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Scott Walker, Governor
Laura Gutiérrez, Secretary

PODIATRY AFFILIATED CREDENTIALING BOARD
Room N206, 4822 Madison Yards Way, Madison
Contact: Tom Ryan (608) 266-2112
October 18, 2018

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

9:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-3)

B. Approval of Minutes of June 21, 2018 (4-6)

C. Administrative Updates
1. Department and Staff Updates
2. Board Members – Term Expiration Dates
   a. Jeffery Giesking – 7/1/2020
   b. Thomas Komp – 7/1/2017
   c. William Weis – 7/1/2019

D. Legislative/Administrative Rule Matters (7-34)
1. Wisconsin Podiatry Affiliated Credentialing Board Opioid Prescribing Guideline
   a. Wisconsin Medical Examining Board Opioid Prescribing Guideline as Updated on April 19, 2018
2. Required Report Under 2017 Wisconsin Act 262 Concerning Opioid Abuse
3. Administrative Rules Reporting Requirement Under 2017 Wisconsin Act 108
4. Review of Revised Draft Proposed Permanent Rules for Pod 3, Relating to Continuing Podiatric Medical Education
5. Proposals for Pod 1 And 9, Relating to Physician Assistants
6. Update on Pending Legislation and Pending and Possible Rulemaking Projects

E. Informational Items

F. Items Added After Preparation of Agenda:
1. Introductions, Announcements and Recognition
2. Election of Board Officers
3. Appointment of Board Liaison(s)
4. Administrative Updates
5. Nominations, Elections, and Appointments
6. Education and Examination Matters
7. Credentialing Matters

8. Practice Matters
9. Legislation/Administrative Rule Matters
10. Liaison Reports
11. Informational Items
12. Disciplinary Matters
13. Presentations of Petitions for Summary Suspension
14. Petitions for Designation of Hearing Examiner
15. Presentation of Proposed Stipulations, Final Decisions and Orders
16. Presentation of Proposed Final Decisions and Orders
17. Presentation of Interim Orders
18. Petitions for Re-Hearing
19. Petitions for Assessments
20. Petitions to Vacate Orders
21. Requests for Disciplinary Proceeding Presentations
22. Motions
23. Petitions
24. Appearances from Requests Received or Renewed
25. Speaking Engagement(s), Travel, or Public Relation Request(s)

G. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02(8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

H. Deliberation on Division of Legal Services and Compliance (DLSC) Matters

1. Case Closing(s)
   a. 17 POD 010 – M.D.H. **(35-53)**

I. Deliberation of Items Added After Preparation of the Agenda

1. Education and Examination Matters
2. Credentialing Matters
3. Disciplinary Matters
4. Monitoring Matters
5. Professional Assistance Procedure (PAP) Matters
6. Petitions for Summary Suspensions
7. Petitions for Designation of Hearing Examiner
8. Proposed Stipulations, Final Decisions and Orders
9. Administrative Warnings
10. Review of Administrative Warnings
11. Proposed Final Decisions and Orders
12. Matters Relating to Costs/Orders Fixing Costs
13. Case Closings
14. Proposed Interim Orders
15. Petitions for Assessments and Evaluations
16. Petitions to Vacate Orders
17. Remedial Education Cases
18. Motions
19. Petitions for Re-Hearing
20. Appearances from Requests Received or Renewed

J. Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

K. Open Session Items Noticed Above Not Completed in the Initial Open Session

L. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

M. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the board's agenda, please call the listed contact person. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112.

TELECONFERENCE/VIRTUAL
PODIATRY AFFILIATED CREDENTIALING BOARD
MEETING MINUTES
JUNE 21, 2018

PRESENT: Jeffery Giesking, DPM; Thomas Komp, DPM; William Weis, DPM *(all attending via GoToMeeting)*

STAFF: Tom Ryan, Executive Director; Dale Kleven, Administrative Rules Coordinator; Kate Stolarzyk, Bureau Assistant; and other Department staff

CALL TO ORDER

William Weis, Chair called the meeting to order at 9:02 a.m. A quorum of three (3) members was confirmed.

ADOPTION OF AGENDA

MOTION: Thomas Komp moved, seconded by William Weis, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF FEBRUARY 1, 2018

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, to approve the minutes of February 1, 2018 as published. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

Preliminary Draft Rules for Pod 3 Relating to Continuing Podiatric Medical Education

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, to request DSPS staff draft a revised Scope Statement for Pod 3 relating to continuing podiatric medical education, and to authorize the Chair to approve the revised Scope Statement for submission to the Department of Administration and Governor's Office, for publication, and for implementation no less than 10 days after publication. Motion carried unanimously.

2017 Wisconsin Act 227 and Related Scope Statement for Pod 1 and 9 Concerning Physician Assistants

MOTION: William Weis moved, seconded by Jeffery Giesking, to approve the Scope Statement for Pod 1 and 9, relating to physician assistants, for submission to the Department of Administration and Governor's Office and for publication. Additionally, the Board authorizes the Chair to approve the Scope Statement for implementation no less than 10 days after publication. Motion carried unanimously.

2017 Wisconsin Act 262 and Required Board Report Concerning Opioid Abuse

MOTION: William Weis moved, seconded by Thomas Komp, to designate Jeffery Giesking to serve as liaison to DSPS staff for drafting the report required under 2017 Wisconsin Act 262. Motion carried unanimously.

CLOSED SESSION

MOTION: Thomas Komp moved, seconded by Jeffery Giesking, to convene to Closed Session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85 (1)(b), and 448.02(8), Stats.); to consider individual histories or disciplinary data (s. 19.85 (1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Jeffery Giesking-yes; Thomas Komp-yes; and William Weis-yes. Motion carried unanimously.

The Board convened into Closed Session at 10:16 a.m.

RECONVENE TO OPEN SESSION

MOTION: William Weis moved, seconded by Jeffery Giesking, to reconvene in Open Session. Motion carried unanimously.

The Board reconvened into Open Session at 10:19 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION,

IF VOTING IS APPROPRIATE

MOTION: William Weis moved, seconded by Thomas Komp, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)

DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Case Closing

17 POD 009

MOTION: Jeffery Giesking moved, seconded by William Weis, to close DLSC case number 17 POD 009, against J.H. for No Violation. Motion carried unanimously.

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: William Weis moved, seconded by Jeffery Giesking, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: William Weis moved, seconded by Thomas Komp, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:21 a.m.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:	2) Date When Request Submitted:
Dale Kleven **Administrative Rules Coordinator**	**10/8/18** Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:
Podiatry Affiliated Credentialing Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
10/18/18	☒ Yes ☐ No	**Legislation and Rule Matters – Discussion and Consideration** 1. **Wisconsin Podiatry Affiliated Credentialing Board Opioid Prescribing Guideline** a. **Wisconsin Medical Examining Board Opioid Prescribing Guideline as Updated on April 19, 2018** 2. **Required Report Under 2017 Wisconsin Act 262 Concerning Opioid Abuse** 3. **Administrative Rules Reporting Requirement Under 2017 Wisconsin Act 108** 4. **Review of Revised Draft Proposed Permanent Rules for Pod 3, Relating to Continuing Podiatric Medical Education** 5. **Proposals for Pod 1 and 9, Relating to Physician Assistants** 6. **Update Concerning Pending Legislation and Pending and Possible Rulemaking Projects**

7) Place Item in:	8) Is an appearance before the Board being scheduled?	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session ☐ Both	☐ Yes (Fill out Board Appearance Request) ☒ No	

10) Describe the issue and action that should be addressed:

1.a. At its April 19, 2018 meeting, the Medical Examining Board revised its Opioid Prescribing Guideline as follows:

MOTION: David Roelke moved, seconded by Robert Zoeller, to add the following language to 14.a. of the Wisconsin Medical Examining Board Opioid Prescribing Guideline: "It is also recommended practitioners discuss with patients the effect opioid use may have on the ability to safely operate machinery or a vehicle in any mode of transportation." Motion carried unanimously.

MOTION: Lee Ann Lau moved, seconded by Padmaja Doniparthi, to revise the title of 23. of the Wisconsin Medical Examining Board Opioid Prescribing Guideline to read: "Current HIPAA Guidance for the Sharing of Protected Health Information with a Patient's Family Members and Loved Ones Irrespective of Patient Wishes." Motion carried unanimously.

11) Authorization

Dale Kleven — *October 8, 2018*

Signature of person making this request — **Date**

Supervisor (if required) — **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) **Date**

Directions for including supporting documents:
1. **This form should be attached to any documents submitted to the agenda.**
2. **Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
3. **If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**

Revised 8/13

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On December 1, 2017 the Podiatry Affiliated Credentialing Board adopted the Wisconsin Medical Examining Board Opioid Prescribing Guideline dated August 16, 2017.

Wisconsin Medical Examining Board Opioid Prescribing Guideline – August 16, 2017

Scope and purpose of the guideline: To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

Identify and treat the cause of the pain, use non-opioid therapies
Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

Start low and go slow
When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

Close follow-up
Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

What's included in the guideline?
The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

1. **Determining when to initiate or continue opioids**
   -Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
   -Establishment of treatment goals
   -Discussion of risks and benefits of therapy with patients

2. **Opioid selection, dosage, duration, follow-up and discontinuation**
   -Selection of immediate-release or extended-release and long-acting opioids
   -Dosage considerations
   -Duration of treatment
   -Considerations for follow-up and discontinuation of opioid therapy

3. **Assessing risk and addressing harms of opioid use**
   -Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
   -Review of prescription drug monitoring program (PDMP) data
   -Use of urine drug testing
   -Considerations for co-prescribing benzodiazepines
   -Arrangement of treatment for opioid use disorder

Prescription Opioid Guideline

1. Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

2. In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

3. A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.

   a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.

   b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.

   c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

4. Opioids should not necessarily be the first choice in treating acute or chronic pain.

   a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy. Although opioids could be simultaneously prescribed if it is apparent from

the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.

c. Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. **Note:** There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

5. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

6. Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

7. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

8. Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

9. Prescribing of opioids is strongly discouraged in patients taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

10. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

11. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

- **a.** Medical history and physical examination targeted to the pain condition.
- **b.** Nature and intensity of the pain.
- **c.** Current and past treatments, with response to each treatment.
- **d.** Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, chronic obstructive pulmonary disease (COPD), etc.).
- **e.** Effect of pain on physical and psychological functioning.
- **f.** Personal and family history of substance abuse.
- **g.** History of psychiatric disorders associated with opioid abuse (bipolar, attention deficit disorders (ADD/ADHD), sociopathic, borderline, untreated/severe depression).
- **h.** Medical indication(s) for use of opioids.

12. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

13. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioids should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

- **a.** Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).
- **b.** Components of ongoing assessment of risk include:
  - **i.** Review of the Prescription Drug Monitoring Program (PDMP) information.
  - **ii.** Periodic urine drug testing (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk.
  - **iii.** Violations of the opioid agreement.
  - **iv.** Periodic pill counts may also be considered for high risk patients.

14. All patients on chronic opioid therapy should have informed consent consisting of:

a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death.

b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects.

15. Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.

16. Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #13.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.

17. The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the QTc, predisposing susceptible patients to potentially fatal arrhythmias.

18. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

19. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

20. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

a. History of overdose (a relative contraindication to chronic opioid therapy).

b. Opioid doses over 50 MMEs/day.

c. Clinical depression.

d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.).

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

21. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient. Discharging a patient from the provider's practice solely due to an opioid use disorder is not considered acceptable.

22. Discontinuing Opioid Therapy

a. If lack of efficacy of opioid therapy is determined, discontinuation of therapy should be performed.

i. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued.

ii. Prescription of clonidine 0.2 mg po BID or tizanidine 2 mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

b. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

i. Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued.

ii. Prescription of clonidine 0.2 mg po BID or tizanidine 2 mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

iii. Physicians can consider weekly or bi-monthly follow-up during the weaning process.

c. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up.

Resources

CDC Guideline for Prescribing Opioids for Chronic Pain--United States 2016. Dowell D1, Haegerich TM1, Chou R1., JAMA. 2016 Apr 19;315(15):1624-45. doi:10.1001/jama.2016.1464.

Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf

Within-subject comparison of the psychopharmacological profiles of oral oxycodone and oral morphine in non-drug-abusing volunteers. Zacny, James, & Lichtor, Stephanie. Psychpharmacology (2008) 196:105-116

Subjective, Psychomotor, and Physiological Effects Profile of Hydrocodone/Acetaminophen and Oxycodone/Acetaminophen Combination Products. Zachny, James, & Gutierrez, Sandra. Pain Medicine (2008) Vol 9, No 4: 433-443

Positive and Negative Subjective Effects of Extended-Release Oxymorphone versus Controlled-Release Oxycodone in Recreational Opioid Users. Schoedel, Kerri et. al. Journal of Opioid Management 7:3 May/June 2011. 179-192

Tapentadol Abuse Potential: A Postmarketing Evaluation Using a Sample of Individuals Evaluated for Substance Abuse Treatment. Stephen F. Butler, PhD et. al., Pain Medicine 2015; 16: 119–130

Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. Chou R1, et. al., J Pain. 2014 Apr;15(4):321-37

Emerging Issues in the Use of Methadone. SAMHSA Substance Abuse Treatment Advisory, Spring 2009, Volume 8, Issue 1, available at http://store.samhsa.gov/shin/content//SMA09-4368/SMA09-4368.pdf

Opioid Use, Misuse, and Abuse in Orthopedic Practice. American Academy of Orthopedic Surgeons, Information Statement 1045, October, 2015, available at http://www.aaos.org/PositionStatements/Statement1045/?ssopc=1

Wisconsin Medical Society Opioid Prescribing Principles. https://www.wisconsinmedicalsociety.org/advocacy/boards-councils/society-initiatives/opioid-task-force/opioid-prescribing-principles/

WISCONSIN MEDICAL EXAMINING BOARD

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Wisconsin Medical Examining Board Opioid Prescribing Guideline – April 19, 2018

Scope and purpose of the guideline: To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

Identify and treat the cause of the pain, use non-opioid therapies
Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

Start low and go slow
When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

Close follow-up
Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

What's included in the guideline?
The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

1. **Determining when to initiate or continue opioids**
   -Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
   -Establishment of treatment goals
   -Discussion of risks and benefits of therapy with patients

2. **Opioid selection, dosage, duration, follow-up and discontinuation**
   -Selection of immediate-release or extended-release and long-acting opioids
   -Dosage considerations
   -Duration of treatment
   -Considerations for follow-up and discontinuation of opioid therapy

3. **Assessing risk and addressing harms of opioid use**
   -Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
   -Review of prescription drug monitoring program (PDMP) data
   -Use of urine drug testing
   -Considerations for co-prescribing benzodiazepines
   -Arrangement of treatment for opioid use disorder

Prescription Opioid Guideline

1. Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

2. In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

3. A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.

   a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.

   b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.

   c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

4. Opioids should not necessarily be the first choice in treating acute or chronic pain.

   a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy. Although opioids could be simultaneously prescribed if it is apparent from

the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.

c. Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. **Note:** There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

5. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

6. Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

7. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

8. Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

9. Prescribing of opioids is strongly discouraged in patients taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

10. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

11. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

- **a.** Medical history and physical examination targeted to the pain condition.
- **b.** Nature and intensity of the pain.
- **c.** Current and past treatments, with response to each treatment.
- **d.** Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, chronic obstructive pulmonary disease (COPD), etc.).
- **e.** Effect of pain on physical and psychological functioning.
- **f.** Personal and family history of substance abuse.
- **g.** History of psychiatric disorders associated with opioid abuse (bipolar, attention deficit disorders (ADD/ADHD), sociopathic, borderline, untreated/severe depression).
- **h.** Medical indication(s) for use of opioids.

12. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

13. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioids should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

- **a.** Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).
- **b.** Components of ongoing assessment of risk include:
  - **i.** Review of the Prescription Drug Monitoring Program (PDMP) information.
  - **ii.** Periodic urine drug testing (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk.
  - **iii.** Violations of the opioid agreement.
  - **iv.** Periodic pill counts may also be considered for high risk patients.

14. All patients on chronic opioid therapy should have informed consent consisting of:

- **a.** Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death. It is also recommended practitioners discuss with patients the effect opioid use may have on the ability to safely operate machinery or a vehicle in any mode of transportation.
- **b.** Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects.

15. Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.

16. Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #13.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.

17. The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the QTc, predisposing susceptible patients to potentially fatal arrhythmias.

18. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

19. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

20. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

- **a.** History of overdose (a relative contraindication to chronic opioid therapy).
- **b.** Opioid doses over 50 MMEs/day.
- **c.** Clinical depression.
- **d.** Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.).

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

21. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient. Discharging a patient from the provider's practice solely due to an opioid use disorder is not considered acceptable.

22. Discontinuing Opioid Therapy

a. If lack of efficacy of opioid therapy is determined, discontinuation of therapy should be performed.

i. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued.

ii. Prescription of clonidine 0.2 mg po BID or tizanidine 2 mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

b. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

i. Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10 mg MED remain at which time the opioid can be fully discontinued.

ii. Prescription of clonidine 0.2 mg po BID or tizanidine 2 mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

iii. Physicians can consider weekly or bi-monthly follow-up during the weaning process.

c. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up.

23. Current HIPAA Guidance for the Sharing of Protected Health Information with a Patient's Family Members and Loved Ones Irrespective of Patient Wishes.

Interpretive guidance from the US Department of Health and Human Services Office of Civil Rights, indicates that HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations such as opioid overdose. HIPAA allows health care professionals to disclose some health information without a patient's permission under certain circumstances, including: in cases where the patient is incapacitated or unconscious, or where a serious and imminent threat to a patient's health or safety exists. For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.

Resources

CDC Guideline for Prescribing Opioids for Chronic Pain--United States 2016. Dowell D1, Haegerich TM1, Chou R1., JAMA. 2016 Apr 19;315(15):1624-45. doi:10.1001/jama.2016.1464.

Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf

Within-subject comparison of the psychopharmacological profiles of oral oxycodone and oral morphine in non-drug-abusing volunteers. Zacny, James, & Lichtor, Stephanie. Psychpharmacology (2008) 196:105-116

Subjective, Psychomotor, and Physiological Effects Profile of Hydrocodone/Acetaminophen and Oxycodone/Acetaminophen Combination Products. Zachny, James, & Gutierrez, Sandra. Pain Medicine (2008) Vol 9, No 4: 433-443

Positive and Negative Subjective Effects of Extended-Release Oxymorphone versus Controlled-Release Oxycodone in Recreational Opioid Users. Schoedel, Kerri et. al. Journal of Opioid Management 7:3 May/June 2011. 179-192

Tapentadol Abuse Potential: A Postmarketing Evaluation Using a Sample of Individuals Evaluated for Substance Abuse Treatment. Stephen F. Butler, PhD et. al., Pain Medicine 2015; 16: 119–130

Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. Chou R1, et. al., J Pain. 2014 Apr;15(4):321-37

Emerging Issues in the Use of Methadone. SAMHSA Substance Abuse Treatment Advisory, Spring 2009, Volume 8, Issue 1, available at http://store.samhsa.gov/shin/content//SMA09-4368/SMA09-4368.pdf

Opioid Use, Misuse, and Abuse in Orthopedic Practice. American Academy of Orthopedic Surgeons, Information Statement 1045, October, 2015, available at http://www.aaos.org/PositionStatements/Statement1045/?ssopc=1

Wisconsin Medical Society Opioid Prescribing Principles. https://www.wisconsinmedicalsociety.org/advocacy/boards-councils/society-initiatives/opioid-task-force/opioid-prescribing-principles/

that he or she has completed only if a complaint is made against the credential holder.

(2m) (a) In this subsection, "controlled substance" has the meaning given in s. 961.01 (4).

(b) The medical examining board, the podiatry affiliated credentialing board, the board of nursing, the dentistry examining board, or the optometry examining board may issue guidelines regarding best practices in prescribing controlled substances for persons credentialed by that board who are authorized to prescribe controlled substances.

(c) 1. The medical examining board, the podiatry affiliated credentialing board, the board of nursing, the dentistry examining board, and the optometry examining board shall, by November 1, 2018, and annually thereafter, submit a report to the persons specified in subd. 2. that does all of the following:

a. Details proactive efforts taken by the board to address the issue of opioid abuse. The board shall specify whether the board has required, or otherwise encouraged, continuing education related to prescribing controlled substances for persons credentialed by that board who are authorized to prescribe controlled substances.

b. Sets goals for addressing the issue of opioid abuse, as that issue pertains to or implicates the practices of the professions regulated by the board.

c. Describes the actions taken by the board so that the goals described in subd. 1. b. that were identified in the board's previous reports under this paragraph can be achieved, whether those goals have been achieved, and, if the goals have not been achieved, the reasons therefor.

2. A report under subd. 1. shall be submitted to all of the following:

a. Any committee, task force, or other body or person designated by the governor.

b. To the appropriate standing committees of the legislature with jurisdiction over health issues under s. 13.172 (3).

History: 1977 c. 418 ss. 25, 793, 929 (41); 1979 c. 32 s. 92 (1); 1979 c. 34; 1989 a. 56 s. 259; 1991 a. 39; 1993 a. 107; 1997 a. 27, 191, 237; 2015 a. 269; 2017 a. 59, 262.

440.04 Duties of the secretary. The secretary shall:

(1) Centralize, at the capital and in such district offices as the operations of the department and the attached examining boards and affiliated credentialing boards require, the routine housekeeping functions required by the department, the examining boards and the affiliated credentialing boards.

(2) Provide the bookkeeping, payroll, accounting and personnel advisory services required by the department and the legal services, except for representation in court proceedings and the preparation of formal legal opinions, required by the attached examining boards and affiliated credentialing boards.

(3) Control the allocation, disbursement, and budgeting of the funds received by the examining boards and affiliated credentialing boards in connection with their credentialing and regulation, including the reimbursement of board members for actual and necessary expenses, including travel expenses, incurred in the performance of their duties.

(4) Employ, assign and reassign such staff as are required by the department and the attached examining boards and affiliated credentialing boards in the performance of their functions.

(5) With the advice of the examining boards or affiliated credentialing boards:

(a) Provide the department with such supplies, equipment, office space and meeting facilities as are required for the efficient operation of the department.

(b) Make all arrangements for meetings, hearings and examinations.

(c) Provide such other services as the examining boards or affiliated credentialing boards request.

(6) Appoint outside the classified service an administrator for any division established in the department and a director for any bureau established in the department as authorized in s. 230.08 (2). The secretary may assign any bureau director appointed in accordance with this subsection to serve concurrently as a bureau director and a division administrator.

(7) Unless otherwise specified in chs. 440 to 480, provide examination development, administration, research and evaluation services as required.

History: 1977 c. 418 s. 26; 1979 c. 34; 1981 c. 20; 1985 a. 29; 1987 a. 27; 1989 a. 316; 1991 a. 39; 1993 a. 102, 107; 1995 a. 333; 2003 a. 270; 2011 a. 32; 2017 a. 329.

440.042 Advisory committees. **(1)** The secretary may appoint persons or advisory committees to advise the department and the boards, examining boards, and affiliated credentialing boards in the department on matters relating to the regulation of credential holders. A person or an advisory committee member appointed under this subsection shall serve without compensation, but may be reimbursed for his or her actual and necessary expenses incurred in the performance of his or her duties.

(2) Any person who in good faith testifies before the department or any examining board, affiliated credentialing board or board in the department or otherwise provides the department or any examining board, affiliated credentialing board or board in the department with advice or information on a matter relating to the regulation of a person holding a credential is immune from civil liability for his or her acts or omissions in testifying or otherwise providing such advice or information. The good faith of any person specified in this subsection shall be presumed in any civil action and an allegation that such a person has not acted in good faith must be proven by clear and convincing evidence.

History: 1993 a. 16 ss. 3269, 3299; 1993 a. 107; 1997 a. 156; 1999 a. 32; 2005 a. 292; 2015 a. 192.

440.043 Behavioral health review committee. **(1)** The secretary shall appoint an advisory committee under s. 440.042 to provide advice concerning behavioral health. The advisory committee shall semiannually conduct a review of the requirements for obtaining a credential under s. 440.88 or ch. 457 or for other credentials related to behavioral health.

(2) The advisory committee shall accept comments from the public related to its review under sub. (1). Before conducting a review under sub. (1), the department shall publish a class 1 notice under ch. 985 and shall publish notice on its Internet site announcing the opportunity for public comment.

(3) The advisory committee established under sub. (1) may propose changes in statutes and rules to the department; the marriage and family therapy, professional counseling, and social work examining board; or other appropriate credentialing board.

History: 2017 a. 262.

440.045 Disputes. Any dispute between an examining board or an affiliated credentialing board and the secretary shall be arbitrated by the governor or the governor's designee after consultation with the disputants.

History: 1977 c. 418 s. 27; 1979 c. 34; 1993 a. 107.

The relationship between the department, cosmetology examining board, and governor is discussed. 70 Atty. Gen. 172.

440.05 Standard fees. Subject to s. 440.052, the following standard fees apply to all initial credentials, except as provided in ss. 440.51, 444.03, 444.11, 446.02 (2) (c), 447.04 (2) (c) 2., 448.07 (2), 449.17 (1m) (d), and 449.18 (2) (d):

NOTE: Section 440.05 (intro.) is amended eff. 12−16−19 by 2017 Wis. Act 319, section 3, to read:

NOTE: Subject to s. 440.052, the following standard fees apply to all initial credentials, except as provided in ss. 440.51, 444.03, 444.11, 446.02 (2) (c), 447.04 (2) (c) 2., 449.17 (1m) (d), and 449.18 (2) (d):

(1) (a) Initial credential: An amount determined by the department under s. 440.03 (9) (a). Each applicant for an initial credential shall pay the initial credential fee to the department when the application materials for the initial credential are submitted to the department, except that no fee is required under this

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Wisconsin Podiatry Affiliated Credentialing Board Report on Opioid Abuse – October 2018

Scope and purpose of the report: 2017 Wisconsin Act 262 requires the Podiatry Affiliated Credentialing Board to annually submit a report related to opioid abuse to the Legislature and Governor's Office. This preliminary report must include proactive efforts taken by the Board to address the issue of opioid abuse and goals for addressing the issue of opioid abuse as it relates to the practice of podiatric medicine and surgery in Wisconsin. Future reports must also include actions taken by the Board to achieve the goals identified in previous reports, and whether those goals have been achieved.

Proactive efforts taken by the Board to address the issue of opioid abuse:

Opioid Prescribing Guideline

In January 2017, the Board reviewed and adopted the Wisconsin Medical Examining Board Opioid Prescribing Guideline. The Board has continued to review and adopt updates to the Guideline, most recently in October of 2018.

Continuing Education Related to Prescribing Controlled Substances

On June 21, 2018, the Board formally started the process for a rule revision that will establish requirements for the completion of continuing podiatric medical education related to prescribing controlled substances. The Board's goal is to have the rules in place for the 2018-2020 biennium.

Goals for addressing the issue of opioid abuse as it relates to the practice of podiatric medicine and surgery in Wisconsin:

Education on the Issue of Opioid Abuse

The Board will work with Prescription Drug Monitoring Program (PDMP) staff to learn what data is available from the PDMP and how extensively the PDMP database is used by licensees.

Enforcement Action

Currently, if an investigation of a podiatrist's prescriptive practices occurs, it is done in response to a complaint filed against the podiatrist. The Board's goal is to, in partnership with the Controlled Substances Board, begin proactively investigating podiatrists whose prescriptive practices with controlled substances may deviate from the course of legitimate professional practice or constitute a danger to the health, welfare, or safety of patients or the public. The Controlled Substances Board will use reports generated from the Prescription Drug Monitoring Program to refer podiatrists to the Board for possible investigation.

Opioid Prescribing Guideline

The Board will continue to review and, as appropriate, adopt updates to the Wisconsin Medical Examining Board Opioid Prescribing Guideline.

on which the petition and proposed rule were submitted to the committee.

3. Following receipt of the petition and proposed rule submitted by the legislative council staff under subd. 2., the joint committee for review of administrative rules shall review the petition and proposed rule and may do any of the following:

a. Approve the agency's petition if the committee determines that the proposed rule would repeal an unauthorized rule.

b. Deny the agency's petition.

c. Request that the agency make changes to the proposed rule and resubmit the petition and proposed rule under subd. 1.

4. The committee shall inform the agency in writing of its decision as to the petition.

(c) If the joint committee for review of administrative rules approves a petition to repeal an unauthorized rule as provided in par. (b) 3. a., the agency shall promulgate the proposed rule by filing a certified copy of the rule with the legislative reference bureau under s. 227.20, together with a copy of the committee's decision.

Section 7. 227.29 of the statutes is created to read:

227.29 Agency review of rules and enactments. (1) By March 31 of each odd−numbered year, each agency with any rules published in the code shall submit a report to the joint committee for review of administrative rules listing all of the following rules promulgated or otherwise administered by that agency:

(a) Unauthorized rules, as defined in s. 227.26 (4) (a), together with a description of the legislation that eliminated the agency's authority to promulgate any such rule.

(b) Rules for which the authority to promulgate has been restricted, together with a description of the legislation that restricted that authority.

(c) Rules that are obsolete or that have been rendered unnecessary, together with a description of why those rules are obsolete or have been rendered unnecessary.

(d) Rules that are duplicative of, superseded by, or in conflict with another rule, a state statute, a federal statute or regulation, or a ruling of a court of competent jurisdiction, together with a citation to or the text of any such statute, regulation, or ruling.

(e) Rules that the agency determines are economically burdensome.

(2) The report under sub. (1) shall also include all of the following:

(a) A description of the agency's actions, if any, to address each rule listed in the report. If the agency has not taken any action to address a rule listed in the report, the agency shall include an explanation for not taking action.

(b) A description of the status of each rule listed in the previous year's report not otherwise listed.

(c) If the agency determines that there is no rule as described under sub. (1) (a), (b), (c), (d), or (e), a statement of that determination.

(3) If an agency identifies an unauthorized rule under sub. (1) (a) and is not otherwise in the process of promulgating a rule that repeals the unauthorized rule, the agency shall, within 30 days after the agency submits the report, submit a petition to the legislative council staff under s. 227.26 (4) (b) 1. to repeal the unauthorized rule if the agency has not previously done so.

(4) (a) In this subsection, "enactment" means an act or a portion of an act that is required to be published under s. 35.095 (3) (a).

(b) Each agency shall review enactments to determine whether any part of an enactment does any of the following:

1. Eliminates or restricts the agency's authority to promulgate any rules promulgated or otherwise administered by that agency.

2. Renders any rules promulgated or otherwise administered by that agency obsolete or unnecessary.

3. Renders, for any reason, any rules promulgated or otherwise administered by that agency not in conformity with or superseded by a state statute, including due to statutory numbering or terminology changes in the enactment.

4. Requires or otherwise necessitates rule making by the agency.

(c) If an agency determines that any consequence specified in par. (b) 1. to 4. results from an enactment or part of an enactment, within 6 months after the applicable effective date for the enactment or part of the enactment, the agency shall do one or more of the following, as applicable, to address the consequence identified by the agency and notify the joint committee for review of administrative rules of its action:

1. Submit a statement of the scope of a proposed rule under s. 227.135 (2), unless the enactment requires otherwise or unless the agency submits a notice to the committee explaining why it is unable to submit the statement of scope within that time period and an estimate of when the agency plans to submit the statement of scope.

2. In the case of an affected rule that the agency determines is an unauthorized rule, as defined in s. 227.26 (4) (a), submit a petition to the legislative council staff under s. 227.26 (4) (b) 1.

3. In the case of a consequence specified under par. (b) 3. that can be addressed by the legislative reference bureau using its authority under s. 13.92 (4) (b), submit a request to the legislative reference bureau to use that authority.

Section 8. Initial applicability.

(1) The treatment of section 227.29 (4) of the statutes first applies to enactments published by the legislative

STATE OF WISCONSIN
PODIATRY AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULEMAKING PROCEEDINGS BEFORE THE PODIATRY AFFILIATED CREDENTIALING BOARD	:	PROPOSED ORDER OF THE PODIATRY AFFILIATED CREDENTIALING BOARD ADOPTING RULES (CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Podiatry Affiliated Credentialing Board to amend Pod 3.02 (1) (intro.) and (a) to (d) and (4) (intro.) and (a), 3.03 (1) to (3), and 3.04 and create Pod 3.01 (1m) and 3.02 (1) (f), relating to continuing podiatric medical education.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 440.03 (4m), Stats.

Statutory authority:

Sections 15.085 (5) (b), 448.665, and 448.695 (2), Stats.

Explanation of agency authority:

Section 15.085 (5) (b), Stats., provides an affiliated credentialing board "[s]hall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . ."

Section 448.665, Stats., provides "[t]he affiliated credentialing board shall promulgate rules establishing requirements and procedures for licensees to complete continuing education programs or courses of study in order to qualify for renewal of a license granted under this subchapter."

Section 448.695 (2), Stats., provides "[t]he affiliated credentialing board may promulgate rules to carry out the purposes of this subchapter."

Related statute or rule:

Chapter Pod 4 provides the requirements for biennial registration of a license to practice podiatry, including the requirements for completion of continuing education under ch. Pod 3.

Plain language analysis:

Section Pod 3.01 (1m) is created to define requirements for the completion of continuing education hours related to prescribing controlled substances for the renewal date occurring on October 31, 2020.

Section Pod 3.04 is revised to reflect s. 440.03 (4m), Stats., as created by 2017 Wisconsin Act 59. Under this provision, the Board may require a credential holder to submit proof of completion of continuing education programs or courses only if a complaint is made against the credential holder.

The proposed rules also revise the provisions in ss. Pod 3.03 (2) and 3.04 to provide a consistent standard for the retention of evidence of completion of continuing education requirements, and make changes throughout the remainder of ch. Pod 3 to provide clarity and conform to current standards for drafting administrative rules.

Summary of, and comparison with, existing or proposed federal regulation:

None.

Comparison with rules in adjacent states:

Illinois:

68 Ill. Admin. Code 1360.70 d) 2) provides the requirements for retention and production of evidence of compliance with the continuing education requirements. The Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation may require additional evidence demonstrating compliance with the continuing education requirements. It is the responsibility of each applicant for renewal to retain or otherwise produce evidence of such compliance. Such additional evidence is required in the context of the Division's random audit.

The rules do not require continuing education related to prescribing opioids.

Iowa:

645 IAC 4.11 provides the requirements for retention and production of evidence of compliance with the continuing education requirements. The Iowa Board of Podiatry may select licensees for audit following license renewal. Upon audit, a licensee is required to provide an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. All licensees must retain documentation of compliance with the continuing education requirements for two years following license renewal.

The rules do not require continuing education related to prescribing opioids.

Michigan:

Mich Admin Code, R 338.8126 (2) provides the requirements for retention and production of evidence of compliance with the continuing education requirements. The Michigan Board of Podiatry may require a licensee to submit evidence of compliance, and all licensees are required to retain documentation of meeting the requirements for a period of 4 years from the date of applying for license renewal.

The rules require a minimum of 5 of the 150 hours of continuing education required for renewal to be earned in the area of pain and symptom management (Mich Admin Code, R 338.8127).

Minnesota:

Minnesota Rules, Part 6900.0200 Subpart 4 provides the requirements for retention and production of evidence of compliance with the continuing education requirements. All licensees must, during each renewal period, submit proof of attendance at qualifying continuing education programs to the Minnesota Board of Podiatric Medicine. Verification must be in the form of a certificate, descriptive receipt, or affidavit.

The rules do not require continuing education related to prescribing opioids.

Summary of factual data and analytical methodologies:

The proposed rules were developed by reviewing the provisions of ch. Pod 3 to ensure clarity and consistency and to reflect applicable Wisconsin Statutes and current standards for drafting administrative rules. Input and feedback were solicited and obtained from the Podiatry Affiliated Credentialing Board.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

The proposed rules will be posted for a period of 14 days for public comment on the economic impact of the proposed rules, including how the proposed rules may affect businesses, local government units, and individuals.

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at NathanielL.Ristow@wisconsin.gov, or by calling (608) 266-3445.

Agency contact person:

Dale Kleven, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, P.O. Box 8366, Madison, Wisconsin 53708-8366; telephone 608-261-4472; email at DSPSAdminRules@wisconsin.gov.

TEXT OF RULE

SECTION 1. Pod 3.01 (1m) is created to read:

Pod 3.01 (1m) (a) Except as provided under par. (b), for the renewal date occurring on October 31, 2020, a minimum of 2 of the 50 hours of continuing podiatric medical education required under sub. (1) shall be an educational course or program related to opioid prescribing that is approved under s. Med 13.03 (3) at the time of the podiatrist's attendance.

(b) This subsection does not apply to a podiatrist who, at the time of making application for a certificate of registration, does not hold a U.S. drug enforcement administration number to prescribe controlled substances.

SECTION 2. Pod 3.02 (1) (intro.) and (a) to (d) are amended to read:

Pod 3.02 (1) (intro.) In satisfaction of the biennial training requirement under s. Pod 3.01 (1) and s. 448.665, Stats., the board shall accept an educational program approved at the time of the podiatrist's attendance by any of the following:

(a) The ~~council~~ Council on ~~podiatric medical education~~ Podiatric Medical Education of the American ~~podiatric medical association~~ Podiatric Medical Association.

(b) The ~~council~~ Council on ~~medical education~~ Medical Education of the American ~~medical association~~ Medical Association.

(c) The ~~council~~ Council on ~~medical education~~ Medical Education of the American ~~osteopathic association~~ Osteopathic Association.

(d) The ~~accreditation council~~ Accreditation Council for ~~continuing medical education~~ Continuing Medical Education.

SECTION 3. Pod 3.02 (1) (f) is created to read:

Pod 3.02 (1) (f) The medical examining board under s. Med 13.03 (3).

SECTION 4. Pod 3.02 (4) (intro.) and (a) are amended to read:

(4) (intro.) The board shall accept as satisfaction of the biennial training requirement under s. Pod 3.01 (1) and s. 448.665, Stats., evidence that the podiatrist graduated from a school of podiatric medicine and surgery approved by the board pursuant to s. Pod 1.03 (2), ~~as long as both of~~ if all of the following ~~are in effect~~ apply:

(a) The podiatrist is, for the first time, renewing a license to practice podiatric medicine and surgery in ~~Wisconsin~~ this state.

SECTION 5. Pod 3.03 (1) to (3) are amended to read:

Pod 3.03 (1) Certification by the providing organization or by one of the approved accrediting bodies shall be accepted by the board as evidence of attendance at and completion of a continuing medical education ~~programs approved under s. Pod 3.01 is satisfactory evidence for purposes of sub. (2) and s. Pod 3.03~~ program.

(2) ~~Evidence~~ A podiatrist shall retain evidence of compliance ~~shall be retained by each podiatrist through the biennium for which 50 hours of credit are required for registration~~ for a minimum of 4 years from the date of completion of an educational program.

(3) A certified copy of an official transcript or a diploma shall be accepted by the board as the evidence of graduation from an approved school of podiatric medicine and surgery ~~from which the podiatrist graduated is satisfactory evidence of compliance with~~ required under s. Pod 3.02 (4)~~, provided that the requirements of s. Pod 3.02 (4) (a) and (b) have been met~~.

SECTION 6. Pod 3.04 is amended to read:

Pod 3.04 Audit. The board ~~may conduct a random~~ shall audit ~~of any licensee on a biennial basis to determine~~ for compliance with the continuing education requirements under this chapter any licensee who is under investigation by the board for alleged misconduct. ~~The board may require any podiatrist to submit evidence to the board of his or her compliance with continuing education requirements during the preceding biennium for the purpose of conducting an audit. Licensees shall retain certificates of continuing education attendance for a minimum period of 4 years.~~

SECTION 7. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

STATEMENT OF SCOPE

Podiatry Affiliated Credentialing Board

Rule No.: Chapters Pod 1 and 9

Relating to: Physician Assistants

Rule Type: Emergency and Permanent

1. Finding/nature of emergency (Emergency Rule only):

The Legislature by SECTION 22 of 2017 Wisconsin Act 227 provides an exemption from a finding of emergency for the adoption of this rule.

2. Detailed description of the objective of the proposed rule:

The objective of the proposed rule is to, as required under the provisions of 2017 Wisconsin Act 227, establish practice standards for a physician assistant practicing podiatry as provided under s. 448.21 (4), Stats., and requirements for a podiatrist who is supervising a physician assistant as provided under s. 448.21 (4), Stats.

3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:

Current rules authorize a podiatric physician to delegate x-ray tasks to a person who has successfully completed a course of instruction for podiatric x-ray assistants approved by the Podiatry Affiliated Credentialing Board. The proposed rule would create ch. Pod 9 to reflect the provisions of 2017 Wisconsin Act 227, which, effective April 5, 2018, allows a podiatric physician to delegate nonsurgical patient services to a physician assistant licensed by the Medical Examining Board. As part of this update, the definitions under ch. Pod 1 may be revised.

If the rules are not updated, they will not reflect the provisions of 2017 Wisconsin Act 227.

4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):

Section 15.08 (5) (b), Stats., provides an affiliated credentialing board "shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . ."

Section 448.695 (4) (a) and (b), Stats., provides the Podiatry Affiliated Credentialing Board shall promulgate rules establishing "[p]ractice standards for a physician assistant practicing podiatry as provided in s. 448.21 (4)" and "[r]equirements for a podiatrist who is supervising a physician assistant as provided in s. 448.21 (4)."

5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:

State employees will spend approximately 120 hours developing the proposed rule.

6. List with description of all entities that may be affected by the proposed rule:

Individuals licensed to practice as podiatrists and physician assistants in Wisconsin.

7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

None.

8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):

The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

Contact Person: Dale Kleven, (608) 261-4472, DSPSAdminRules@wisconsin.gov

Approved for publication:

Authorized Signature

Date Submitted

Approved for implementation:

Authorized Signature

Date Submitted

Chapter Pod 1

LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

Pod 1.01 Authority and purpose.
Pod 1.02 Definitions.
Pod 1.03 Licensure requirements.
Pod 1.04 Translation of documents.
Pod 1.06 Examinations.
Pod 1.07 Failure and reexamination.
Pod 1.08 Temporary educational license.
Pod 1.09 Locum tenens license.
Pod 1.10 Temporary license.
Pod 1.11 Examination review by applicant.
Pod 1.12 Board review of examination error claim.

Pod 1.01 Authority and purpose. Chapters Pod 1 to 8 are adopted by the podiatry affiliated credentialing board under ss. 15.085 (5) (b), 227.11 (2) and 448.695, Stats., and govern the practice of podiatric medicine and surgery under subch. IV of ch. 448, Stats.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; correction made under s. 13.92 (4) (b) 6., Stats., Register September 2012 No. 68; **CR 17−030: am. Register January 2018 No. 745 eff. 2−1−18.**

Pod 1.02 Definitions. As used in chs. Pod 1 to 8:

(1) "Board" means the podiatry affiliated credentialing board.

(2) "Controlled substance" has the meaning under s. 961.01 (4), Stats.

(2m) "Direct supervision" means a podiatric physician has assumed responsibility for directing, supervising, and inspecting the work of the person being supervised and the supervising podiatric physician is physically present on the same premises as the person being supervised, with face−to−face contact as necessary.

(3) "License" means any license issued by the board.

(4) "Licensee" means any person validly possessing any license granted and issued to that person by the board.

(5) "Patient" means a person who receives health care services from a podiatrist.

(6) "Patient health care record" has the meaning given in s. 146.81 (4), Stats.

(6m) "Podiatric x−ray assistant" means a person who is under the direct supervision of a licensed podiatric physician and who performs only those radiographic functions that are within the scope of practice of a podiatric physician licensed under s. 448.61, Stats., and that the podiatric physician is competent to perform.

(7) "Practitioner" means a person holding a license to practice podiatric medicine and surgery.

(8) "Prescription drug" has the meaning under s. 450.01 (20), Stats.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; CR 06−056: am. (2) Register April 2007 No. 616, eff. 5−1−07; correction in (2) made under s. 13.93 (2m) (b) 7., Stats., Register April 2007 No. 616; correction in (1) made under s. 13.92 (4) (b) 6., Stats., Register September 2012 No. 681; CR 13−110: am. (intro.), cr. (2m), (6m) Register August 2014 No. 704, eff. 9−1−14; **CR 17−030: am. (intro.) Register January 2018 No. 745 eff. 2−1−18**.

Pod 1.03 Licensure requirements. Every person applying for a license to practice podiatric medicine and surgery shall submit all of the following:

(1) A completed and verified application form provided by the board and the required fee under s. 440.05 (1), Stats.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, or from the department of safety and professional services' website at http://dsps.wi.gov.

(2) Verified documentary evidence of graduation from a school of podiatric medicine and surgery approved by the board and a verified photographic copy of the diploma conferring the degree of doctor of podiatric medicine or its equivalent as determined by the board granted to the applicant by the school. The board shall approve the podiatric medical schools recognized and approved at the time of the applicant's graduation by the council on education of the American podiatric association.

(3) Evidence of successful completion of the examination requirements under s. Pod 1.06.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; **CR 17−030: am. (title), (intro.), (1), cr. (3) Register January 2018 No. 745 eff. 2−1−18**.

Pod 1.04 Translation of documents. If any of the documents required under this chapter are in a language other than English, the applicant shall also submit a verified English translation and the cost of translation shall be borne by the applicant.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00.

Pod 1.06 Examinations. (1) (a) An applicant shall complete the examination under sub. (2), and an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin. In addition, an applicant may be required to complete an oral examination if the applicant:

1. Has a medical condition which in any way impairs or limits the applicant's ability to practice podiatric medicine and surgery with reasonable skill and safety.

2. Uses chemical substances so as to impair in any way the applicant's ability to practice podiatric medicine and surgery with reasonable skill and safety.

3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

4. Has been found negligent in the practice of podiatric medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of podiatric medicine.

5. Has been convicted of a crime the circumstances of which substantially relate to the practice of podiatric medicine.

6. Has lost, had reduced or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant's period of licensure following postgraduate training.

7. Has been graduated from a school of podiatric medicine not approved by the board.

8. Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

9. Has within the past 2 years engaged in the illegal use of controlled substances.

10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.

11. Has not practiced podiatric medicine and surgery for a period of 6 months prior to application, unless the applicant has been graduated from a school of podiatric medicine within that period.

(b) An application filed under s. Pod 1.03 shall be reviewed by an application review panel of at least 2 board members designated by the chairperson of the board. The panel shall determine whether the applicant is eligible for a license without completing an oral examination.

(c) All examinations shall be conducted in the English language. Each examination is scored separately, and the applicant shall achieve passing scores on each examination to qualify for a license.

(2) The board shall utilize as its examination the American Podiatric Medical Licensing Examination, Parts I, II, II Clinical Skills Patient Encounter, and III. The passing scores are set by the National Board of Podiatric Medical Examiners and represent the minimum competency required to protect public health and safety. The board may accept the recommendations of the examination provider.

(3) The board may deny release of scores or issuance of a credential if the board determines that the applicant violated rules of conduct of the examination or otherwise acted dishonestly in the examination process.

(4) An applicant who has received passing grades in examinations for a license to practice podiatry conducted by another licensing jurisdiction of the United States, shall submit to the board documentary evidence. The board shall review the documentary evidence to determine whether the scope and passing grades of the examinations are substantially equivalent to those of this state at the time of the applicant's examination. If the board finds equivalency, the board shall accept this in lieu of requiring the applicant to achieve the passing scores under sub. (2). The burden of proof of equivalency is on the applicant.

(5) The oral examination of each applicant is conducted by members of the board and is scored as pass or fail.

(6) The board shall notify each applicant found eligible for examination of the time and place scheduled for that applicant's oral examination. Unless prior scheduling arrangements have been made with the board by the applicant, failure of an applicant to appear for examination as scheduled shall void that applicant's application and require the applicant to reapply for licensure.

(7) Any applicant who is a graduate of a school of podiatric medicine and surgery in which English is not the primary language of communication shall be examined by the board on his or her proficiency in the English language

(8) Otherwise qualified applicants with disabilities, as defined by the Americans with disabilities act, shall be provided with reasonable accommodations.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; **CR 17−030: am. (1) (a) (intro.), (2), (4) Register January 2018 No. 745 eff. 2−1−18**.

Pod 1.07 Failure and reexamination. An applicant who fails to achieve a passing grade in the examinations required under this chapter may apply for reexamination. An applicant who fails to achieve a passing grade in the examinations required under this chapter may be reexamined twice at not less than 4 month intervals. If the applicant fails to achieve a passing grade on the second reexamination, the applicant shall not be admitted to further examination until he or she reapplies for licensure and also presents to the board evidence of further professional training or education as the board may deem appropriate in each applicant's particular case.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00.

Pod 1.08 Temporary educational license. (1) An applicant who has been appointed to a postgraduate training program in a facility in this state approved by the board may apply to the board for a temporary educational license to practice podiatric medicine and surgery and shall submit to the board all of the following:

(a) A completed and verified application form provided by the board.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, or from the department of safety and professional services' website at http://dsps.wi.gov.

(b) The documentary evidence and credentials required under ss. Pod 1.04 and 1.06.

(c) The required fees under s. 440.05 (1), Stats.

(d) Evidence of successful completion of an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin.

(3) The holder of a temporary educational license to practice podiatric medicine and surgery may, under the direction of a person licensed to practice podiatric medicine and surgery in this state, perform services requisite to the training program in which that holder is serving. Acting under such direction, the holder of a temporary educational license shall also have the right to prescribe drugs other than controlled substances and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice podiatric medicine and surgery. The holder of a temporary educational license shall confine his or her entire practice to the facility in which he or she is taking the training.

(4) Violation by the holder of a temporary educational license to practice podiatric medicine and surgery of any of the provisions of chs. Pod 1 to 6 or of subch. IV of ch. 448, Stats., which apply to persons licensed to practice podiatric medicine and surgery, shall be cause for the revocation of the temporary educational license.

(5) Temporary educational licenses granted under this chapter shall expire 2 years from date of issuance.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; CR 12−047: am. (5) Register March 2014 No. 699, eff. 4−1−14; **CR 17−030: renum. (2) to (1) (d) and am. Register January 2018 No. 745 eff. 2−1−18; correction in (1) (b) made under s. 13.92 (4) (b) 7., Stats., Register January 2018 No. 745.**

Pod 1.09 Locum tenens license. (1) An applicant who holds a valid license to practice podiatric medicine and surgery issued by another licensing jurisdiction of the United States may apply to the board for a locum tenens license to practice podiatric medicine and surgery and shall submit to the board all of the following:

(a) A completed and verified application form provided by the board.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, or from the department of safety and professional services' website at http://dsps.wi.gov.

(b) A letter from a podiatrist licensed to practice podiatric medicine and surgery in this state requesting the applicant's services.

(c) A verified photostatic copy of a license to practice podiatric medicine and surgery issued by another licensing jurisdiction of the United States to the applicant.

(d) The required fees under s. 440.05 (1), Stats.

(e) Evidence of successful completion of an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin.

(3) The application and documentary evidence submitted by the applicant shall be reviewed by the board, acting through a designated member of the board and, upon the finding of the member that the applicant is qualified, the board, acting through the designated member, shall issue a locum tenens license to practice podiatric medicine and surgery to the applicant.

(4) The holder of a locum tenens license to practice podiatric medicine and surgery shall practice podiatric medicine and surgery as defined in s. 448.60 (4), Stats., providing the practice is confined to the geographical area for which the license is issued.

(5) A locum tenens license to practice podiatric medicine and surgery shall expire 90 days from the date of its issuance. For cause shown to its satisfaction, the board, acting through its designated member, may renew the locum tenens license for additional periods of 90 days each, but no license may be renewed more than 3 consecutive times.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; CR 06−056: am. (4) Register April 2007 No. 616, eff. 5−1−07; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register April 2007 No. 616; **CR 17−030: renum. (2) to (1) (e) and am. Register January 2018 No. 745 eff. 2−1−18**.

Pod 1.10 Temporary license. (1) (a) An applicant for a license to practice podiatric medicine and surgery who is a graduate of a school of podiatric medicine and surgery approved by the board may apply to the board for a temporary license to practice podiatric medicine and surgery. An applicant for a temporary license shall submit to the board the documentary evidence and credentials required under s. Pod 1.04, a completed application for a temporary license, and the required fees under s. 440.05 (1), Stats.

(b) The application and information submitted under par. (a), shall be reviewed by the board through a designated member. The board, acting through the designated member, shall issue a temporary license to practice podiatric medicine and surgery if the applications and information submitted under par. (a) are satisfactory.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, or from the department of safety and professional services' website at http://dsps.wi.gov.

(2) (a) A temporary license to practice podiatric medicine and surgery granted under this section expires on the earliest of the following dates:

1. Sixty days after the next examination for a license is given by the board if the temporary licensee submits to the examination.

2. The first day the board begins its examination of applicants for a license to practice podiatric medicine and surgery after the temporary license is issued, if the temporary licensee does not submit to the examination on that date.

3. The date following the examination on which the board grants or denies the temporary licensee a license to practice podiatric medicine and surgery.

(b) A license to practice podiatric medicine and surgery is deemed denied by the board under par. (a) 3., on the date the applicant is notified that he or she has failed the examination for a license to practice podiatric medicine and surgery.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00; **CR 17−030: am. (1) (a) Register January 2018 No. 745 eff. 2−1−18; correction in (1) (a) made under s. 13.92 (4) (b) 7., Stats., Register January 2018 No. 745.**

Pod 1.11 Examination review by applicant. (1) An applicant who fails the oral examination or statutes and rules examination may request a review of that examination by filing a written request and the required fee under s. 440.05 (1), Stats., with the board within 30 days of the date on which examination results were mailed.

(2) Examination reviews are by appointment only.

(3) An applicant shall review the statutes and rules examination for not more than one hour.

(4) An applicant shall review the oral examination for not more than 2 hours.

(5) An applicant shall not be accompanied during the review by any person other than the proctor.

(6) At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet or oral tape and a copy of the master answer sheet.

(7) An applicant shall review the examination in the presence of a proctor. The applicant shall be provided with a form on which to write comments, questions or claims of error regarding any items in the examination. Bound reference books shall be permitted. An applicant shall not remove any notes from the area. Notes shall be retained by the proctor and made available to the applicant for use at a hearing, if desired. The proctor shall not defend the examination or attempt to refute claims of error during the review.

(8) An applicant shall not review the examination more than once.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00.

Pod 1.12 Board review of examination error claim. (1) An applicant claiming examination error shall file a written request for board review in the board office within 30 days of the date the examination was reviewed. The request shall include all of the following:

(a) The applicant's name and address.

(b) The type of license for which the applicant applied.

(c) A description of the mistakes the applicant believes were made in the examination content, procedures, or scoring, including the specifics or procedures claimed to be in error.

(d) The facts which the applicant intends to prove, including reference text citations or other supporting evidence for the applicant's claim.

(2) The board shall review the claim, make a determination of the validity of the objections and notify the applicant in writing of the board's decision and any resulting grade changes.

(3) If the board confirms the failing status following its review, the application shall be deemed incomplete and the board shall issue a notice of denial.

History: Cr. Register, January, 2000, No. 529, eff. 2−1−00.