

Chapter 246-922 WAC

PODIATRIC PHYSICIANS AND SURGEONS

WAC

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Statutory Authority: RCW 18.22.015.</p> <p>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 Repealed by WSR 94-05-051, filed 2/10/94, effective 3/13/94.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.</p> <p>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 Repealed by WSR 94-05-051, filed 2/10/94, effective 3/13/94.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.</p> <p>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 Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98.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.</p> <p>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 Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98.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.</p> <p>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 Repealed by WSR 98-05-060, filed 2/13/98, effective 3/16/98.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.</p> <p>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 Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11.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).</p> <p>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 Repealed by WSR 11-10-063, filed 5/2/11, effective 7/1/11.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).</p> <p>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).</p> <p>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-</p>
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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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).

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 18.22.010 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. 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. (1) Chiropractic, podiatry, and podiatric medicine and surgery shall be synonymous.

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

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(3) "Secretary" shall mean the secretary of the department of health.

(4) "Supervision" shall mean that a licensed podiatric physician and surgeon whose patient is being treated has personally diagnosed the condition to be treated and has personally authorized and directed the procedures to be performed. A podiatric physician and surgeon shall be physically present in the treatment facility while the procedures are performed.

(5) "Treatment facility" means a podiatric medical office or connecting suite of offices, podiatric medical clinic, room or area with equipment to provide podiatric medical treatment, or the immediately adjacent rooms or areas. A treatment facility does not extend to any other area of a building in which the treatment facility is located.

(6) "Unlicensed person" means a person who is not a podiatric physician and surgeon duly licensed pursuant to the provisions of chapter 18.22 RCW.

(7) 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.

Prefabricated orthotic devices that have been adjusted or modified may not be dispensed and sold to consumers as custom fabricated or custom-made orthotics. All orthotic devices must be correctly represented and charged to the patient.

[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 following list of schools of podiatric medicine: California College of Podiatric Medicine, San Francisco, California; College of Podiatric Medicine and Surgery, Des Moines, Iowa; New York College of Podiatric Medicine, New York, New York; Ohio College of Podiatric Medicine, Cleveland, Ohio; Pennsylvania College of Podiatric Medicine, Philadelphia, Pennsylvania; Dr. William Scholl

College of Podiatric Medicine, Chicago, Illinois; Barry University School of Podiatric Medicine, Miami Shores, Florida.

[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 246-922-040 Examinations. (1) In order to be licensed to practice podiatric medicine and surgery in the state of Washington, all applicants except those who are seeking licensure by endorsement from another state under subsection (8) of this section, must pass Part I and Part II of the national examination prepared by the National Board of Podiatric Medical Examiners in addition to the PMLexis examination approved by the Washington state podiatric medical board as the state examination.

(2) The Washington state podiatric medical examination shall include the following topics: Medicine and general podiatric medicine, to include but not limited to, microbiological diseases, dermatology, neurology, cardiovascular-respiratory, musculoskeletal, metabolic and endocrine, medical emergencies and trauma, rheumatology; and therapeutics, to include but not limited to, pharmacology, physical medicine and rehabilitation, local therapy, systemic therapy, surgery, and biomechanics.

(3) The state examination shall be administered twice annually on the second Tuesday of June and the first Tuesday of December. Applications for examination or reexamination shall be received in the office of the professional licensing services division, department of health, no later than April 15th for the following June examination and October 1 for the following December examination.

(4) Every applicant for a podiatric physician and surgeon license shall be required to pass the state examination with a grade of at least 75.

(5) The board shall approve the method of grading each examination, and shall apply such method uniformly to all applicants taking the examination.

(6) The board and the department shall not disclose any applicant's examination score to anyone other than the applicant, unless requested to do so in writing by the applicant.

(7) The applicant will be notified, in writing, of his or her examination scores.

(8) Applicants for licensure who have been licensed by examination in another state or who have successfully passed

the examinations given by the National Board of Podiatric Medical Examiners will be required to pass the state approved examination. If the examination taken in another state is the Virginia or PMLexis examination and the applicant passed the Virginia examination or PMLexis on or after June 1988 the applicant shall be deemed to have passed the approved examination in this state.

(9) Applicants failing the state approved examination whether taken in this or another state in which the Virginia or PMLexis examination was taken after June 1988 may be reexamined no more than three times. Applicants who have failed the state approved examination three times may petition the board to be permitted to retake the examination on additional occasions and the applicant must provide satisfactory evidence to the board that he or she has taken remedial measures to increase his or her likelihood of passing the examination. If the applicant does not provide satisfactory evidence to the board, the board shall deny the request to retake the examination until such time that the applicant can provide satisfactory evidence of remedial measures undertaken to increase his or her likelihood of passing the examination.

[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 246-922-045 Examination conduct. Failure to follow written or oral instructions relative to the conduct of the examination, including termination time of the examination will be considered grounds for expulsion from the examination.

Applicants will be required to refrain from talking to other examinees during the examination unless specifically directed or permitted to do so by a test proctor. Any applicant observed talking or attempting to give or receive information, or using unauthorized materials during any portion of the examination may be expelled from the examination and deemed to have failed the examination.

[Statutory Authority: RCW 18.22.015. WSR 91-10-041 (Order 158B), § 246-922-045, filed 4/25/91, effective 5/26/91.]

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.

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[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 at least equal in all respects to those of this state.

[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 246-922-100 Acts that may be delegated to an unlicensed person. A podiatric physician and surgeon may authorize the delegation of certain duties to nonpodiatric personnel and prohibit the delegation of certain other duties. The licensed podiatric physician and surgeon is ultimately responsible for all treatments performed at his or her direction. Duties that may be delegated to a person not licensed to practice podiatric medicine and surgery may be performed only under the supervision of a licensed podiatric physician and surgeon. The extent of delegation and the degree of supervision required to assure that the treatment is appropriate and does not jeopardize the systemic or pedal health of the patient varies with, among other considerations, the nature of the procedure and the qualifications of the person to whom the duty is delegated. A podiatric physician and surgeon may allow an unlicensed person to perform the following acts under the podiatric physician and surgeon's supervision limited to the following:

- (1) Patient education in foot hygiene.
- (2) Deliver a sedative drug in an oral dosage form to patient.
- (3) Give preoperative and postoperative instructions.
- (4) Assist in administration of nitrous oxide analgesia or sedation, but the unlicensed person shall not start the administration of the gases and shall not adjust the flow of the gases unless instructed to do so by the podiatric physician and surgeon. Patients must never be left unattended while nitrous oxide analgesia or sedation is administered to them. This regulation shall not be construed to prevent any person from taking appropriate action in the event of a medical emergency.
- (5) Take health histories.
- (6) Determine rate and quality of patient's radial pulses.
- (7) Measure the patient's blood pressure.
- (8) Perform a plethysmographic or doppler study.
- (9) Observe the nature of the patient's shoes and hose.
- (10) Observe and report wearing patterns on the patient's shoes.
- (11) Assist in obtaining material for a culture-sensitivity test.
- (12) Take scrapings from the skin or nails of the feet, prepare them for microscopic and culture examination.
- (13) Perform weightbearing and nonweightbearing X rays.
- (14) Photograph patient's foot disorder.
- (15) Debride hyperkeratotic tissues of the foot.
- (16) Remove and apply dressing and/or padding.
- (17) Make necessary adjustments to the biomechanical device.
- (18) Produce impression casting of the foot.
- (19) Produce the following:
 - (a) Removable impression insoles and modifications.
 - (b) Protective devices for alleviating or dispersing pressure on certain deformities or skin lesions such as ulcers, corns, calluses, digital amputation stumps (e.g., latex shields).
- (20) Apply strap and/or pad to the foot and/or leg.
- (21) Prepare the foot for anesthesia as needed.
- (22) Know the indications for and application of cardiopulmonary resuscitation (CPR).
- (23) Prepare and maintain a surgically sterile field.
- (24) Apply flexible cast (e.g., Unna Boot).

- (25) Apply cast material for immobilization of the foot and leg.
- (26) Remove sutures.
- (27) Debride nails.
- (28) Administer mechanical, manipulative and electrical treatment as directed by the podiatric physician and surgeon.
- (29) Counsel and instruct patients in the basics of:
 - (a) Their examination, treatment regimen and prophylaxis for a problem.
 - (b) Patient and family foot health promotion practices.
 - (c) Patient and family care of specific diseases affecting the foot (e.g., diabetes, cerebrovascular accident, arthritis).
 - (d) Performing certain exercises and their importance.
- (30) Give patient or family supplementary health education materials.

[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.]

WAC 246-922-120 General provisions. (1) "Unprofessional conduct" as used in these regulations shall mean the conduct described in RCW 18.130.180.

(2) "Hospital" shall mean any health care institution licensed pursuant to chapter 70.41 RCW.

(3) "Nursing home" shall mean any health care institution which comes under chapter 18.51 RCW.

(4) "Board" shall mean the Washington state podiatric medical board, whose address is:

Department of Health
Professional Licensing Services
1300 Quince St.,
P.O. Box 47868
Olympia, WA 98504-7868

(5) "Podiatric physician and surgeon" shall mean a person licensed pursuant to chapter 18.22 RCW.

(6) "Mentally or physically disabled podiatric physician and surgeon" shall mean a podiatric physician and surgeon who has either been determined by a court to be mentally incompetent or mentally ill or who is unable to practice podiatric medicine and surgery with reasonable skill and safety to patients by reason of any mental or physical condition.

[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.]

WAC 246-922-130 Mandatory reporting. (1) All reports required by these regulations shall be submitted to the board as soon as possible, but no later than sixty days after a determination is made.

(2) A report should contain the following information if known:

- (a) The name, address and telephone number of the person making the report.

(b) The name, address and telephone number of the podiatric physician and surgeon being reported.

(c) The case number of any patient whose treatment is a subject of the report.

(d) A brief description or summary of the facts which gave rise to the issuance of the report, including dates of occurrences.

(e) If court action is involved, the name of the court in which the action is filed along with the date of filing and docket number.

(f) Any further information which would aid in the evaluation of the report.

[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 246-922-140 Health care institutions. The chief administrator or executive officer of any hospital or nursing home shall report to the board when any podiatric physician and surgeon's services are terminated or are restricted based on a determination that the podiatric physician and surgeon has either committed an act or acts which may constitute unprofessional conduct or that the podiatric physician and surgeon may be mentally or physically impaired. Said officer shall also report if a podiatric physician and surgeon accepts voluntary termination or restriction of clinical privileges in lieu of formal action based upon unprofessional conduct or upon being mentally or physically impaired.

[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.]

WAC 246-922-150 Podiatric medical associations or societies. The president or chief executive officer of any podiatric medical association or society within this state shall report to the board when the association or society determines that a podiatric physician and surgeon has committed unprofessional conduct or that a podiatric physician and surgeon may not be able to practice podiatric medicine and surgery with reasonable skill and safety to patients as the result of any mental or physical condition and constitutes an apparent risk to the public health, safety or welfare. The report required by this subsection shall be made without regard to whether the license holder appeals, accepts or acts upon the determination made by the association or society. Notification of appeal shall be included.

[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.]

WAC 246-922-160 Health care service contractors and disability insurance carriers. The executive officer of every health care service contractor and disability insurer regulated under chapters 48.20, 48.21, 48.21A and 48.44 RCW, operating in the state of Washington shall report to the board all final determinations that a podiatric physician and

surgeon may have engaged in over-utilization of services, has charged fees for services not actually provided, may have engaged in unprofessional conduct, or by reason of mental or physical impairment may be unable to practice the profession with reasonable skill and safety.

[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.]

WAC 246-922-170 State and federal agencies. The board requests the assistance of executive officers of any state or federal program operating in the state of Washington, under which a podiatric physician and surgeon is employed to provide patient care services, to report to the board whenever such a podiatric physician and surgeon has been judged to have demonstrated his/her incompetency or negligence in the practice of podiatric medicine and surgery, or has otherwise committed unprofessional conduct, or is mentally or physically impaired.

[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.]

WAC 246-922-180 Professional review organizations. Unless prohibited by federal law, every professional review organization operating within the state of Washington shall report to the board any determinations that a podiatric physician and surgeon may have engaged in unprofessional conduct, or by reason of mental or physical impairment may be unable to practice the profession with reasonable skill and safety.

[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.]

WAC 246-922-190 Malpractice suit reporting. Every licensed podiatric physician and surgeon shall, within sixty days after settlement or judgment, notify the board of any and all malpractice settlements or judgments in excess of twenty thousand dollars as a result of a claim or action for damages alleged to have been caused by a podiatric physician and surgeon's incompetency or negligence in the practice of podiatric medicine and surgery. Every podiatric physician and surgeon shall also report the settlement or judgment of three or more claims or actions for damages during a one-year period as the result of the alleged podiatric physician and surgeon's incompetence or negligence in the practice of podiatric medicine and surgery regardless of the dollar amount of the settlement or judgment.

[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.]

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 developments 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. 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. 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. The podiatric medical board encourages licensees 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 encourages participation in podiatric continuing education as a mechanism to maintain and enhance competence.

(1) Fifty contact hours of scientific podiatric continuing education is required every two years when the license is renewed to maintain a current license as provided in chapter 246-12 WAC, Part 7.

Five credit hours may be granted for one hour of course instruction. A maximum of ten hours may be claimed per reporting period.

(2) Approved courses shall be scientific in nature designed to provide information and enhancement of current knowledge of the mechanisms of disease and treatment, which may include applicable clinical information.

(a) Serving as a resident in an approved post-graduate residency training program shall satisfy the continuing education credit for the reporting period.

(b) Continuing education activities which do not affect the delivery of patient care, (e.g., marketing and billing), may not be claimed for continuing education credit.

[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. The following categories of creditable podiatric continuing education activities sponsored by the following organizations are approved by the board. The credits must be earned in the twenty-four month period preceding the licensee's reporting period. One contact hour is defined as a typical fifty-minute classroom instructional session or its equivalent.

(1) Scientific courses or seminars approved by the American Podiatric Medical Association and its component societies and affiliated and related organizations.

(2) Scientific courses or seminars offered by accredited, licensed, or otherwise approved hospitals, colleges, and universities and their associated foundations and institutes offering continuing education programs in podiatric medicine.

(3) Scientific courses or seminars offered by recognized nonpodiatric medical and health-care related societies (e.g., the American Medical Association, the American Physical Therapy Association) offering continuing education programs related to podiatric medicine.

(4) Scientific courses or seminars offered by other non-profit organizations, other proprietary organizations, and individuals offering continuing education in podiatric medicine.

(5) A post-graduate residency training program accredited by the council on podiatric medical education.

[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) Definitions:

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the 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 treat-

ment 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) 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.

(4) 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.

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

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

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

[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.

[Statutory Authority: RCW 18.22.015, 18.130.050 and 18.130.180. WSR 07-12-092, § 246-922-620, filed 6/6/07, effective 7/7/07.]

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 anesthesiologist. 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.]

PAIN MANAGEMENT

WAC 246-922-660 Pain management—Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

[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. The rules adopted under WAC 246-922-660 through 246-922-673 do not apply to:

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

[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 in WAC 246-922-600 through 246-922-673 unless the context clearly requires otherwise.

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

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

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

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

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

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

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

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

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

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

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-662, filed 5/2/11, effective 7/1/11.]

WAC 246-922-663 Patient evaluation. The podiatric physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

- (1) The patient's health history shall include:
 - (a) Current and past treatments for pain;
 - (b) Comorbidities; and

- (c) Any substance abuse.
- (2) The patient's health history should include:
 - (a) A review of any available prescription monitoring program or emergency department-based information exchange; and
 - (b) Any relevant information from a pharmacist provided to the podiatric physician.
- (3) The initial patient evaluation shall include:
 - (a) Physical examination;
 - (b) The nature and intensity of the pain;
 - (c) The effect of the pain on physical and psychological function;
 - (d) Medications including indication(s), date, type, dosage, and quantity prescribed;
 - (e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:
 - (i) History of addiction;
 - (ii) Abuse or aberrant behavior regarding opioid use;
 - (iii) Psychiatric conditions;
 - (iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;
 - (v) Poorly controlled depression or anxiety;
 - (vi) Evidence or risk of significant adverse events, including falls or fractures;
 - (vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;
 - (viii) Repeated visits to emergency departments seeking opioids;
 - (ix) History of sleep apnea or other respiratory risk factors;
 - (x) Possible or current pregnancy; and
 - (xi) History of allergies or intolerances.
- (4) The initial patient evaluation should include:
 - (a) Any available diagnostic, therapeutic, and laboratory results; and
 - (b) Any available consultations.
- (5) The health record shall be maintained in an accessible manner, readily available for review, and should include:
 - (a) The diagnosis, treatment plan, and objectives;
 - (b) Documentation of the presence of one or more recognized indications for the use of pain medication;
 - (c) Documentation of any medication prescribed;
 - (d) Results of periodic reviews;
 - (e) Any written agreements for treatment between the patient and the podiatric physician; and
 - (f) The podiatric physician's instructions to the patient.

[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.]

WAC 246-922-664 Treatment plan. (1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:

- (a) Any change in pain relief;
 - (b) Any change in physical and psychosocial function; and
 - (c) Additional diagnostic evaluations or other planned treatments.
- (2) After treatment begins the podiatric physician should adjust drug therapy to the individual health needs of the patient. The podiatric physician shall include indications for

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medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The podiatric physician shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

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

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-664, filed 5/2/11, effective 7/1/11.]

WAC 246-922-665 Informed consent. The podiatric physician shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-665, filed 5/2/11, effective 7/1/11.]

WAC 246-922-666 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one prescriber and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing podiatric physician shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

- (1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the 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 drug therapy may be discontinued (e.g., violation of agreement);
- (4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;
- (5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
- (6) A written authorization for:
 - (a) The podiatric physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and
 - (b) Other practitioners to report violations of the agreement back to the podiatric physician;
- (7) A written authorization that the podiatric physician may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;
- (8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;
- (9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and
- (10) Acknowledgment that if the patient violates the terms of the agreement, the violation and the podiatric physi-

cian's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[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.]

WAC 246-922-667 Periodic review. The podiatric physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

(1) During the periodic review, the podiatric physician shall determine:

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

(b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and

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

(2) The podiatric physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The podiatric physician shall consider tapering, changing, or discontinuing treatment when:

(a) Function or pain does not improve after a trial period;

(b) There is evidence of significant adverse effects;

(c) Other treatment modalities are indicated; or

(d) There is evidence of misuse, addiction, or diversion.

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

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

[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.]

WAC 246-922-668 Long-acting opioids, including methadone. Long-acting opioids, including methadone, should only be prescribed by a podiatric physician who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The podiatric physician prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.

[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.]

WAC 246-922-669 Episodic care. (1) When evaluating patients for episodic care, such as emergency or urgent care, the podiatric physician should review any available prescrip-

tion monitoring program, emergency department-based information exchange, or other tracking system.

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

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

(4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under WAC 246-922-666(6) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-669, filed 5/2/11, effective 7/1/11.]

WAC 246-922-670 Consultation—Recommendations and requirements. (1) The podiatric physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED) (oral). In the event a podiatric physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-922-673 is required, unless the consultation is exempted under WAC 246-922-671 or 246-922-672. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referral to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

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

(ii) A telephone consultation between the pain management specialist and the podiatric physician;

(iii) An electronic consultation between the pain management specialist and the podiatric physician; or

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

(b) A podiatric physician shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the spe-

cialist. If the specialist provides a written record of the consultation to the podiatric physician, the podiatric physician shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-922-660 through 246-922-673, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-670, filed 5/2/11, effective 7/1/11.]

WAC 246-922-671 Consultation—Exemptions for exigent and special circumstances. A podiatric physician is not required to consult with a pain management specialist as described in WAC 246-922-673 when he or she has documented adherence to all standards of practice as defined in WAC 246-922-660 through 246-922-673 and when any one or more of the following conditions apply:

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

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-671, filed 5/2/11, effective 7/1/11.]

WAC 246-922-672 Consultations—Exemptions for the podiatric physician. The podiatric physician is exempt from the consultation requirement in WAC 246-922-670 if one or more of the following qualifications are met:

- (1) The podiatric physician is a pain management specialist under WAC 246-922-673; or
- (2) The podiatric physician has successfully completed, within the last two years, a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organization, with at least two of these hours dedicated to long acting opioids, to include methadone; or
- (3) The podiatric physician is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility; or
- (4) The podiatric physician has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of his or her current practice is the direct provision of pain management care.

[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.]

WAC 246-922-673 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

- (1) If a physician or osteopathic physician:
 - (a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or
 - (b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or
 - (c) Has a certification of added qualification in pain management by the AOA; or
 - (d) A minimum of three years of clinical experience in a chronic pain management care setting; and
 - (i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and
 - (ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians; and
 - (iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.
- (2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.
- (3) If an advanced registered nurse practitioner (ARNP):
 - (a) A minimum of three years of clinical experience in a chronic pain management care setting;
 - (b) Credentialed in a specialty that includes a focus on chronic noncancer pain management by a Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity;
 - (c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and
 - (d) At least thirty percent of the ARNP's current practice is the direct provision of pain management or is in a multidisciplinary pain clinic.
- (4) If a podiatric physician:
 - (a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or
 - (b) A minimum of three years of clinical experience in a chronic pain management care setting; and
 - (c) Credentialed in pain management by a Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity; and
 - (d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the

podiatric physician's current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.22.240, 18.22.015(5). WSR 11-10-063, § 246-922-673, filed 5/2/11, effective 7/1/11.]

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
Application	\$650.00
License renewal	650.00
Inactive license renewal	175.00
Inactive late renewal penalty	100.00
Active late renewal penalty	300.00
Active expired license reissuance	300.00
Expired inactive license reissuance	67.50
Duplicate license	30.00
Certification of license	50.00
Retired active status	275.00
Temporary practice permit	50.00
Limited license application	400.00
Limited license renewal	475.00
Substance abuse monitoring surcharge	25.00
UW online access fee (HEAL-WA)	16.00

[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.]