus;

(C) peribulbar; and

(D) retrobulbar;

blocks.

(3) Intravenous regional anesthesia, such as Bier blocks.

(b) A superficial nerve block or application of a local anesthetic agent in which the total dosage administered exceeds the recommended maximum dosage per body weight described in the manufacturer's package insert shall be considered regional anesthesia for purposes of this rule. *(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-15; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-1.1-16 "Supervisory agreement" defined

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 16. "Supervisory agreement" means a written document signed by the supervising physician or physicians and the physician assistant that:

(1) includes the tasks delegated to the physician assistant;

(2) describes the supervisory plan for the physician assistant, including emergency procedures that the physician assistant must follow;

(3) specifies the names of the drug or drug classification the physician assistant is delegated to prescribe and the protocol the physician assistant shall follow in prescribing a drug;

(4) specifies the names of medical devices the physician is delegated to prescribe;

(5) includes the:

(A) name;

(B) address; and

(C) phone number;

of the physician or physicians who will be supervising the physician assistant; and

(6) includes a description of the setting or settings in which the physician assistant will be working.

(Medical Licensing Board of Indiana; 844 IAC 2.2-1.1-16; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

Rule 2. General Provisions

844 IAC 2.2-2-1 Applications

Authority: IC 25-22.5-2-7; IC 25-27.5-3-5
Affected: IC 25-22.5-1-2; IC 25-27.5

Sec. 1. (a) The application for licensure of a physician assistant must be made upon forms supplied by the committee.

(b) Each application for licensure as a physician assistant or for a temporary permit shall include all of the following information:

(1) Complete names, address, and telephone number of the physician assistant.
(2) Satisfactory evidence of the following:
(A) Completion of an approved educational program.
(B) Passage of the Physician Assistant National Certifying Examination administered by the NCCPA.
(C) A current NCCPA certificate.
(D) Official transcripts or a notarized copy of transcripts or a notarized copy of CE certificates indicating completion of thirty (30) contact hours of pharmacology.
(E) A letter signed by an employer, past or present, listing the time frame of full-time employment resulting in one thousand eight hundred (1,800) hours in a twelve (12) month period.
(F) Must possess a current Indiana physician assistant license or have submitted an application in conjunction with prescribing authority application.
(3) All names used by the physician assistant, explaining the reason for such name change or use.
(4) The date and place of birth of the physician assistant and age at the time of application.
(5) Citizenship and visa status, if applicable.
(6) Whether the physician assistant has been licensed, certified, or registered in any other jurisdiction and, if so, the dates thereof.
(7) Whether the physician assistant has had disciplinary action taken against the license, certificate, or registration by the licensing or regulatory agency of any other state or jurisdiction and the details and dates thereof.
(8) A complete listing of all places of employment, including:
(A) the name and address of the employers;
(B) the dates of each employment; and
(C) employment responsibilities held or performed;
that the applicant has had since becoming a physician assistant in any state or jurisdiction.
(9) Whether the physician assistant is, or has been, addicted to, or is chemically dependent upon, any narcotic drugs, alcohol, or other drugs and, if so, the details thereof.
(10) Whether the applicant has been denied licensure, certification, approval, or registration as a physician assistant by any other state or jurisdiction and, if so, the details thereof, including the following:
(A) The name and location of the state or jurisdiction denying:
(i) licensure;
(ii) certification;
(iii) approval; or
(iv) registration.
(B) The date of the denial.
(C) The reasons relating to the denial.
(11) Whether the physician assistant has been convicted of, or pleaded guilty to, any violation of federal, state, or local law relating the:
(A) use;
(B) manufacturing;
(C) distributing;
(D) sale;
(E) dispensing; or
(F) possession;
of controlled substances or of drug addiction and, if so, all of the details relating thereto.
(12) Whether the physician assistant has been convicted of, or pleaded guilty to, any federal or state criminal offense, felony, or misdemeanor, except for traffic violations that resulted only in fines and, if so, all of the details thereto.
(13) Whether the physician assistant was denied privileges in any hospital or health care facility, or had such privileges revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitation, and, if so, all of the details relating thereto, including the:
(A) name and address of the hospital or health care facility;

(B) date of the action; and

(C) reasons therefor.

(14) Whether the physician assistant has ever been admonished, censured, reprimanded, or requested to withdraw, resign, or retire from any hospital or health care facility in which the physician assistant was employed, worked, or held privileges.

(15) Whether the physician assistant has had any malpractice judgments entered against him or her or settled any malpractice action or cause of action and, if so, a complete, detailed description of the facts and circumstances relating thereto.

(16) One (1) passport-type photo taken of the applicant within the last eight (8) weeks.

(c) All information in the application shall be submitted under oath or affirmation, subject to the penalties of perjury.

(d) Each applicant for licensure as a physician assistant shall submit an executed authorization and release form supplied by the committee that:

(1) authorizes the committee or any of its authorized representatives to inspect, receive, and review all documents, records, or other information pertaining to the applicant;

(2) authorizes and directs any:

(A) person;

(B) corporation;

(C) partnership;

(D) association;

(E) organization;

(F) institute;

(G) forum; or

(H) officer thereof;

to furnish, provide, and supply to the committee all relevant documents, records, or other information pertaining to the applicant; and

(3) releases the committee, or any of its authorized representatives, and any:

(A) person;

(B) corporation;

(C) partnership;

(D) association;

(E) organization;

(F) institute;

(G) forum; or

(H) officer thereof;

from any and all liability regarding such inspection, review, receipt, furnishing, or supply of any such information.

(e) Application forms submitted to the committee must be complete. All supporting documents required by the application must be submitted with the application.

(f) Applicants for a temporary permit to practice as a physician assistant while waiting to take the examination or awaiting results of the examination must submit all requirements of subsection (b), except for subsection (b)(2)(B) and (b)(2)(C), in order to apply for a temporary permit.

(g) A temporary permit becomes invalid if the temporary permit holder fails to sit or fails to register for the next available examination.

(h) Prior to beginning practice as a physician assistant, the physician assistant must submit a supervisory agreement to the committee, which must be approved by the board. The supervisory agreement must:

(1) be submitted on employer's letterhead;

(2) be written specifically for the applicant; and

(3) contain the original signature of both the applicant and supervising physician and the date signed.

(Medical Licensing Board of Indiana; 844 IAC 2.2-2-1; filed May 26, 2000, 8:52 a.m.: 23 IR 2498; errata filed Sep 21, 2000, 3:21 p.m.: 24 IR 382; filed Jan 2, 2003, 10:38 a.m.: 26 IR 1558; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA) NOTE: Expiration postponed by Executive Order #09-12, posted

at 20100113-IR-GOV100002EOA.

844 IAC 2.2-2-2 Registration of supervising physician

Authority: IC 25-22.5-2-7; IC 25-27.5-3-5
Affected: IC 25-27.5-6

Sec. 2. (a) A physician licensed under IC 25-22.5 who intends to supervise a physician assistant shall register his or her intent to do so with the board on a form approved by the board prior to commencing supervision of a physician assistant. The supervising physician shall include the following information on the form supplied by the board:

(1) The:
(A) name;
(B) business address; and
(C) telephone number;
of the supervising physician.

(2) The:
(A) name;
(B) business address;
(C) telephone number; and
(D) certification number;
of the physician assistant.

(3) The current license number of the physician.

(4) A statement that the physician will be supervising not more than two (2) physician assistants, and the name and certificate numbers of the physician assistants he or she is currently supervising.

(5) A description of the setting in which the physician assistant will practice under the supervising physician, including the specialty, if any, of the supervising physician.

(6) A statement that the supervising physician:
(A) will exercise continuous supervision over the physician assistant in accordance with IC 25-27.5-6 and this article;
(B) shall review all patient encounters maintained by the physician assistant within twenty-four (24) hours after the physician assistant has seen a patient; and
(C) at all times, retain professional and legal responsibility for the care rendered by the physician assistant.

(7) A detailed description of the process maintained by the physician for evaluation of the physician assistant's performance.

(b) The supervising physician may not:

(1) be the designated supervising physician for more than two (2) physician assistants; or

(2) supervise more than two (2) physician assistants at one (1) time as the primary or designated supervising physician.

(c) The designated supervising physician is to accept responsibility of supervising the physician assistant in the absence of the primary supervising physician of record. Protocol is to be established by the physician practice.

(d) The supervising physician shall, within fifteen (15) days, notify both the board and the committee that the supervising relationship with the physician assistant is terminated. The notification shall state the reason for the termination. *(Medical Licensing Board of Indiana; 844 IAC 2.2-2-2; filed May 26, 2000, 8:52 a.m.: 23 IR 2499; errata filed Sep 21, 2000, 3:21 p.m.: 24 IR 382; filed Jan 2, 2003, 10:38 a.m.: 26 IR 1559; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA) NOTE: Expiration postponed by Executive Order #09-12, posted at 20100113-IR-GOV100002EOA.*

844 IAC 2.2-2-3 License renewal

Authority: IC 25-22.5-2-7
Affected: IC 25-27.5-5-2

Sec. 3. (a) Every physician assistant holding a license issued by the committee shall renew his or her license every two (2) years, in even-numbered years.

(b) On or before April 30 of a renewal year, the committee, or its duly authorized agent, shall notify each license holder that the license holder is required to renew with the committee. The committee, or its agent, shall furnish a license holder a form to be completed for renewal.

(c) Applications for all renewals must be made under oath or affirmation.

(d) Each license holder shall do the following:

(1) Submit the following:

(A) Evidence of current NCCPA certification.

(B) A fee as determined by the committee, in the form of a:

(i) check;

(ii) certified check;

(iii) cashier's check; or

(iv) postal money order;

payable to the order of the "Indiana Professional Licensing Agency".

(2) Inform the committee, in writing, of all changes in address or name within thirty (30) days of the change.

(e) A license holder's failure to receive notification of renewal due to failure to notify the committee of a change of address or name shall not:

(1) constitute an error on the part of the committee or the Indiana professional licensing agency; or

(2) exonerate or otherwise excuse the license holder from renewing the license.

(f) A physician assistant who is less than three (3) years delinquent in renewing a license may be reinstated upon receipt of the:

(1) renewed application;

(2) renewal fees; and

(3) penalty fee.

(g) If more than three (3) years have elapsed since the expiration of a license to practice as a physician assistant, prior to reinstatement, the applicant may be required by the committee to take and pass examination approved by the committee. *(Medical Licensing Board of Indiana; 844 IAC 2.2-2-3; filed May 26, 2000, 8:52 a.m.: 23 IR 2500; readopted filed Nov 16, 2006, 10:49 a.m.: 20061129-IR-844060239RFA; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA) NOTE: Expiration postponed by Executive Order #09-12, posted at 20100113-IR-GOV100002EOA.*

844 IAC 2.2-2-4 Reporting requirements

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-1-2

Sec. 4. If for any reason a physician assistant discontinues working at the direction or under the supervision, or both, of the physician under which the physician assistant is registered with the board, the physician assistant shall inform both the board and the committee, in writing, within fifteen (15) days of the event. The physician assistant shall not commence practice under a new supervising physician until that physician registers his or her intent to supervise the physician assistant to the board under section 2 of this rule. The physician assistant, in the written report, shall state the specific reason for the discontinuation of supervision. *(Medical Licensing Board of Indiana; 844 IAC 2.2-2-4; filed May 26, 2000, 8:52 a.m.: 23 IR 2500; readopted filed Nov 16, 2006, 10:49 a.m.: 20061129-IR-844060239RFA; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-2-5 Privileges and duties

Authority: IC 25-22.5-2-7; IC 25-27.5-3-5
Affected: IC 25-22.5-1-2; IC 25-27.5

Sec. 5. (a) When engaged in the physician assistant's professional activities, a physician assistant shall:

(1) wear a name tag identifying the individual as a physician assistant; and

(2) inform patients that he or she is a physician assistant.

A physician assistant shall not portray himself or herself as a licensed physician.

(b) A physician assistant shall make available for inspection at his or her primary place of business:

(1) the physician assistant's license issued by the committee; and

(2) a statement from the supervising physician that the physician assistant is, or will be, supervised by that physician.

(c) The physician assistant may perform, under the supervision of the supervising physician, such duties and responsibilities that are:

(1) delegated by the supervising physician; and

(2) within the supervising physician's scope of practice.

(Medical Licensing Board of Indiana; 844 IAC 2.2-2-5; filed May 26, 2000, 8:52 a.m.: 23 IR 2500; filed Jan 2, 2003, 10:38 a.m.: 26 IR 1560; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-2-6 Competent practice of physician assistants

Authority: IC 25-22.5-2-7

Affected: IC 25-22.5-1-2; IC 25-27.5-5-4; IC 35-48-2

Sec. 6. It shall be deemed willful misconduct or the incompetent practice as a physician assistant under IC 25-27.5 if a physician assistant licensed by the committee has committed any of the following acts:

(1) Held himself or herself out or permitted another to represent him or her as a licensed physician.

(2) Performed a task other than under the direction or supervision of a physician licensed by the board.

(3) Been delegated a task or performed a task beyond his or her competence unless under mitigating circumstances, such as the physician assistant attending to a patient in a life-threatening emergency with no physician immediately available.

(4) Used intoxicants or drugs to such an extent that he or she is unable to perform competently and with safety as a physician assistant.

(5) Been convicted of a felony or other criminal offense involving moral turpitude in this state or any other state, territory, or country. As used in this subdivision, "conviction" includes:

(A) a conviction of an offense that, if committed in this state, would be deemed a felony or other criminal offense without regard to its designation elsewhere; or

(B) a criminal proceeding in which a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(6) Been adjudicated as mentally or physically incompetent or his or her condition renders him or her unable to safely perform as a physician assistant, or both.

(7) Failed to:

(A) while on duty, wear a name tag with a designation of physician assistant thereon;

(B) make available for inspection his or her license as a physician assistant in the office of his or her primary employment as a physician assistant; or

(C) be of good moral character and to abide by ethical standards.

(8) Engaged in independent practice or received remuneration for medical services directly from the patient or a third party except as provided by federal or state law.

(9) Failed to work under the supervision of the supervising physician designee.

(10) Advertised himself or herself in any manner that would mislead the public generally or the patients of the supervising physician as to the physician assistant's role and status.

(11) Failed to maintain certification issued by the NCCPA.

(12) Neglected or failed to keep adequate patient records of services performed by the physician assistant or not submitted those encounters for review by the supervising physician within twenty-four (24) hours of the time services were performed.

(13) Failed to follow the request of a patient to be seen, examined, or treated by a physician. In the event a patient makes such a request, the physician assistant and supervising physician shall take all necessary and appropriate actions to comply with the patient's request.

(14) Prescribed the use of a drug or medicine outside of those drugs included in the prescribing authority delegated by the supervising physician as identified in the supervisory agreement and prohibited under IC 25-27.5-5-4.

(15) Made a diagnosis or instituted a treatment without the authorization of the supervising physician or physician designee. *(Medical Licensing Board of Indiana; 844 IAC 2.2-2-6; filed May 26, 2000, 8:52 a.m.: 23 IR 2501; readopted filed Nov 16, 2006, 10:49 a.m.: 20061129-IR-844060239RFA; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-2-7 Discipline of physician assistants (Repealed)

Sec. 7. *(Repealed by Medical Licensing Board of Indiana; filed Apr 6, 2010, 2:52 p.m.: 20100505-IR-844090164FRA)*

844 IAC 2.2-2-8 Certification of physician assistants; fees

Authority: IC 25-22.5-2-7; IC 25-27.5-3-5
Affected: IC 25-22.5-1-1.1; IC 25-22.5-1-2; IC 25-27.5

Sec. 8. (a) A nonrefundable fee of one hundred dollars ($100) shall accompany the initial application for certification.

(b) A nonrefundable fee of fifty dollars ($50*)* shall accompany an application for changing supervising physicians.

(c) A fee of fifty dollars ($50) shall accompany each biennial application for renewal of the physician assistant certificate. A fee of fifty dollars ($50) shall accompany each request for a temporary permit in addition to the fee for initial certification.

(d) A fee of ten dollars ($10) shall accompany each request for verification of licensure to another state.

(e) All such fees are nonrefundable. *(Medical Licensing Board of Indiana; 844 IAC 2.2-2-8; filed May 26, 2000, 8:52 a.m.: 23 IR 2501; filed Jan 2, 2003, 10:38 a.m.: 26 IR 1560; readopted filed Dec 1, 2009, 9:13 a.m.: 20091223-IR-844090779RFA; readopted filed Jun 16, 2010, 12:14 p.m.: 20100630-IR-844090779RFA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

Rule 3. Opioid Prescribing Requirements

844 IAC 2.2-3-1 Scope

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 1. This rule establishes standards and protocols for physician assistants in the prescribing of opioid controlled substances for pain management treatment. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-1; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-2 Definitions

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5; IC 35-48-1-9

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Abuse deterrent formulation" means an opioid formulation that has properties shown to meaningfully deter the intentional, nontherapeutic use, even once, to achieve a desirable psychological or physiological effect, even if such formulation does not fully prevent such intentional, nontherapeutic uses.

(c) "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.

(d) "Controlled substances" has the meaning set forth in IC 35-48-1-9.

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

(f) "Opioid" means any of various narcotics containing opium or one (1) or more of its natural or synthetic derivatives. However, if such a narcotic is not a controlled substance, it shall not be an opioid for the purposes of this rule.

(g) "Outset of an opioid treatment plan" means that a patient has been prescribed opioids as described in section 3(c) of this rule, and, therefore, the provisions stated in section 3(a) of this rule become applicable to that patient.

(h) "Terminal" means a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:

(1) there can be no recovery; and

(2) progression to death can be anticipated as an eventual consequence of that condition.

(Medical Licensing Board of Indiana; 844 IAC 2.2-3-2; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-3-3 Triggers for imposition of requirements; exemptions

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 16-21; IC 16-25; IC 16-28; IC 25-1-9; IC 25-27.5

Sec. 3. (a) This section and sections 4 through 9 of this rule establish requirements concerning the use of opioids for chronic pain management for patients.

(b) Notwithstanding subsection (a), this section and sections 4 through 9 of this rule shall not apply to the use of opioids for chronic pain management for the following:

(1) Patients with a terminal condition.

(2) Residents of a health facility licensed under IC 16-28.

(3) Patients enrolled in a hospice program licensed under IC 16-25.

(4) Patients enrolled in an inpatient or outpatient palliative care program of a hospital licensed under IC 16-21 or a hospice licensed under IC 16-25.

However, a period of time that a patient who was, but is no longer, a resident or patient as described in subdivisions (2) through (4) shall be included in the calculations under subsection (c).

(c) The requirements in the sections identified in subsection (a) only apply if a patient has been prescribed:

(1) more than sixty (60) opioid-containing pills a month for more than three (3) consecutive months;

(2) a morphine equivalent dose of more than fifteen (15) milligrams per day for more than three (3) consecutive months;

(3) a transdermal opioid patch for more than three (3) consecutive months;

(4) tramadol, but only if the patient's tramadol dose reaches a morphine equivalent dose of more than sixty (60) milligrams per day for more than three (3) consecutive months; or

(5) an extended release opioid medication that is not in an abuse deterrent form for which an FDA-approved abuse deterrent form is available.

Subdivisions (1) and (2) do not apply to the controlled substances addressed by subdivisions (3) through (5).

(d) Because the requirements in the sections identified in subsection (a) do not apply until the time stated in subsection (c), the initial evaluation of the patient for the purposes of sections 4, 7, and 8(a) of this rule shall not be required to take place until that time.

(e) Notwithstanding subsection (d), the physician assistant may undertake those actions earlier than required if the physician assistant deems it medically appropriate and, if those actions meet the requirements, a further initial evaluation is not required. If the physician assistant conducts actions earlier than required under this subsection, any subsequent requirements are determined by when the initial evaluation would have been required and not at the earlier date it actually was conducted. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-3; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-4 Evaluation and risk stratification by physician assistant

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 4. (a) The physician assistant shall do the physician assistant's own evaluation and risk stratification of the patient by doing the following in the initial evaluation of the patient:

(1) Performing an appropriately focused history and physical exam and obtain or order appropriate tests, as indicated.

(2) Making a diligent effort to obtain and review records from previous health care providers to supplement the physician assistant's understanding of the patient's chronic pain problem, including past treatments, and documenting this effort.

(3) Asking the patient to complete an objective pain assessment tool to document and better understand the patient's specific pain concerns.

(4) Assessing both the patient's mental health status and risk for substance abuse using available validated screening tools.

(5) After completing the initial evaluation, establishing a working diagnosis and tailoring a treatment plan to meaningful and functional goals, with the patient reviewing them from time to time.

(b) Where medically appropriate, the physician assistant shall utilize nonopioid options instead of or in addition to prescribing opioids. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-4; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-5 Physician assistant discussion with patient; treatment agreement

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 5. The physician assistant shall discuss with the patient the potential risks and benefits of opioid treatment for chronic pain, as well as expectations related to prescription requests and proper medication use. In doing so, the physician assistant shall do the following:

(1) Where alternative modalities to opioids for managing pain exist for a patient, discuss them with the patient.

(2) Provide a simple and clear explanation to help patients understand the key elements of their treatment plans.

(3) Counsel women between fourteen (14) and fifty-five (55) years of age with child bearing potential about the risks to the fetus when the mother has been taking opioids while pregnant. Such described risks shall include fetal opioid dependency and neonatal abstinence syndrome (NAS).

(4) Discuss with the patient risks of dependency and addiction.

(5) Discuss with the patient safe storage practices for prescribed opioids.

(6) Provide a written warning to the patient disclosing the risks associated with taking extended release medications that are not in an abuse deterrent form, if the physician assistant prescribes for the patient a hydrocodone-only extended release medication that is not in an abuse deterrent form.

(7) Discuss with the patient the risks and benefits of using an abuse deterrent formulation, as opposed to a non-abuse deterrent formulation, if such a formulation exists for the opioid product the physician assistant is prescribing to the patient. Nothing in this subdivision shall be construed to require a physician assistant to prescribe an opioid in an abuse deterrent formulation.

(8) Together with the patient, review and sign a "Treatment Agreement", which shall include at least the following:

(A) The goals of the treatment.

(B) The patient's consent to drug monitoring testing in circumstances where the physician assistant determines that drug monitoring testing is medically necessary.

(C) The physician assistant's prescribing policies, which must include at least a:

(i) requirement that the patient take the medication as prescribed; and

(ii) prohibition of sharing medication with other individuals.

(D) A requirement that the patient inform the physician assistant:

(i) about any other controlled substances prescribed or taken by the patient; and

(ii) if the patient drinks alcohol while taking opioids.

(E) The granting of permission to the physician assistant to conduct random pill counts.

(F) Reasons the opioid therapy may be changed or discontinued by the physician assistant.

A copy of the treatment agreement shall be retained in the patient's chart.

(Medical Licensing Board of Indiana; 844 IAC 2.2-3-5; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted

filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)

844 IAC 2.2-3-6 Patient visits to physician assistant

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 6. (a) Physician assistants shall not prescribe opioids for patients without periodic scheduled visits. Visits for patients with a stable medication regimen and treatment plan shall occur face-to-face at least once every four (4) months. More frequent visits may be appropriate for patients working with the physician assistant to achieve optimal management. For patients requiring changes to the medication and treatment plan, if changes are prescribed by the physician assistant, the visits required by this subsection shall be scheduled at least once every two (2) months until the medication and treatment has been stabilized.

(b) During the visits required by subsection (a), the physician assistant shall evaluate patient progress and compliance with the patient's treatment plan regularly and set clear expectations along the way, such as attending physical therapy, counseling, or other treatment options. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-6; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-7 INSPECT report

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5; IC 35-48-7-11.1

Sec. 7. At the outset of an opioid treatment plan, and at least annually thereafter, a physician assistant prescribing opioids for a patient shall run an INSPECT report on that patient under IC 35-48-7-11.1(d)(4) and document in the patient's chart whether the INSPECT report is consistent with the physician assistant's knowledge of the patient's controlled substance use history. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-7; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-8 Drug monitoring testing

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 8. (a) At any time the physician assistant determines that it is medically necessary, whether at the outset of an opioid treatment plan, or any time thereafter, a physician assistant prescribing opioids for a patient shall perform or order a drug monitoring test, which must include a confirmatory test using a method selective enough to differentiate individual drugs within a drug class, on the patient.

(b) In determining whether a drug monitoring test under subsection (a) is medically necessary, the physician assistant shall consider, subject to the provisions of subsection (c), each of the following factors where applicable and reasonably feasible:

(1) Whether there is reason to believe a patient is not taking the prescribed opioids or is diverting the opioids.

(2) Whether there has been no appreciable impact on the patient's chronic pain despite being prescribed opioids for a period of time that would generally have an impact.

(3) Whether there is reason to believe the patient is taking or using controlled substances other than opioids or other drugs or medications including illicit street drugs that might produce significant polypharmacological effects or have other detrimental interaction effects.

(4) Whether there is reason to believe the patient is taking or using opioids in addition to the opioids being prescribed by the physician assistant and any other treating practitioner.

(5) Attempts by the patient to obtain early refills of opioid containing prescriptions.

(6) The number of instances in which the patient alleges that the patient's opioid containing prescription has been lost or stolen.

(7) When the patient's INSPECT report provides irregular or inconsistent information.

(8) When a previous drug monitoring test conducted on the patient raised concerns about the patient's usage of opioids.

(9) Necessity of verifying that the patient no longer has substances in the patient's system that are not appropriate under the patient's treatment plan.
(10) When the patient engages in apparent aberrant behaviors or shows apparent intoxication.
(11) When the patient's opioid usage shows an unauthorized dose escalation.
(12) When the patient is reluctant to change medications or is demanding certain medications.
(13) When the patient refuses to participate in or cooperate with a full diagnostic workup or examination.
(14) Whether a patient has a history of substance abuse.
(15) When the patient has a health status change (for example, pregnancy).
(16) Co-morbid psychiatric diagnoses.
(17) Other evidence of chronic opioid use, controlled substance abuse or misuse, illegal drug use or addiction, or medication noncompliance.
(18) Any other factor the physician assistant believes is relevant to making an informed professional judgment about the medical necessity of a prescription.

(c) It shall not be considered a violation of this section for a physician assistant to fail to conduct a review of all eighteen (18) factors listed in subsection (b) if the physician assistant reasonably determines following a review of less than all of the factors listed in subsection (b) that a drug monitoring test is medically necessary.

(d) Nothing about subsection (b) shall be construed to prohibit the physician assistant from performing or ordering a drug monitoring test at any other time the physician assistant considers appropriate.

(e) If a test performed under subsection (a), or conducted under subsection (d), reveals inconsistent medication use patterns or the presence of illicit substances, a review of the current treatment plan shall be required. Documentation of the revised treatment plan and discussion with the patient must be recorded in the patient's chart. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-8; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-9 Morphine equivalent doses above 60; revising of assessments and treatment plans

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-27.5

Sec. 9. When a patient's opioid dose reaches a morphine equivalent dose of more than sixty (60) milligrams per day, a face-to-face review of the treatment plan and patient evaluation must be scheduled, including consideration of referral to a specialist. If the physician assistant elects to continue providing opioid therapy at a morphine equivalent dose of more than sixty (60) milligrams per day, the physician assistant must develop a revised assessment and treatment plan for ongoing treatment. The revised assessment and treatment plan must be documented in the patient's chart, including an assessment of increased risk for adverse outcomes, including death, if the physician assistant elects to provide ongoing opioid treatment. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-9; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

844 IAC 2.2-3-10 Scope of practice in prescribing opioids

Authority: IC 25-22.5-2-7; IC 25-22.5-13-3
Affected: IC 25-1-9; IC 25-22.5; IC 25-27.5

Sec. 10. IC 25-27.5-5 addresses the scope of practice of physician assistants in their dependent practice under supervising physicians, including limiting the duties and responsibilities of physician assistants to those that are delegated by the supervising physician and that are within the supervising physician's scope of practice. IC 25-27.5-6 addresses supervisory responsibilities of the supervising physician, or when applicable, a physician designee. The prescribing of opioids for chronic pain management as regulated by this rule falls within the requirements on supervising physicians, or when applicable, on physician designees, under IC 25-27.5-5 and IC 25-27.5-6, including appropriate delegating of duties and responsibilities to physician assistants and appropriate supervision of physician assistants. *(Medical Licensing Board of Indiana; 844 IAC 2.2-3-10; filed Sep 2, 2016, 1:04 p.m.: 20160928-IR-844150420FRA; readopted filed Nov 22, 2016, 12:11 p.m.: 20161221-IR-844160317RFA)*

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