

Chapter 246-922 WAC
PODIATRIC PHYSICIANS AND SURGEONS

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WAC

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246-922-090 Delegation of acts to unlicensed persons. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-090, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-090, filed 1/18/91, effective 2/18/91; WSR 87-04-050 (Order PM 638), § 308-31-100, filed 2/3/87; WSR 84-02-077 (Order PL 450), § 308-31-100, filed 1/4/84.] Repealed by WSR 99-14-074, filed 7/6/99, effective 8/6/99. Statutory Authority: RCW 18.22.015 and 18.130.050.

246-922-100 Acts that may be delegated to an unlicensed person. [Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 99-14-074, § 246-922-100, filed 7/6/99, effective 8/6/99. Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-100, filed 2/10/94, effective 3/13/94; WSR 91-10-041 (Order 158B), § 246-922-100, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-100, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-110, filed 1/4/84.] Repealed by WSR 16-01-114, filed 12/17/15, effective 1/17/16. Statutory Authority: RCW 18.22.015 and 18.130.050.

246-922-110 Acts that may not be performed by unlicensed persons. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-110, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-110, filed 1/18/91, effective 2/18/91; WSR 87-04-050 (Order PM 638), § 308-31-120, filed 2/3/87; WSR 84-02-077 (Order PL 450), § 308-31-120, filed 1/4/84.] Repealed by WSR 94-05-051, filed 2/10/94, effective 3/13/94. Statutory Authority: RCW 18.22.015.

246-922-120 General provisions. [Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-120, filed 2/10/94, effective 3/13/94; WSR 91-10-041 (Order 158B), § 246-922-120, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-120, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-210, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-052, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015 and 18.22.005.

246-922-140 Health care institutions. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-140, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-140, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-230, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-150 Podiatric medical associations or societies. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-150, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-150, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-240, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-160 Health care service contractors and disability insurance carriers. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-160, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-160, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-250, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-170 State and federal agencies. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-170, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-170, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-260, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-180 Professional review organizations. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-180, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-180, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-270, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-190 Malpractice suit reporting. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-190, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-190, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-280, filed 5/30/90, effective 6/30/90.] Repealed by WSR 18-18-053, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005.

246-922-220 Exercise of professional judgment and skills. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-220, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-220, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-520, filed 1/4/84.] Repealed by WSR 94-05-051, filed 2/10/94, effective 3/13/94. Statutory Authority: RCW 18.22.015.

246-922-250 Excessive fees. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-250, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-250, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.22.015 and

18.22.010(5). WSR 86-22-042 (Order PM 624), § 308-31-550, filed 11/3/86. Statutory Authority: RCW 18.22.015. WSR 84-02-077 (Order PL 450), § 308-31-550, filed 1/4/84.] Repealed by WSR 94-05-051, filed 2/10/94, effective 3/13/94. Statutory Authority: RCW 18.22.015.

246-922-275 Address notification. [Statutory Authority: RCW 18.22.015. WSR 93-18-036, § 246-922-275, filed 8/26/93, effective 9/26/93.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-922-280 Renewal expiration date. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-280, filed 4/25/91, effective 5/26/91.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-922-320 Certification of compliance. [Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-320, filed 4/25/91, effective 5/26/91.] Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-922-510 Use of controlled substances for pain control. [Statutory Authority: RCW 18.22.015, 18.130.050, and chapters 18.22, 18.130 RCW. WSR 07-11-059, § 246-922-510, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.22.240, 18.22.015(5).

246-922-520 What specific guidance should a podiatric physician follow? [Statutory Authority: RCW 18.22.015, 18.130.050, and chapters 18.22, 18.130 RCW. WSR 07-11-059, § 246-922-520, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.22.240, 18.22.015(5).

246-922-530 What knowledge should a podiatric physician who elects to treat chronic pain patients possess? [Statutory Authority: RCW 18.22.015, 18.130.050, and chapters 18.22, 18.130 RCW. WSR 07-11-059, § 246-922-530, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.22.240, 18.22.015(5).

246-922-540 How will the board evaluate prescribing for pain? [Statutory Authority: RCW 18.22.015, 18.130.050, and chapters 18.22, 18.130 RCW. WSR 07-11-059, § 246-922-540, filed 5/11/07, effective 6/11/07.] Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11. Statutory Authority: RCW 18.22.240, 18.22.015(5).

246-922-663 Patient evaluation. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-663, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-664 Treatment plan. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-664, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-665 Informed consent. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-665, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-666 Written agreement for treatment. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-666, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-667 Periodic review. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-667, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-668 Long-acting opioids, including methadone. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-668, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-669 Episodic care. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-669, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-670 Consultation—Recommendations and requirements. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-670, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-671 Consultation—Exemptions for exigent and special circumstances. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-671, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-672 Consultations—Exemptions for the podiatric physician. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-672, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-673 Pain management specialist. [Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-673, filed 5/2/11, effective 7/1/11.] Repealed by WSR 18-20-085, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297.

246-922-995 Conversion to a birthday renewal cycle. [Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-995, filed 2/13/98, effective 3/16/98.] Repealed by WSR 05-12-012, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110.

WAC 246-922-001 Scope of practice. (1) An "ailment of the human foot" as set forth in RCW 18.22.035 is defined as any condition, symptom, disease, complaint, or disability involving the functional foot. The functional foot includes the anatomical foot and any muscle, tendon, ligament, or other soft tissue structure directly attached to the anatomical foot and which impacts upon or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

(2) In diagnosing or treating the ailments of the functional foot, a podiatric physician and surgeon is entitled to utilize medical, surgical, mechanical, manipulative, radiological, and electrical treatment methods and the diagnostic procedure or treatment method may be utilized upon an anatomical location other than the functional foot. The diagnosis and treatment of the foot includes diagnosis and treatment necessary for preventive care of the well foot.

(3) A podiatric physician and surgeon may examine, diagnose, and commence treatment of ailments for which differential diagnoses include an ailment of the human foot. Upon determination that the condition presented is not an ailment of the human foot, the podiatric physician and surgeon shall obtain an appropriate consultation or make an appropriate referral to a licensed health care practitioner authorized by law to treat systemic conditions. The podiatric physician and surgeon may take emergency actions as are reasonably necessary to protect the patient's health until the intervention of a licensed health care practitioner authorized by law to treat systemic conditions.

(4) A podiatric physician and surgeon may diagnose or treat an ailment of the human foot caused by a systemic condition provided an appropriate consultation or referral for the systemic condition is made to a licensed health care practitioner authorized by law to treat systemic conditions.

(5) A podiatric physician and surgeon shall not administer a general or spinal anesthetic, however, a podiatric physician and surgeon may treat ailments of the human foot when the treatment requires use of a general or spinal anesthetic provided that the administration of the general or spinal anesthetic is by a physician authorized under chapter 18.71 or 18.57 RCW; or a certified registered nurse anesthetist authorized under chapter 18.79 RCW.

[Statutory Authority: RCW 18.22.015, 18.130.050 and 18.22.005. WSR 18-14-089, § 246-922-001, filed 7/2/18, effective 8/2/18. Statutory Authority: RCW 18.22.015. WSR 07-13-071, § 246-922-001, filed 6/18/07, effective 7/19/07; WSR 91-10-041 (Order 158B), § 246-922-001, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-001, filed 1/18/91, effective 2/18/91; WSR 87-09-045 (Order PM 643), § 308-31-025, filed 4/14/87; WSR 87-04-050 (Order PM 638), § 308-31-025, filed 2/3/87.]

WAC 246-922-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) Podiatry and podiatric medicine and surgery are synonymous.

(2) "Board" means the Washington state podiatric medical board.

(3) "Hospital" means any health care institution licensed pursuant to chapter 70.41 RCW.

(4) "Nursing home" has the same meaning as that in RCW 18.51.010(3).

(5) Orthotic devices defined:

(a) Prefabricated or off-the-shelf orthotics, are devices that are manufactured as commercially available stock items for no specific patient. It is appropriate to dispense prefabricated orthotic devices for some conditions.

(b) Direct-formed orthotics are devices formed or shaped during the molding process directly on the patient's foot.

(c) Custom-fabricated orthotics, also known as custom-made orthotics, are devices designed and fabricated, in turn, from raw materials for a specific patient, and require the generation of an image, form, or mold that replicates the patient's foot, and, in turn, involves the rectification of dimensions, contours, and volumes to achieve proper fit, comfort, and function for that specific patient.

(6) "Podiatric physician and surgeon" means a person licensed pursuant to chapter 18.22 RCW.

(7) "Secretary" means the secretary of the department of health.

(8) "Unprofessional conduct" means the conduct described in RCW 18.130.180.

[Statutory Authority: RCW 18.22.015 and 18.22.005. WSR 18-18-052, § 246-922-010, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 99-14-074, § 246-922-010, filed 7/6/99, effective 8/6/99. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-010, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-010, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-020, filed 1/4/84; Order PL 128, § 308-31-020, filed 7/7/72.]

WAC 246-922-020 Board officers. In addition to electing a board member to serve as chairperson as required by RCW 18.22.014, the board shall also elect a vice chairperson and a secretary from among its members.

The board shall schedule an annual election of members to the above named offices.

[Statutory Authority: RCW 18.22.015. WSR 91-03-095 (Order 118B), recodified as § 246-922-020, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.22.015(8). WSR 86-01-041 (Order PL 573), § 308-31-001, filed 12/13/85.]

WAC 246-922-030 Approved schools of podiatric medicine. For the purpose of the laws relating to podiatric medicine, the board approves the schools accredited by the Council on Podiatric Medical Education.

[Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 16-01-114, § 246-922-030, filed 12/17/15, effective 1/17/16. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-030, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-030, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.22.015 and 18.22.010(5). WSR 86-22-042 (Order PM 624), § 308-31-030, filed 11/3/86. Statutory Authority: 1982 c 21 § 10. WSR 83-03-032 (Order 418), § 308-31-030, filed 1/14/83.]

WAC 246-922-032 Postgraduate podiatric medical training defined.

(1) For the purposes of this chapter, postgraduate podiatric medical training shall be considered to mean clinical training that meets the educational standards established by the profession. The training must be acquired after satisfactory completion of a course in an approved school of podiatric medicine and surgery as specified in RCW 18.22.040. Clinical performance shall be deemed satisfactory to fulfill the purposes of this requirement. This definition shall be considered to include, but not be limited to, rotating podiatric residency, podiatric orthopedic residency, and podiatric surgical residency.

(2) The board approves the following postgraduate clinical training courses: Programs approved by the American Podiatric Medical Association Council on Podiatric Medical Education which are listed in the 1992-1993 directory of *Approved Residencies in Podiatric Medicine*, and programs approved by the Council on Podiatric Medical Education at the time the postgraduate training was obtained.

[Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-032, filed 2/10/94, effective 3/13/94.]

WAC 246-922-033 Eligibility for licensure. An applicant for licensure or limited licensure must file a completed application and applicable fee, which shall include information and documentation relative to education and training, past practice performance, licensure history, and a record of all adverse or correctional actions taken by another state or appropriate regulatory body, ability to safely practice podiatric medicine with reasonable skill and safety to the consumer, and other relevant documentation or information as the board may require to determine fitness or eligibility for licensure.

(1) Applicants requesting a license to practice podiatric medicine shall have completed one year postgraduate podiatric medical training in a program approved by the board as defined in WAC 246-922-032, provided that applicants graduating before July 1, 1993, shall be exempt from the postgraduate training requirement.

(2) Applicants requesting a limited license to practice in an approved postgraduate podiatric medical training program shall have graduated from an approved school of podiatric medicine and surgery.

[Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-033, filed 2/10/94, effective 3/13/94.]

WAC 246-922-035 Temporary practice permit. A temporary permit to practice podiatric medicine and surgery may be issued to an individual licensed in another state that has substantially equivalent licensing standards to those in Washington.

(1) The temporary permit may be issued upon receipt of the following:

(a) Documentation from the reciprocal state that the licensing standards used for issuing the license are substantially equivalent to the current Washington licensing standards;

(b) A completed application form and application and temporary permit fees;

(c) Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment; and

(d) Verification from the federation of state podiatric medical board's disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency.

(2) The temporary permit shall be issued for sixty days at which time it will become invalid.

(3) A temporary permit shall be issued only once to each applicant. An applicant who does not complete the application process shall not receive a subsequent temporary permit or refund.

[Statutory Authority: RCW 18.22.015. WSR 93-18-036, § 246-922-035, filed 8/26/93, effective 9/26/93.]

WAC 246-922-036 Temporary practice permit—Military spouse eligibility and issuance. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for podiatric physicians and surgeons. The board adopts the procedural rules as adopted by the department of health in WAC 246-12-051.

[Statutory Authority: RCW 18.22.015, 18.340.020, and chapter 18.340 RCW. WSR 18-18-054, § 246-922-036, filed 8/29/18, effective 9/29/18.]

WAC 246-922-040 Examinations. In order to obtain a license to practice podiatric medicine and surgery in the state of Washington, an applicant must:

(1) Successfully pass all parts of the American Podiatric Medical Licensing Examination administered through the National Board of Podiatric Medical Examiners; or

(2) Be licensed by examination in another state or territory of the United States, or the District of Columbia; and

(a) If graduated on or after June 1988, have successfully passed Parts I, II, and III of the national examination prepared by the National Board of Podiatric Medical Examiners; or

(b) If graduated prior to June 1988, have successfully passed Parts I and II of the national examination administered through the National Board of Podiatric Medical Examiners in addition to the Virginia licensing examination or the PM-Lexis examination.

[Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 16-01-114, § 246-922-040, filed 12/17/15, effective 1/17/16. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-040, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-040, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.22.015 and 1988 c 206 § 604. WSR 89-02-047 (Order PM 813), § 308-31-010, filed 12/30/88. Statutory Authority: RCW 18.22.015(8). WSR 88-11-034 (Order 733), § 308-31-010, filed 5/13/88. Statutory Authority: RCW 18.22.015 and 18.22.010(5). WSR 86-22-042 (Order PM 624), § 308-31-010, filed 11/3/86. Statutory Authority: 1982 c 21 § 10. WSR 83-03-032 (Order 418), § 308-31-010, filed 1/14/83; Order PL 250, § 308-31-010, filed 5/28/76; Order PL 128, § 308-31-010, filed 7/7/72.]

WAC 246-922-050 Identification of licensees. Each person licensed pursuant to chapter 18.22 RCW must be clearly identified to the public as a doctor of podiatric medicine at every establishment in which he or she is engaged in the practice of podiatric medicine and surgery. Such identification must indicate the name of the licensee at or near the entrance to the licensee's office. Only the names of people actually practicing at a location may appear at that location or in any advertisements or announcements regarding that location. The name of an individual who has previously practiced at a location may remain in use in conjunction with that location for a period of no more than one year from the date that person ceases to practice at the location.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-050, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-050, filed 1/18/91, effective 2/18/91. Statutory Authority: 1982 c 21 § 10. WSR 83-03-032 (Order 418), § 308-31-040, filed 1/14/83.]

WAC 246-922-055 Reciprocity requirements. An applicant licensed in another state must file with the secretary verification of the license certified by the proper authorities of the issuing state to include the issue date, license number, current expiration date, and whether any action has been taken to revoke, suspend, restrict, or otherwise sanction the licensee for unprofessional conduct or that the licensee may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a physical or mental condition. The applicant must document that the educational standards, eligibility requirements, and examinations of that state are substantially equivalent to those of this state.

[Statutory Authority: RCW 18.22.015, 18.130.050 and 18.22.005. WSR 18-14-089, § 246-922-055, filed 7/2/18, effective 8/2/18. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-055, filed 4/25/91, effective 5/26/91.]

WAC 246-922-060 Presumption of responsibility for advertisements. Any licensed doctor of podiatric medicine whose name, office address or place of practice is mentioned in any advertisement of any kind or character shall be presumed to have caused, allowed, permitted, approved and sanctioned such advertising and shall be presumed to be personally responsible for the content and character thereof. Once sufficient evidence of the existence of the advertisement has been introduced at any hearing before the Washington podiatric medical board, the burden of establishing proof to rebut this presumption by a preponderance of the evidence shall be upon the doctor of podiatric medicine.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-060, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-060, filed 1/18/91, effective 2/18/91. Statutory Authority: 1982 c 21 § 10. WSR 83-03-032 (Order 418), § 308-31-050, filed 1/14/83.]

WAC 246-922-070 AIDS prevention and information education requirements. Applicants must complete seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-070, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-070, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-070, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.22.015 and 1988 c 206 § 604. WSR 89-02-047 (Order PM 813), § 308-31-057, filed 12/30/88.]

WAC 246-922-080 Advertisements prior to licensure prohibited. Any individual who has not been licensed to practice as a podiatric physician and surgeon by the state of Washington is prohibited from advertising as practicing podiatric medicine and surgery in this state, by any means including placement of a telephone listing in any telephone directory.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-080, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-080, filed 1/18/91, effective 2/18/91. Statutory Authority: 1982 c 21 § 10. WSR 83-03-032 (Order 418), § 308-31-060, filed 1/14/83.]

WAC 246-922-130 Mandatory reporting. Any person including, but not limited to, a podiatric physician and surgeon, health care facility, or governmental agency shall always report in compliance with the uniform mandatory reporting rules found in WAC 246-16-200 through 246-16-270.

[Statutory Authority: RCW 18.22.015, 18.130.050, and 18.22.005. WSR 18-18-053, § 246-922-130, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-130, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-130, filed 1/18/91, effective 2/18/91. Statutory Authority: RCW 18.130.170 and chapter 18.22 RCW. WSR 90-12-013 (Order 060), § 308-31-220, filed 5/30/90, effective 6/30/90.]

WAC 246-922-200 Professional and ethical standards. In addition to those standards specifically expressed in chapter 18.22 RCW and chapter 18.130 RCW, the board adopts the standards that follow in governing or regulating the practice of podiatric physicians and surgeons within the state of Washington.

Podiatric medicine and surgery is that specialty of medicine and research that seeks to diagnose, treat, correct and prevent ailments of the human foot. A podiatrist shall hold foremost the principal objectives to render appropriate podiatric medical services to society and to assist individuals in the relief of pain or correction of abnormalities, and shall always endeavor to conduct himself or herself in such a manner to further these objectives.

The podiatric physician and surgeon owes to his or her patients a reasonable degree of skill and quality of care. To this end, the podiatric physician and surgeon shall endeavor to keep abreast of new de-

velopments in podiatric medicine and surgery and shall pursue means that will lead to improvement of his or her knowledge and skill in the practice of podiatric medicine and surgery. "Quality of care" consists of the following elements:

- (1) Necessity of care.
- (2) Appropriateness of service rendered in view of the diagnosis.
- (3) Utilization of services (over or under).
- (4) Quality of service(s) rendered.
- (5) Whether the service(s) reported had been actually rendered.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-200, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-200, filed 1/18/91, effective 2/18/91; WSR 87-09-045 (Order PM 643), § 308-31-500, filed 4/14/87; WSR 87-04-050 (Order PM 638), § 308-31-500, filed 2/3/87; WSR 84-02-077 (Order PL 450), § 308-31-500, filed 1/4/84.]

WAC 246-922-210 Patient abandonment. The podiatric physician and surgeon shall always be free to accept or reject a particular patient, but once care is undertaken, the podiatric physician and surgeon shall not neglect the patient as long as that patient cooperates with, requests, and authorizes the podiatric medical services for the particular problem.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-210, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-210, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-510, filed 1/4/84.]

WAC 246-922-230 Prohibited transactions. A podiatric physician and surgeon shall not compensate or give anything of value to a representative of the press, radio, television or other communication media in anticipation of or in return for professional publicity of any individual podiatric physician and surgeon in a news item.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-230, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-230, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-530, filed 1/4/84.]

WAC 246-922-235 Prohibited publicity and advertising. A podiatric physician and surgeon shall not use or allow to be used any form of public communications or advertising connected with his or her profession or in his or her professional capacity as a podiatric physician which is false, fraudulent, deceptive, or misleading or which contains any implication or statement likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts.

[Statutory Authority: RCW 18.22.015. WSR 93-18-036, § 246-922-235, filed 8/26/93, effective 9/26/93.]

WAC 246-922-240 Soliciting patients. In accordance with chapter 19.68 RCW, a podiatric physician and surgeon shall not participate in

the division of fees or agree to split or divide fees received for podiatric medical services with any person for bringing or referring patients.

[Statutory Authority: RCW 18.22.015 and 18.22.005. WSR 18-18-052, § 246-922-240, filed 8/29/18, effective 9/29/18. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-240, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-240, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-540, filed 1/4/84.]

WAC 246-922-260 Maintenance of patient records. Any podiatric physician and surgeon who treats patients in the state of Washington shall maintain complete and legible treatment records regarding patients treated. These records shall include, but shall not be limited to X-rays, treatment plans, patient charts, patient histories, correspondence, financial data and billing. These records shall be retained by the podiatric physician and surgeon in an orderly, accessible file and shall be readily available for inspection by the Washington state podiatric medical board or its authorized representative. Complete patient treatment records shall be maintained for a minimum of seven years after treatment is rendered.

[Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-260, filed 2/10/94, effective 3/13/94; WSR 91-10-041 (Order 158B), § 246-922-260, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-260, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-560, filed 1/4/84.]

WAC 246-922-270 Inventory of legend drugs and controlled substances. Every podiatric physician and surgeon shall maintain a record of all legend drugs and controlled substances that he or she has prescribed or dispensed. This record shall include the date prescribed or the date dispensed, the name of the patient prescribed or dispensed to, the name of the medication, and the dosage and amount of the medication prescribed or dispensed. The record of the medication prescribed or dispensed will be clearly indicated on the patient record.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-270, filed 4/25/91, effective 5/26/91; WSR 91-03-095 (Order 118B), recodified as § 246-922-270, filed 1/18/91, effective 2/18/91; WSR 84-02-077 (Order PL 450), § 308-31-570, filed 1/4/84.]

WAC 246-922-285 Retired active credential. A practitioner may obtain a retired active credential. Refer to the requirements of chapter 246-12 WAC, Part 5.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-285, filed 2/13/98, effective 3/16/98.]

WAC 246-922-290 Inactive credential. A practitioner may obtain an inactive credential. Refer to the requirements of chapter 246-12 WAC, Part 4.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-290, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-290, filed 4/25/91, effective 5/26/91.]

WAC 246-922-295 Expired license. (1) If the license has expired for three years or less, the practitioner must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the license has expired for over three years, and the practitioner has been in active practice in another United States jurisdiction, the practitioner must:

(a) Submit verification of active practice from any other United States jurisdiction;

(b) Provide documentation relative to any malpractice settlements or judgments within the past five years;

(c) Meet the requirements of chapter 246-12 WAC, Part 2.

(3) If the license has expired for over three years, and the practitioner has not been in active practice in another United States jurisdiction, the practitioner:

(a) May be required to be reexamined as provided in RCW 18.22.083;

(b) Provide documentation relative to any malpractice settlements or judgments within the past five years;

(c) Must meet the requirements of chapter 246-12 WAC, Part 2.

[Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-295, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-295, filed 4/25/91, effective 5/26/91.]

WAC 246-922-300 Podiatric continuing education required. (1) The board encourages podiatric physicians and surgeons to deliver high-quality patient care. The board recognizes that continuing education programs designed to inform practitioners of recent developments within podiatric medicine and relative fields and review of various aspects of basic professional education and podiatric practice are beneficial to professional growth. The board requires participation in podiatric continuing education as a mechanism to maintain and enhance competence.

(2) A podiatric physician and surgeon must complete one hundred hours of continuing education every two years and comply with chapter 246-12 WAC, Part 7 and WAC 246-922-310.

(3) To satisfy the continuing medical education requirements identified in subsection (2) of this section, a podiatric physician and surgeon may:

(a) Serve as a resident in an approved postgraduate residency training program; or

(b) Certify or recertify within the previous four years with a specialty board.

[Statutory Authority: RCW 18.22.005, 18.22.015, and 18.130.050. WSR 16-01-106, § 246-922-300, filed 12/16/15, effective 10/1/17. Statutory Authority: RCW 18.22.015. WSR 99-20-096, § 246-922-300, filed 10/5/99, effective 11/5/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060,

§ 246-922-300, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.22.015. WSR 94-05-051, § 246-922-300, filed 2/10/94, effective 3/13/94; WSR 91-10-041 (Order 158B), § 246-922-300, filed 4/25/91, effective 5/26/91.]

WAC 246-922-310 Categories of creditable podiatric continuing education activities. To meet the requirements of WAC 246-922-300, a podiatric physician and surgeon shall earn continuing medical education in the following board-approved categories:

(1) Category 1 - A minimum of fifty hours; however, all one hundred credit hours may be earned in this category. Category 1 activities include:

(a) Scientific courses or seminars approved, offered, or sponsored by the American Podiatric Medical Association and its component societies and affiliated and related organizations; and

(b) Scientific courses or seminars offered or sponsored by entities such as the American Medical Association, the American Osteopathic Association, the American Heart Association, or the American Physical Therapy Association when offering or sponsoring continuing education programs related to podiatric medicine.

(2) Category 2 - A maximum of fifty hours. Category 2 activities include courses or seminars related to health care delivery offered or sponsored by entities such as nonprofit organizations, other proprietary organizations, and individuals when offering or sponsoring continuing education in health care delivery.

(3) Category 3 - A maximum of fifty hours. Category 3 credit hours and activities include:

(a) Up to twenty hours through teaching, lecturing, and publishing in a peer-reviewed, scientific journal or textbook;

(b) Up to twenty hours through online study and programs;

(c) Up to twenty hours through self-study including, but not limited to, specialty board examination preparation, reading papers and publications, or viewing or attending exhibits; and

(d) Up to thirty hours for participation on a staff committee for quality of care or utilization review in a health care institution or government agency, such as serving on a hospital peer-review committee or serving as a board member on the podiatric medical board.

(4) One contact hour is defined as a typical fifty-minute classroom instructional session or its equivalent.

(5) The board will not give prior approval for any continuing medical education. The board will accept any continuing education that reasonably falls within these regulations and relies upon the integrity of each individual podiatric physician and surgeon to comply with these requirements.

[Statutory Authority: RCW 18.22.005, 18.22.015, and 18.130.050. WSR 16-01-106, § 246-922-310, filed 12/16/15, effective 10/1/17. Statutory Authority: RCW 18.22.015. WSR 99-20-096, § 246-922-310, filed 10/5/99, effective 11/5/99; WSR 94-05-051, § 246-922-310, filed 2/10/94, effective 3/13/94; WSR 91-10-041 (Order 158B), § 246-922-310, filed 4/25/91, effective 5/26/91.]

WAC 246-922-400 Intent. It is the intent of the legislature that the podiatric medical board seek ways to identify and support the rehabilitation of podiatric physicians and surgeons where practice or

competency may be impaired due to the abuse of or dependency upon drugs or alcohol. The legislature intends that these practitioners be treated so that they can return to or continue to practice podiatric medicine and surgery in a way which safeguards the public. The legislature specifically intends that the podiatric medical board establish an alternate program to the traditional administrative proceedings against podiatric physicians and surgeons.

In lieu of disciplinary action under RCW 18.130.160, if the podiatric medical board determines that the unprofessional conduct may be the result of substance abuse or dependency, the board may refer the licensee to a voluntary substance abuse monitoring program approved by the board.

[Statutory Authority: RCW 18.22.015 and chapter 18.22 RCW. WSR 94-14-082, § 246-922-400, filed 7/5/94, effective 8/5/94.]

WAC 246-922-405 Definitions used relative to substance abuse monitoring.

(1) "Approved substance abuse/dependency monitoring program" or "approved monitoring program" is a program the board has determined meets the requirements of the law and rules established by the board according to the Washington Administrative Code which enters into a contract with podiatric practitioners who have substance abuse/dependency problems. The approved substance abuse monitoring program oversees compliance of the podiatric practitioner's recovery activities as required by the board. Substance abuse monitoring programs may provide evaluation and/or treatment to participating podiatric practitioners.

(2) "Impaired podiatric practitioner" means a podiatric physician and surgeon who is unable to practice podiatric medicine and surgery with judgment, skill, competence, or safety due to chemical dependence/substance abuse.

(3) "Contract" is a comprehensive, structured agreement between the recovering podiatric practitioner and the approved monitoring program wherein the podiatric practitioner consents to comply with the monitoring program and the required components for the podiatric practitioner's recovery activity.

(4) "Approved treatment facility" is a facility approved by the bureau of alcohol and substance abuse, department of social and health services.

(5) "Chemical dependence/substance abuse" means an illness/condition which involves the inappropriate use of alcohol and/or other drugs to a degree that such use interferes in the functional life of the licensee, as manifested by personal, family, physical, emotional, occupational (professional services), legal, or spiritual problems.

(6) "Drug" means a chemical substance alone or in combination with other drugs, including alcohol.

(7) "Aftercare/continuing care" means that period of time after intensive treatment that provides the podiatric practitioner and the podiatric practitioner's family with group, or individualized counseling sessions, discussions with other families, ongoing contact and participation in self-help groups, and ongoing continued support of treatment program staff.

(8) "Podiatric practitioner support group" is a group of podiatric practitioners and/or other health care professionals meeting regularly to support the recovery of its members. The group provides a confidential setting with a trained and experienced facilitator in

which participants may safely discuss drug diversion, licensure issues, return to work, and other professional issues related to recovery.

(9) "Twelve-step groups" are groups such as Alcoholics Anonymous, Narcotics Anonymous, and related organizations based on a philosophy of anonymity, belief in a power greater than oneself, peer group association, and self-help.

(10) "Random drug screens" are laboratory tests to detect the presence of drugs of abuse or dependency in body fluids which are performed at irregular intervals not known in advance by the person to be tested. The collection of the body fluids must be observed by a treatment or health care professional or other board or monitoring program-approved observer.

(11) "Recovering" means that a chemically dependent podiatric practitioner is in compliance with a treatment plan of rehabilitation in accordance with criteria established by an approved treatment facility and an approved substance abuse monitoring program.

(12) "Rehabilitation" means the process of restoring a chemically dependent podiatric practitioner to a level of professional performance consistent with public health and safety.

(13) "Reinstatement" means the process whereby a recovering podiatric practitioner is permitted to resume the practice of podiatric medicine and surgery.

[Statutory Authority: RCW 18.22.015 and chapter 18.22 RCW. WSR 94-14-082, § 246-922-405, filed 7/5/94, effective 8/5/94.]

WAC 246-922-410 Approval of substance abuse monitoring programs.

The board will approve the monitoring program(s) which will participate in the recovery of podiatric practitioners. The board will enter into a contract with the approved substance abuse monitoring program(s).

(1) An approved monitoring program:

(a) May provide evaluations and/or treatment to the participating podiatric practitioners;

(b) Shall enter into a contract with the podiatric practitioner and the board to oversee the podiatric practitioner's compliance with the requirement of the program;

(c) Shall maintain records on participants;

(d) Shall be responsible for providing feedback to the podiatric practitioner as to whether treatment progress is acceptable;

(e) Shall report to the board any podiatric practitioner who fails to comply with the requirements of the monitoring program;

(f) Shall provide the board with a statistical report and financial statement on the program, including progress of participants, at least annually, or more frequently as requested by the board;

(g) Shall provide for the board a complete biennial audited financial statement;

(h) Shall enter into a written contract with the board and submit monthly billing statements supported by documentation;

(2) Approved monitoring program staff must have the qualifications and knowledge of both substance abuse/dependency and the practice of podiatric medicine and surgery as defined in chapter 18.22 RCW to be able to evaluate:

(a) Drug screening laboratories;

(b) Laboratory results;

(c) Providers of substance abuse treatment, both individual and facilities;

(d) Podiatric practitioner support groups;

(e) Podiatric practitioners' work environment; and

(f) The ability of the podiatric practitioners to practice with reasonable skill and safety.

(3) The program staff of the approved monitoring program may evaluate and recommend to the board, on an individual basis, whether a podiatric practitioner will be prohibited from engaging in the practice of podiatric medicine and surgery for a period of time and restrictions, if any, on the podiatric practitioner's access to controlled substances in the workplace.

(4) The board shall provide the approved monitoring program board orders requiring treatment, monitoring, and/or limitations on the practice of podiatric medicine and surgery for those participating in the program.

[Statutory Authority: RCW 18.22.015 and chapter 18.22 RCW. WSR 94-14-082, § 246-922-410, filed 7/5/94, effective 8/5/94.]

WAC 246-922-415 Participation in approved substance abuse monitoring program.

(1) The podiatric practitioner who has been investigated by the board may accept board referral into the approved substance abuse monitoring program. Referral may occur in lieu of disciplinary action under RCW 18.130.160 or as a result of a board order as final disposition of a disciplinary action. The podiatric practitioner:

(a) Shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation is to be performed by a health care professional(s) with expertise in chemical dependency;

(b) Shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to: The podiatric practitioner:

(i) Shall undergo intensive substance abuse treatment by an approved treatment facility;

(ii) Shall agree to abstain from the use of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101. Said prescriber shall notify the monitoring program of all drugs prescribed within fourteen days of the date care was provided;

(iii) Must complete the prescribed aftercare/continuing care program of the intensive treatment facility. This may include individual and/or group psychotherapy;

(iv) Must cause the treatment counselor(s) and authorized prescriber(s) to provide reports to the appropriate monitoring program at specified intervals. Reports shall include treatment prognosis, goals, drugs prescribed, etc;

(v) Shall submit to random drug screening, with observed specimen collection, as specified by the approved monitoring program;

(vi) Shall attend podiatric practitioner support groups facilitated by health care professionals and/or twelve-step group meetings as specified by the contract;

(vii) Shall comply with specified employment conditions and restrictions as defined by the contract;

(viii) Shall sign a waiver allowing the approved monitoring program to release information to the board if the podiatric practitioner does not comply with the requirements of the contract;

(c) Is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse/dependency treatment, random urine screens and other personal expenses incurred in compliance with the contract;

(d) May be subject to disciplinary action under RCW 18.130.160 and 18.130.180 if the podiatric practitioner does not consent to be referred to the approved monitoring program, does not comply with specified practice restrictions, or does not successfully complete the program.

(2) A podiatric practitioner who is not being investigated by the board or subject to current disciplinary action, not currently being monitored by the board for substance abuse or dependency, may voluntarily participate in the approved substance abuse monitoring program without being referred by the board. Such voluntary participants shall not be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for their substance abuse/dependency, and shall not have their participation made known to the board if they continue to satisfactorily meet the requirements of the approved monitoring program. The podiatric practitioner:

(a) Shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation will be performed by a health care professional with expertise in chemical dependency;

(b) Shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to: The podiatric practitioner:

(i) Shall undergo intensive substance abuse treatment by an approved treatment facility;

(ii) Shall agree to abstain from the use of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101. Said prescriber shall notify the monitoring program of all drugs prescribed within fourteen days of the date care was provided;

(iii) Must complete the prescribed aftercare/continuing care program of the intensive treatment facility. This may include individual and/or group therapy;

(iv) Must cause the treatment counselor(s) and authorized prescriber(s) to provide reports to the approved monitoring program at specified intervals. Reports shall include treatment prognosis, goals, drugs prescribed, etc;

(v) Shall submit to random drug screening, with observed specimen collection, as specified by the approved monitoring program;

(vi) Shall attend podiatric practitioner support groups facilitated by a health care professional and/or twelve-step group meetings as specified by the contract;

(vii) Shall comply with specified employment conditions and restrictions as defined by the contract;

(viii) Shall sign a waiver allowing the approved monitoring program to release information to the board if the podiatric practitioner does not comply with the requirements of the contract. The podiatric practitioner may be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for noncompliance with the contract or if he/she does not successfully complete the program;

(c) Is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse/dependency treatment, random urine screens, and other personal expenses incurred in compliance with the contract.

[Statutory Authority: RCW 18.22.015 and chapter 18.22 RCW. WSR 94-14-082, § 246-922-415, filed 7/5/94, effective 8/5/94.]

WAC 246-922-500 Adjudicative proceedings. The board adopts the model procedural rules for adjudicative proceedings as adopted by the department of health and contained in chapter 246-11 WAC, including subsequent amendments.

[Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 94-09-008, § 246-922-500, filed 4/11/94, effective 5/12/94.]

WAC 246-922-600 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 podiatric physician-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 podiatric physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Podiatric physician" means a person licensed to practice podiatric medicine and surgery under chapter 18.22 RCW.

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

(2) A podiatric physician shall not engage in sexual misconduct with a current patient or a key third party. A podiatric physician 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 podiatric physician or masturbation by the podiatric physician 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 podiatric physician.

(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) A podiatric physician 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 podiatric physician:

(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 podiatric physician'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 podiatric physician;

(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 section shall constitute grounds for disciplinary action.

[Statutory Authority: RCW 18.22.015, 18.130.050, 18.130.062, and Executive Order 06-03. WSR 17-01-163, § 246-922-600, filed 12/21/16, effective 1/21/17. Statutory Authority: RCW 18.22.015, 18.130.050 and 18.130.180. WSR 07-12-092, § 246-922-600, filed 6/6/07, effective 7/7/07.]

WAC 246-922-620 Abuse. (1) A podiatric physician commits unprofessional conduct if the podiatric physician abuses a patient or key third party. "Podiatric physician," "patient" and "key third party" are defined in WAC 246-922-600. A podiatric physician 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;

(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 section shall constitute grounds for disciplinary action.

WAC 246-922-650 Safe and effective analgesia and anesthesia administration in office-based settings. (1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The podiatric medical board establishes the following rule for physicians licensed under chapter 18.22 RCW who perform surgical procedures and use analgesia or sedation in office-based settings. This rule does not apply to any office-based procedures performed with the use of general anesthesia.

(2) Definitions. The following terms used in this subsection apply throughout this rule unless the context clearly indicates otherwise:

(a) "Board" means the podiatric medical board.

(b) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(c) "General anesthesia" means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body, in which the patient is without protective reflexes and is unable to maintain an airway. Sedation that unintentionally progresses to the point at which the patient is without protective reflexes and is unable to maintain an airway is not considered general anesthesia.

(d) "Local infiltration" means the process of infusing a local anesthetic agent into the skin and other tissues to allow painless wound irrigation, exploration and repair, and other procedures.

(e) "Major conduction anesthesia" means the administration of a drug or combination of drugs to interrupt nerve impulses without loss of consciousness, such as epidural, caudal, or spinal anesthesia, lumbar or brachial plexus blocks, and intravenous regional anesthesia. Major conduction anesthesia does not include isolated blockade of small peripheral nerves, such as digital nerves.

(f) "Minimal sedation" or "analgesia" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral or intramuscular medications, or both.

(g) "Moderate sedation" or "analgesia" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(h) "Office-based surgery" means any surgery or invasive medical procedure requiring analgesia or sedation, performed in a location other than a hospital, or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(i) "Physician" means a podiatric physician licensed under chapter 18.22 RCW.

(3) Exemptions. This rule does not apply to physicians when:

(a) Performing surgery and medical procedures that require only minimal sedation (anxiolysis) or analgesia, or infiltration of local anesthetic around peripheral nerves;

(b) Performing surgery in a hospital, or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW;

(c) Performing surgery using general anesthesia. General anesthesia cannot be a planned event in an office-based surgery setting. Facilities in which physicians perform procedures in which general anesthesia is a planned event are regulated by rules related to hospitals, or hospital-associated surgical centers licensed under chapter 70.41 RCW, or ambulatory surgical facilities licensed under chapter 70.230 RCW.

(4) Application of rule. This rule applies to physicians practicing independently or in a group setting who perform office-based surgery employing one or more of the following levels of sedation or anesthesia:

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia below the ankle.

(5) Accreditation or certification. Within three hundred sixty-five calendar days of the effective date of this rule, a physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification from one of the following:

(a) The Joint Commission (JC);

(b) The Accreditation Association for Ambulatory Health Care (AAAHC);

(c) The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF); or

(d) The Centers for Medicare and Medicaid Services (CMS).

(6) Presence of an anesthesiologist or anesthetist. For procedures requiring spinal or major conduction anesthesia above the ankle, a physician authorized under chapter 18.71 or 18.57 RCW or a certified registered nurse anesthetist authorized under chapter 18.79 RCW must administer the anesthesia. Under RCW 18.22.035 (4)(b), podiatrists shall not administer spinal anesthetic or any anesthetic that renders the patient unconscious.

(7) Qualifications for administration of sedation and analgesia shall include:

(a) Completion of a continuing medical education course in conscious sedation; or

(b) Relevant training in a residency training program; or

(c) Having privileges for conscious sedation granted by a hospital medical staff.

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group (e.g., advanced cardiac life support (ACLS), pediatric advanced life support (PALS) or advanced pediatric life support (APLS)) must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility.

(9) Sedation assessment and management.

(a) Sedation is a continuum. Depending on the patient's response to drugs, the drugs administered, and the dose and timing of drug administration, it is possible that a deeper level of sedation will be produced than initially intended.

(b) Licensed health care practitioners intending to produce a given level of sedation should be able to "rescue" patients who enter a deeper level of sedation than intended.

(c) If a patient enters into a deeper level of sedation than planned, the licensed health care practitioner must return the patient to the lighter level of sedation as quickly as possible, while closely monitoring the patient to ensure the airway is patent, the patient is breathing, and that oxygenation, the heart rate and blood pressure are within acceptable values.

(10) Separation of surgical and monitoring functions.

(a) The physician performing the surgical procedure must not provide the anesthesia or monitoring.

(b) The licensed health care practitioner, designated by the physician to administer intravenous medications and monitor the patient who is under moderate sedation, may assist the operating physician with minor, interruptible tasks of short duration once the patient's level of sedation and vital signs have been stabilized, provided that adequate monitoring of the patient's condition is maintained. The licensed health care practitioner who administers intravenous medications and monitors a patient under deep sedation or analgesia must not perform or assist in the surgical procedure.

(11) Emergency care and transfer protocols. A physician performing office-based surgery must ensure that in the event of a complication or emergency:

(a) All office personnel are familiar with a written and documented plan to timely and safely transfer patients to an appropriate hospital.

(b) The plan must include arrangements for emergency medical services and appropriate transfer of the patient to the hospital.

(12) Medical record. The physician performing office-based surgery must maintain a legible, complete, comprehensive and accurate medical record for each patient.

(a) The medical record must include:

(i) Identity of the patient;

(ii) History and physical, diagnosis, and plan;

(iii) Appropriate lab, X-ray, or other diagnostic reports;

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

(vii) Documentation of which, if any, tissues and other specimens have been submitted for histopathologic diagnosis;

(viii) Provision for continuity of post-operative care; and

(ix) Documentation of the outcome and the follow-up plan.

(b) When moderate or deep sedation, or major conduction anesthesia is used, the patient medical record must include a separate anesthesia record that documents:

(i) Type of sedation or anesthesia used;

(ii) Drugs (name and dose) and time of administration;

(iii) Documentation at regular intervals of information obtained from the intraoperative and post-operative monitoring;

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

- (vii) Estimated blood loss;
- (viii) Duration of procedure; and
- (ix) Any complication or unusual events related to the procedure or sedation/anesthesia.

[Statutory Authority: RCW 18.22.015 and 18.130.050. WSR 11-01-141, § 246-922-650, filed 12/21/10, effective 1/21/11.]

OPIOID PRESCRIBING—GENERAL PROVISIONS

WAC 246-922-660 Intent and scope. WAC 246-922-660 through 246-922-790 govern the prescribing of opioids in the treatment of pain.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-660, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-660, filed 5/2/11, effective 7/1/11.]

WAC 246-922-661 Exclusions. WAC 246-922-660 through 246-922-790 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 provision of procedural premedications; or
- (4) The treatment of admitted inpatient and observation hospital patients.

[Statutory RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-661, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-661, filed 5/2/11, effective 7/1/11.]

WAC 246-922-662 Definitions. The definitions in this section apply to WAC 246-922-660 through 246-922-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, unauthorized use of alcohol or other controlled substances, or active opioid use disorder. This includes, but is not limited to: Multiple early refills or renewals or obtaining prescriptions for the same or similar drugs from more than one 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 testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.

(4) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years post-completion 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 more than twelve weeks in duration. Chronic pain includes pain resulting from cancer or treatment of cancer in a patient who is two years post-completion of curative anticancer treatment with no current evidence of disease.

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

(7) "Episodic care" means medical care provided by a podiatric physician other than the designated primary practitioner in the acute care setting, for example, urgent care or emergency department.

(8) "High dose" means ninety milligrams morphine equivalent dose, or more, per day.

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

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

(11) "Hospital" means any institution, place, building, or agency licensed 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, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(12) "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.

(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) "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, tramadol, buprenorphine, and methadone.

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

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

(17) "Pain management clinic" means a facility that provides comprehensive pain management and may include care provided by multiple available disciplines, practitioners, or treatment modalities.

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

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

(20) "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.

(21) "Refill" or "renewal" means a second or subsequent filling of a previously issued prescription. For the purposes of WAC 246-922-660 through 246-922-790, refills or renewals are subject to the same limitations and requirements as initial prescriptions.

(22) "Subacute pain" means a continuation of pain, of six weeks 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 that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-662, filed 10/1/18, effective 11/1/18. Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-662, filed 5/2/11, effective 7/1/11.]

WAC 246-922-675 Patient notification, secure storage, and disposal. (1) The podiatric physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment. The podiatric physician 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.

(4) The patient notification requirements in this section shall be deemed fulfilled by providing board-approved patient education information.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-675, filed 10/1/18, effective 11/1/18.]

WAC 246-922-680 Use of alternative modalities for pain treatment. Podiatric physicians shall exercise professional judgment in selecting appropriate treatment modalities for the treatment of pain, including the use of nonopioid multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable,

clinically appropriate, evidence-based alternatives exist. Nonopioid pain management modalities may include, but are not limited to, antidepressants, anticonvulsants, anti-inflammatory medications, acetaminophen, interventional procedures, or any nonpharmacological pain treatments, or any combination of the above modalities.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-680, filed 10/1/18, effective 11/1/18.]

WAC 246-922-685 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, a podiatric physician shall complete a one-time continuing education regarding best practices in the prescribing of opioids and the rules in this chapter on opioid prescribing. The continuing education must be at least one hour in length.

(2) The podiatric physician shall complete the one-time continuing education described in subsection (1) of this section by the end of the podiatric physician'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 Category 1 continuing education requirements.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-685, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

WAC 246-922-690 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the podiatric physician 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 type, dosage, and quantity prescribed.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-690, filed 10/1/18, effective 11/1/18.]

WAC 246-922-695 Acute nonoperative pain. The podiatric physician 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 podiatric physician, or his or her authorized designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-922-790 and document their review and any concerns in the patient record.

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

(3) The podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

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

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

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

(5) Long-acting or extended release opioids are not typically indicated for acute nonoperative pain. Should a podiatric physician need to use a long-acting or extended release opioid for acute pain, the podiatric physician shall document the reason in the patient record.

(6) A podiatric physician shall not discontinue medication assisted treatment medications when treating acute pain, except when consistent with the provisions of WAC 246-922-780.

(7) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the podiatric physician 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 246-922-705 and 246-922-710 shall apply.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-695, filed 10/1/18, effective 11/1/18.]

WAC 246-922-700 Acute perioperative pain. The podiatric physician 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 podiatric physician, or his or her authorized designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-922-790 and document their review and any concerns in the patient record.

(2) If the podiatric physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The podiatric physician 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 podiatric physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical direc-

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

(3) The podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

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

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

(5) If the podiatric physician elects to prescribe a combination of opioids with a Schedule II-V medication listed in WAC 246-922-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-922-775 from another practitioner, such prescribing must be in accordance with WAC 246-922-775.

(6) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the podiatric physician 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 246-922-705 and 246-922-710 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 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-700, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING FOR SUBACUTE PAIN

WAC 246-922-705 Patient evaluation and patient record. The podiatric physician 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 an opioid for subacute pain, the podiatric physician 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 about other medications the patient is prescribed or is taking, including type, dosage, and quantity prescribed;

(d) Conduct, or cause his or her authorized designee to conduct, a query of the PMP in accordance with provisions of WAC 246-922-790 and document the review and any concerns in the patient record;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the podiatric physician 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;

(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 podiatric physician 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 or reported improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP and any concerns the podiatric physician may have;

(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 results 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 conducted if opioids and any of the medications listed in WAC 246-922-775(1) are prescribed concurrently; 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 may include:

(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 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-705, filed 10/1/18, effective 11/1/18.]

WAC 246-922-710 Subacute pain. (1) The podiatric physician 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 podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing the use of opioids is clinically indicated. The podiatric physician 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 podiatric physician 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. During the subacute phase, the podiatric physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.

(4) If the podiatric physician elects to prescribe a combination of opioids with a medication listed in WAC 246-922-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-922-775 from another practitioner, the podiatric physician shall prescribe in accordance with WAC 246-922-775.

(5) If the podiatric physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the podiatric physician 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 246-922-715 through 246-922-760 shall apply.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-710, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

WAC 246-922-715 Patient evaluation and patient record. (1) For the purpose of this section, "risk assessment tool" means validated tools or questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The podiatric physician 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 the 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), type, dosage, quantity prescribed, and, as related to treatment of pain, efficacy of medications tried;
- (iv) Review of the PMP in accordance with the provisions of WAC 246-922-790;
- (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 podiatric physician 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 practitioner; and

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

(c) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in this subsection, as well as all other required components of the patient record, as established in statute or rule.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-715, filed 10/1/18, effective 11/1/18.]

WAC 246-922-720 Treatment plan. (1) When the patient enters the chronic pain phase, the podiatric physician 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:

(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 podiatric physician shall adjust drug therapy to the individual health needs of the patient.

(4) The podiatric physician shall complete patient notification in accordance with the provisions of WAC 246-922-675.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-720, filed 10/1/18, effective 11/1/18.]

WAC 246-922-725 Written agreement for treatment. The podiatric physician shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain. The written agreement shall outline the patient's responsibilities and must include:

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

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

(3) Reasons for which opioid therapy may be discontinued, such as violation of a written agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, a 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 podiatric physician 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 podiatric physician to report known violations of the agreement to the practitioner 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 podiatric physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-725, filed 10/1/18, effective 11/1/18.]

WAC 246-922-730 Periodic review. (1) The podiatric physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-922-790 must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior;

and

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

(2) During the periodic review, the podiatric physician 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 podiatric physician's evaluation of progress toward treatment objectives.

(3) Periodic patient evaluations must also include:

(a) History and physical examination 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 of 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 246-922-790 and subsection (1) of this section.

(4) The podiatric physician 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 podiatric physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-922-755.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-730, filed 10/1/18, effective 11/1/18.]

WAC 246-922-735 Consultation—Recommendations and requirements.

(1) The podiatric physician shall consider referring the chronic pain 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 chronic 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 per day. Unless the consultation is exempt under WAC 246-922-740 or 246-922-745, a podiatric physician who prescribes a dosage amount at or above the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-922-750. The mandatory consultation must consist of at least one of the following:

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

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

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

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

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

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-735, filed 10/1/18, effective 11/1/18.]

WAC 246-922-740 Consultation—Exemptions for exigent and special circumstances. A podiatric physician is not required to consult with a pain management specialist as defined in WAC 246-922-750 when they

have documented adherence to all standards of practice as defined in WAC 246-922-715 through 246-922-760 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 podiatric physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing at or above one hundred twenty MED per day without first obtaining a consultation; or
- (4) The podiatric physician documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-740, filed 10/1/18, effective 11/1/18.]

WAC 246-922-745 Consultation—Exemptions for the podiatric physician. A podiatric physician is not required to consult with a pain management specialist as defined in WAC 246-922-735 if one or more of the following qualifications are met:

- (1) The podiatric physician is a pain management specialist under WAC 246-922-750;
- (2) The podiatric physician has successfully completed, every four years, a minimum of twelve continuing education hours on chronic pain management in accordance with WAC 246-922-310. At least two of these hours must be in substance use disorders;
- (3) The podiatric physician is a pain management practitioner working in a pain management clinic or a multidisciplinary academic research facility; or
- (4) The podiatric physician has a minimum of three years of clinical experience in a pain management clinic, and at least thirty percent of their current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-745, filed 10/1/18, effective 11/1/18.]

WAC 246-922-750 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

- (1) If a podiatric physician, the podiatric physician must:
 - (a) Be board certified or board eligible by a specialty that includes a focus on pain management by the American Board of Foot and Ankle Surgery or its predecessor, the American Board of Podiatric Medicine, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or
 - (b) Have a minimum of three years of clinical experience in a chronic pain management care clinic;
 - (c) Be credentialed in pain management by a Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity;

(d) Have successfully completed a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(e) At least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

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

(3) If an allopathic physician assistant, in accordance with WAC 246-918-885;

(4) If an osteopathic physician, in accordance with WAC 246-853-750;

(5) If an osteopathic physician assistant, in accordance with WAC 246-854-330;

(6) If a dentist, in accordance with WAC 246-817-965; or

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-750, filed 10/1/18, effective 11/1/18.]

WAC 246-922-755 Evaluation of, or change in, treatment plan.

(1) The podiatric physician 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 plan is unsatisfactory.

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

(a) The patient requests tapering, changing, discontinuing treatment, or referral for a substance use disorder;

(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 of doses; or

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-755, filed 10/1/18, effective 11/1/18.]

WAC 246-922-760 Patients with chronic pain, including those on high doses—Establishing a relationship with a new podiatric physician.

(1) When a patient receiving chronic opioid pain medications changes to a new podiatric physician, it is normally appropriate for the podiatric physician to initially maintain the patient's current opioid doses. Over time, the podiatric physician may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A podiatric physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of

WAC 246-922-735 and the tapering requirements of WAC 246-922-755 for the first three months of newly established care if:

(a) The patient was previously being treated with a dosage of opioids at or above one hundred twenty milligrams MED per day 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 presenting dose.

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-760, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—SPECIAL POPULATIONS

WAC 246-922-765 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 podiatric physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

(2) Pregnant patients. Use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The podiatric physician 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 podiatric physician shall treat pain in a manner commensurate with 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 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-765, filed 10/1/18, effective 11/1/18.]

WAC 246-922-770 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the podiatric physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the podiatric physician shall review the PMP and document the review and any concerns in the patient record.

(2) A podiatric physician providing episodic care to a patient who the podiatric physician knows is being treated with opioids for chronic pain should provide additional opioids equal to the severity of the acute pain. If opioids are provided, the podiatric physician 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 episodic care podiatric physician shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-770, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—COPRESCRIBING

WAC 246-922-775 Coprescribing of opioids with certain medications. (1) The podiatric physician shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation of clinical judgment:

- (a) Benzodiazepines;
- (b) Barbiturates;
- (c) Sedatives;
- (d) Carisoprodol; or
- (e) Nonbenzodiazepine hypnotics, 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 podiatric physician prescribing opioids shall consult, or make a reasonable effort to 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 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-775, filed 10/1/18, effective 11/1/18.]

WAC 246-922-780 Coprescribing of opioids for patients receiving medication assistant treatment. (1) Where practicable, the podiatric physician 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 a pain specialist.

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-780, filed 10/1/18, effective 11/1/18.]

WAC 246-922-785 Coprescribing of naloxone. (1) The podiatric physician shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed to a high-risk patient.

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-785, filed 10/1/18, effective 11/1/18.]

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

WAC 246-922-790 Prescription monitoring program—Required registration, queries, and documentation. (1) The podiatric physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if the podiatric physician prescribes opioids in Washington state.

(2) The podiatric physician is permitted to delegate performance of a required PMP query to an authorized designee in accordance with WAC 246-470-050.

(3) At a minimum, the podiatric physician shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

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

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

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

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

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

(b) For a moderate-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least semiannually.

(c) For a low-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least annually.

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

(6) The podiatric physician shall ensure a PMP query is performed when providing episodic care to a patient who the podiatric physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-922-770.

(7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the podiatric physician due to a temporary technological or electrical failure.

(8) If the podiatric physician is working in a practice, group, or institution that integrates access to the PMP into the workflow of the EMR, the podiatric physician shall ensure a PMP query is performed for all prescriptions of opioids and coprescribed medications listed in WAC 246-922-755(1) for acute pain.

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

[Statutory Authority: RCW 18.22.005, 18.22.015, 18.22.800, and 2017 c 297. WSR 18-20-085, § 246-922-790, filed 10/1/18, effective 11/1/18.]

WAC 246-922-990 Podiatry fees and renewal cycle. (1) Licenses must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2, except for postgraduate training limited licenses.

(2) Postgraduate training limited licenses must be renewed every year to correspond to program dates.

(3) The following nonrefundable fees will be charged:

Title of Fee	Fee
Original application	
Application	\$650.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Active license renewal	
Renewal	650.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Late renewal penalty	300.00
Expired license reissuance	300.00
Inactive license renewal	
Renewal	175.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Late renewal penalty	90.00
Expired license reissuance	70.00
Retired active license renewal	
Renewal	275.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Late renewal penalty	140.00
Postgraduate training license application	
Application	400.00
UW online access fee (HEAL-WA)	16.00
Postgraduate training license renewal	
Renewal	475.00
UW online access fee (HEAL-WA)	16.00
Substance abuse monitoring surcharge	50.00
Temporary practice permit	50.00
Duplicate license	10.00
Verification of license	25.00

[Statutory Authority: RCW 43.70.110, 43.70.250, and 18.22.015. WSR 17-22-051, § 246-922-990, filed 10/25/17, effective 2/1/18. Statutory Authority: RCW 43.70.250, 43.70.280, and 2013 c 129. WSR 13-21-069, § 246-922-990, filed 10/16/13, effective 1/1/14. Statutory Authority: RCW 43.70.110 (3)(c) and 43.70.250. WSR 12-19-088, § 246-922-990, filed 9/18/12, effective 11/1/12. Statutory Authority: RCW 43.70.110, 43.70.250, 2008 c 329. WSR 08-15-014, § 246-922-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. WSR 05-12-012, § 246-922-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 43.70.250, 2001 2nd sp.s. c 7 and RCW

18.22.120. WSR 01-23-101, § 246-922-990, filed 11/21/01, effective 1/21/02. Statutory Authority: RCW 43.70.250. WSR 99-24-064, § 246-922-990, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-922-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.250 and chapters 18.57, 18.57A, 18.22 and 18.59 RCW. WSR 94-22-055, § 246-922-990, filed 11/1/94, effective 1/1/95. Statutory Authority: RCW 43.70.250. WSR 92-14-053 (Order 280), § 246-922-990, filed 6/25/92, effective 7/26/92; WSR 91-13-002 (Order 173), § 246-922-990, filed 6/6/91, effective 7/7/91. Statutory Authority: RCW 43.70.040. WSR 91-05-029 (Order 134), recodified as § 246-922-990, filed 2/12/91, effective 3/15/91. Statutory Authority: RCW 43.70.250 and chapter 18.22 RCW. WSR 90-16-057 (Order 072), § 308-31-055, filed 7/27/90, effective 8/27/90. Statutory Authority: RCW 43.24.086. WSR 89-17-156, § 308-31-055, filed 8/23/89, effective 9/23/89; WSR 87-18-031 (Order PM 667), § 308-31-055, filed 8/27/87. Statutory Authority: 1983 c 168 § 12. WSR 83-22-060 (Order PL 446), § 308-31-055, filed 11/2/83; WSR 83-17-031 (Order PL 442), § 308-31-055, filed 8/10/83. Formerly WAC 308-31-310.]