



RULE-MAKING ORDER

PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 01, 2018
TIME: 10:28 AM

WSR 18-20-085

Agency: Department of Health- Podiatric Medical Board

Effective date of rule:

Permanent Rules

- ☒ 31 days after filing.
☐ Other (specify) (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

- ☐ Yes ☒ No If Yes, explain:

Purpose: Chapter 246-922 WAC--Podiatric physicians and surgeons. The Podiatric Medical Board (board) has adopted new sections, amendments, and repeal of existing rule establishing requirements and standards for prescribing opioid medications by podiatric physicians. The adopted rules provide a necessary framework and structure for safe, consistent opioid prescribing practice that comply with the directed of Engrossed Substitute House Bill (ESHB) 1427.

Citation of rules affected by this order:

New: WAC 246-922-675, 246-922-680, 246-922-685, 246-922-690, 246-922-695, 246-922-700, 246-922-705, 246-922-710, 246-922-715, 246-922-720, 246-922-725, 246-922-730, 246-922-735, 246-922-740, 246-922-745, 246-922-750, 246-922-755, 246-922-760, 246-922-765, 246-922-770, 246-922-775, 246-922-780, 246-922-785, and 246-922-790
Repealed: WAC 246-922-663, 246-922-664, 246-922-665, 246-922-666, 246-922-667, 246-922-668, 246-922-669, 246-922-670, 246-922-671, 246-922-672, and 246-922-673
Amended: WAC 246-922-660, 246-922-661, and 246-922-662
Suspended: None.

Statutory authority for adoption: RCW 18.22.005, 18.22.015, and 18.22.800

Other authority: ESHB 1427 (Chapter 297, Laws of 2017), codified in part as RCW 18.22.800.

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-15-064 on 07/16/2018 (date).

Describe any changes other than editing from proposed to adopted version: There were four instances throughout the rules where "practitioner" was changed to "podiatric physician" - WAC 246-922-662(6) renumbered as (7), 246-922-720(3), 246-922-725(1), and in the title to 246-922-760.

Under WAC 246-922-661, the board amended subsection (4) to clarify what constitutes an inpatient patient.

Under WAC 246-922-662, the board made the following amendments:

- * deleted "or other health care practitioner" from subsection (1) as it was redundant.
- * revised the definition of "Biological specimen test" or "biological specimen testing" in subsection (3) to clarify that it means testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.
- * added a new subsection(4) for "cancer-related pain" to clarify when pain falls under the exclusion in 246-922-661 and the pain that falls under the chronic pain definition.
- * the remaining subsections were renumbered.
- * changed the tense in former subsection (5), now (6), from singular to plural as that is how the term is used in the rules.
- * included "opioid induced" to former subsection (8), now (9), to clarify the type of risk to morbidity and mortality.
- * deleted former subsection (13) for "multidisciplinary pain clinic" and much of the verbiage was inserted into the definition for "pain management clinic", then all references throughout the rules were updated to a single term.
- * amended subsection (17) as meaning "a facility that provides comprehensive pain management and may include care provided by multiple available disciplines, practitioners, or treatment modalities."
- * deleted "that is authorized to be dispensed when the patient has exhausted their current supply" from subsection (21) as being redundant.

Under WAC 246-922-680, the board changed "acute, subacute, or perioperative pain" to "the treatment of pain" for simplification and clarification.

Under WAC 246-922-685(1), the board removed "licensed to prescribe opioids" as superfluous.

Under WAC 246-922-695(2), the board restored the sentence "A three day supply or less will often be sufficient; more than a seven day supply will rarely be needed." This change eliminates the perception that a seven day supply would be the standard for all patients.

Under WAC 246-922-700(2), the board restored the sentences "A three day supply or less will often be sufficient; more than a fourteen day supply will rarely be needed for perioperative pain." and "For more specific best practices, the podiatric physician may refer to clinical practice guidelines including, but not limited to, those produced by the Agency Medical Directors' Group, the Centers for Disease Control and Prevention, or the Bree Collaborative."

Under WAC 246-922-705, the board made the following amendments:

- * changed subsection (2)(b) from "The observed documented improvement" to "The observed or reported improvement" for clarity.
- * changed subsection (2)(i) to clarify when a risk-benefit analysis should be conducted.

Under WAC 246-922-735, the board made the following amendments:

- * added "per day" in subsection (2) to MED.
- * clarified in subsection (2)(b) a consultation can be "telephone, electronic, or in-person".
- * deleted "licensed health care" from "practitioner" as redundant from subsection (2)(c).

Under WAC 246-922-745, the board amended the two references to pain clinics to the single uniform term "pain management clinic".

Under WAC 246-922-750, the board will now refer to the WAC sections of the other professions' rules describing pain management specialist qualifications rather than list out the requirements for other practitioners in the podiatric physician rules. The change ensures that if changes are made to other professions' pain management specialist requirements, the podiatric physician rules will remain accurate.

Under WAC 246-922-755, the board changed the title from "Tapering requirements" to "Evaluation of, or change in, treatment plan" to better describe the section's subject.

Under WAC 246-922-760(2)(a), the board changed the title to indicate podiatric physician rather than practitioner and added "per day" to MED.

Under WAC 246-922-775(1)(e), the board changed "Sleeping medications" to "Nonbenzodiazepine hypnotics".

Under WAC 246-922-790, the board made the following amendments:

- * in subsection (2), authorized designee was clarified as being "in accordance with WAC 246-470-050".
- * in subsections (4)(b) and (4)(c), verbiage was added to clarify that moderate-risk and low risk patients are determined using the risk assessment tool described in WAC 246-922-715.
- * in subsection (8), "sedative hypnotics" was change to "co-prescribed medications listed in WAC 246-922-775(1)" to clarify that PMP checks with an integrated EMR are required for medications when co-prescribed, not for when any sedative hypnotic is prescribed.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Susan Gragg

Address: PO Box 47852, Olympia, WA 98504-7852

Phone: 360-236-4941

Fax: 360-236-2901

TTY: (360) 833-6388 or 711

Email: susan.gragg@doh.wa.gov

Web site: www.doh.wa.gov

Other:

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Federal rules or standards:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Recently enacted state statutes:	New	<u>24</u>	Amended	<u>3</u>	Repealed	<u>11</u>

The number of sections adopted at the request of a nongovernmental entity:

New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
-----	----------	---------	----------	----------	----------

The number of sections adopted in the agency's own initiative:

New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
-----	----------	---------	----------	----------	----------

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
-----	----------	---------	----------	----------	----------

The number of sections adopted using:

Negotiated rule making:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Pilot rule making:	New	<u>0</u>	Amended	<u>0</u>	Repealed	<u>0</u>
Other alternative rule making:	New	<u>24</u>	Amended	<u>3</u>	Repealed	<u>11</u>

Date Adopted: 09/06/2018

Name: Randy Anderson, DPM

Title: Chair

Signature:



((PAIN MANAGEMENT)) OPIOID PRESCRIBING—GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 11-10-063, filed 5/2/11, effective 7/1/11)

WAC 246-922-660 ~~((Pain management--))~~ **Intent and scope.** ~~((These rules))~~ WAC 246-922-660 through 246-922-790 govern the ((use)) pre-
scribing of opioids in the treatment of ((patients for chronic non-
cancer)) pain.

AMENDATORY SECTION (Amending WSR 11-10-063, 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))~~ 246-922-790 do not apply to:
(1) The treatment of patients with cancer-related pain;
(2) The provision of palliative, hospice, or other end-of-life
care; ((or
(2) The management of acute pain caused by an injury or surgical
procedure.))
(3) The provision of procedural premedications; or
(4) The treatment of admitted inpatient and observation hospital
patients.

AMENDATORY SECTION (Amending WSR 11-10-063, filed 5/2/11, effective 7/1/11)

WAC 246-922-662 Definitions. The definitions in this section
apply ~~((in))~~ to WAC ((246-922-600 through 246-922-673)) 246-922-660
through 246-922-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, di-
version, unauthorized use of alcohol or other controlled substances,
or active opioid use disorder. This includes, but is not limited to:
Multiple early refills or renewals or obtaining prescriptions for the
same or similar drugs from more than one practitioner.

(2) "Acute pain" means the normal, predicted physiological re-
sponse to a noxious chemical, thermal, or mechanical stimulus and typ-
ically is associated with invasive procedures, trauma, and disease.
((It is generally time-limited, often less than three months in dura-
tion, 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.))~~

Acute pain is considered to be six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.

(4) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years post-completion of curative anti-cancer treatment with current evidence of disease.

(5) "Chronic ~~((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))~~ more than twelve weeks in duration. Chronic pain includes pain resulting from cancer or treatment of cancer in a patient who is two years post-completion of curative anti-cancer treatment with no current evidence of disease.

~~((4))~~ "Comorbidity" (6) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.

~~((5))~~ (7) "Episodic care" means medical care provided by a ~~((provider))~~ podiatric physician other than the designated primary ~~((provider))~~ practitioner in the acute care setting, for example, urgent care or emergency department.

~~((6))~~ (8) "High dose" means ninety milligrams morphine equivalent dose, or more, per day.

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

(10) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less ~~((. 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 free-standing hospice facilities, hospitals, nursing homes, or other long-term care facilities))~~.

~~((7))~~ (11) "Hospital" means any institution, place, building, or agency licensed under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

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

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

~~((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))~~ (14) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semisynthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone.

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

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

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

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

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

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

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

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

(23) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

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

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

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

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

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

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

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

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

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

NEW SECTION

WAC 246-922-680 Use of alternative modalities for pain treatment. Podiatric physicians shall exercise professional judgment in selecting appropriate treatment modalities for the treatment of pain, including the use of nonopioid multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist. Nonopioid pain management modalities may include, but are not limited to, antidepressants, anticonvulsants, anti-inflammatory medications, acetaminophen, interventional procedures, or any nonpharmacological pain treatments, or any combination of the above modalities.

NEW SECTION

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

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

(3) The continuing education required under this section counts toward meeting any applicable Category 1 continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

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

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

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

(3) Inquire about any other medications the patient is prescribed or is taking, including type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-922-695 Acute nonoperative pain. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

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

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

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

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

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

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

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

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

(7) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the podiatric physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-922-705 and 246-922-710 shall apply.

NEW SECTION

WAC 246-922-700 Acute perioperative pain. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

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

(2) If the podiatric physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The podiatric physician shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the podiatric physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

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

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

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

(c) Change in psychosocial function; and
(d) Additional planned diagnostic evaluations or other treatments.

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

(6) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the podiatric physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-922-705 and 246-922-710 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

OPIOID PRESCRIBING FOR SUBACUTE PAIN

NEW SECTION

WAC 246-922-705 Patient evaluation and patient record. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record:

(1) Prior to prescribing an opioid for subacute pain, the podiatric physician shall:

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

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

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

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

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

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

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

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

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

(b) The observed or reported improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

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

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

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

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

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

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

(i) The risk-benefit analysis conducted if opioids and any of the medications listed in WAC 246-922-775(1) are prescribed concurrently; and

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

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

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-922-710 Subacute pain. (1) The podiatric physician shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing the use of opioids is clinically indicated. The podiatric physician shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the podiatric physician prescribes opioids for effective pain control, such prescription shall be in no greater quantity than

needed for the expected duration of pain severe enough to require opioids. During the subacute phase, the podiatric physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.

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

(5) If the podiatric physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the podiatric physician shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-922-715 through 246-922-760 shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

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

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

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

- (i) The nature and intensity of the pain;
- (ii) The effect of pain on physical and psychosocial function;
- (iii) Current and past treatments for pain, including medications and their efficacy;
- (iv) Review of any significant comorbidities;
- (v) Any current or historical substance use disorder;
- (vi) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and
- (vii) Medication allergies.

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

- (i) Appropriate physical examination;
- (ii) Consideration of the risks and benefits of chronic pain treatment for the patient;
- (iii) Medications the patient is taking including indication(s), type, dosage, quantity prescribed, and, as related to treatment of pain, efficacy of medications tried;
- (iv) Review of the PMP in accordance with the provisions of WAC 246-922-790;

- (v) Any available diagnostic, therapeutic, and laboratory results;
 - (vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The podiatric physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;
 - (vii) Any available consultations, particularly as related to the patient's pain;
 - (viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;
 - (ix) Treatment plan and objectives including:
 - (A) Documentation of any medication prescribed;
 - (B) Biologic specimen testing ordered; and
 - (C) Any labs or imaging ordered.
 - (x) Written agreements, also known as a "pain contract," for treatment between the patient and the practitioner; and
 - (xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.
- (c) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in this subsection, as well as all other required components of the patient record, as established in statute or rule.

NEW SECTION

- WAC 246-922-720 Treatment plan.** (1) When the patient enters the chronic pain phase, the podiatric physician shall reevaluate the patient by treating the situation as a new disease.
- (2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include:
- (a) Any change in pain relief;
 - (b) Any change in physical and psychosocial function; and
 - (c) Additional diagnostic evaluations or other planned treatments.
- (3) After treatment begins, the podiatric physician shall adjust drug therapy to the individual health needs of the patient.
- (4) The podiatric physician shall complete patient notification in accordance with the provisions of WAC 246-922-675.

NEW SECTION

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

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

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

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

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

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

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

(7) A written authorization for:

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

(i) Local emergency departments;

(ii) Urgent care facilities;

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

(iv) Pharmacies.

(b) The podiatric physician to report known violations of the agreement to the practitioner treating the patient's chronic pain and to the PMP.

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

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

NEW SECTION

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

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

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

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

(d) Immediately upon indication of concerning aberrant behavior; and

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

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

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

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

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

(3) Periodic patient evaluations must also include:

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

(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-922-790 and subsection (1) of this section.

(4) The podiatric physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The podiatric physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-922-755.

NEW SECTION

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

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

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

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

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

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

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

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

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

NEW SECTION

WAC 246-922-740 Consultation—Exemptions for exigent and special circumstances. A podiatric physician is not required to consult with a pain management specialist as defined in WAC 246-922-750 when they have documented adherence to all standards of practice as defined in WAC 246-922-715 through 246-922-760 and when one or more of the following conditions are met:

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

NEW SECTION

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

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

NEW SECTION

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

- (1) If a podiatric physician, the podiatric physician must:
 - (a) Be board certified or board eligible by a specialty that includes a focus on pain management by the American Board of Foot and Ankle Surgery or its predecessor, the American Board of Podiatric Med-

icine, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or

(b) Have a minimum of three years of clinical experience in a chronic pain management care clinic;

(c) Be credentialed in pain management by a Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity;

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

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

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

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

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

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

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

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

NEW SECTION

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

(1) The podiatric physician shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment plan is unsatisfactory.

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

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

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

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

(d) Other treatment modalities are indicated;

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

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

(g) There is unauthorized escalation of doses; or

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

NEW SECTION

WAC 246-922-760 Patients with chronic pain, including those on high doses—Establishing a relationship with a new podiatric physician. (1) When a patient receiving chronic opioid pain medications changes to a new podiatric physician, it is normally appropriate for the podiatric physician to initially maintain the patient's current opioid doses. Over time, the podiatric physician may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A podiatric physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-922-735 and the tapering requirements of WAC 246-922-755 for the first three months of newly established care if:

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

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

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

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

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-922-765 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the podiatric physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

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

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The podiatric physician shall treat pain in a manner commensurate with the distinctive needs of patients who

are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

NEW SECTION

WAC 246-922-770 Episodic care of chronic opioid patients. (1)

When providing episodic care for a patient who the podiatric physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the podiatric physician shall review the PMP and document the review and any concerns in the patient record.

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

(3) The episodic care podiatric physician shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

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

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

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

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

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the podiatric physician prescribing opioids shall consult, or make a reasonable effort to consult, with the other prescriber(s) to establish a patient care plan for the use

of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-922-780 Coprescribing of opioids for patients receiving medication assistant treatment. (1) Where practicable, the podiatric physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

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

NEW SECTION

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

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

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

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

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

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

- (a) Upon the second refill or renewal of an opioid prescription for acute nonoperative pain or acute perioperative pain;
- (b) The time of transition from acute to subacute pain; and
- (c) The time of transition from subacute to chronic pain.
- (4) For chronic pain management, the podiatric physician shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:
- (a) For a high-risk patient, a PMP query shall be completed at least quarterly.
- (b) For a moderate-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least semiannually.
- (c) For a low-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least annually.
- (5) The podiatric physician shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.
- (6) The podiatric physician shall ensure a PMP query is performed when providing episodic care to a patient who the podiatric physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-922-770.
- (7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the podiatric physician due to a temporary technological or electrical failure.
- (8) If the podiatric physician is working in a practice, group, or institution that integrates access to the PMP into the workflow of the EMR, the podiatric physician shall ensure a PMP query is performed for all prescriptions of opioids and coprescribed medications listed in WAC 246-922-755(1) for acute pain.
- (9) Pertinent concerns discovered in the PMP must be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-922-663	Patient evaluation.
WAC 246-922-664	Treatment plan.
WAC 246-922-665	Informed consent.
WAC 246-922-666	Written agreement for treatment.
WAC 246-922-667	Periodic review.
WAC 246-922-668	Long-acting opioids, including methadone.
WAC 246-922-669	Episodic care.
WAC 246-922-670	Consultation—Recommendations and requirements.
WAC 246-922-671	Consultation—Exemptions for exigent and special circumstances.

WAC 246-922-672	Consultations—Exemptions for the podiatric physician.
WAC 246-922-673	Pain management specialist.