FIRST REGULAR SESSION

SENATE BILL NO. 79

102ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHROER.

0644S.01I KRISTINA MARTIN, Secretary

AN ACT

To repeal sections 190.098, 190.600, 190.603, 190.606, 190.609, 190.612, 190.615, 191.940, 191.1145, 191.1146, 193.015, 195.070, 195.100, 208.152, 334.037, 334.104, 334.108, 334.735, 334.810, 335.016, 335.019, 335.036, 335.046, 335.051, 335.056, 335.076, 335.086, 335.175, 338.198, 630.175, and 630.875, RSMo, and to enact in lieu thereof thirty-two new sections relating to nurses.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 190.098, 190.600, 190.603, 190.606, 190.609, 190.612, 190.615, 191.940, 191.1145, 191.1146, 193.015, 195.070, 195.100, 208.152, 334.037, 334.104, 334.108, 334.735, 334.810, 335.016, 335.019, 335.036, 335.046, 335.051, 335.056, 335.076, 335.086, 335.175, 338.198, 630.175, and 630.875, RSMo, are repealed and thirty-two new sections enacted in lieu thereof, to be known as sections 190.098, 190.600, 190.603, 190.606, 190.609, 190.612, 190.615, 191.940, 191.1145, 191.1146, 193.015, 195.070, 195.100, 208.152, 334.037, 334.104, 334.108, 334.735, 334.810, 335.016, 335.019, 335.036, 335.046, 335.049, 335.051, 335.056, 335.076, 335.086, 335.175, 338.198, 630.175, and 630.875, to read as follows:

190.098. 1. In order for a person to be eligible for certification by the department as a community paramedic, an individual shall:

(1) Be currently certified as a paramedic;

(2) Successfully complete or have successfully completed a community paramedic certification program from a

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

college, university, or educational institution that has been approved by the department or accredited by a national accreditation organization approved by the department; and

(3) Complete an application form approved by the department.

2. A community paramedic shall practice in accordance with protocols and supervisory standards established by the medical director. A community paramedic shall provide services of a health care plan if the plan has been developed by the patient's physician **[**or**]**, by **[**an**]the patient's** advanced practice registered nurse **[**through a collaborative practice arrangement with a physician**]**, or **by** a physician assistant through a collaborative practice arrangement with a physician and there is no duplication of services to the patient from another provider.

3. Any ambulance service shall enter into a written contract to provide community paramedic services in another ambulance service area, as that term is defined in section 190.100. The contract that is agreed upon may be for an indefinite period of time, as long as it includes at least a sixty-day cancellation notice by either ambulance service.

4. A community paramedic is subject to the provisions of sections 190.001 to 190.245 and rules promulgated under sections 190.001 to 190.245.

5. No person shall hold himself or herself out as a community paramedic or provide the services of a community paramedic unless such person is certified by the department.

6. The medical director shall approve the implementation of the community paramedic program.

7. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective

only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

190.600. 1. Sections 190.600 to 190.621 shall be known and may be cited as the "Outside the Hospital Do-Not-Resuscitate Act".

2. As used in sections 190.600 to 190.621, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Attending physician **or advanced practice registered nurse**":

(a) A physician licensed under chapter 334 **or advanced practice registered nurse, as defined in section 335.016,** selected by or assigned to a patient who has primary responsibility for treatment and care of the patient; or

(b) If more than one physician **or advanced practice registered nurse** shares responsibility for the treatment and care of a patient, one such physician **or advanced practice registered nurse** who has been designated the attending physician **or advanced practice registered nurse** by the patient or the patient's representative shall serve as the attending physician **or advanced practice registered nurse**;

(2) "Cardiopulmonary resuscitation" or "CPR", emergency medical treatment administered to a patient in the event of the patient's cardiac or respiratory arrest, and shall include cardiac compression, endotracheal intubation

and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures;

(3) "Department", the department of health and senior services;

(4) "Emergency medical services personnel", paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the ordinary course and scope of their professions, but excluding physicians **and advanced practice registered nurses**;

(5) "Health care facility", any institution, building, or agency or portion thereof, private or public, excluding federal facilities and hospitals, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. Health care facility includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, infirmaries, renal dialysis centers, long-term care facilities licensed under sections 198.003 to 198.186, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, and residential treatment facilities;

(6) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not less than twenty-four consecutive hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four consecutive hours

in any week medical or nursing care for three or more nonrelated individuals. Hospital does not include any long-term care facility licensed under sections 198.003 to 198.186;

(7) "Outside the hospital do-not-resuscitate identification" or "outside the hospital DNR identification", a standardized identification card, bracelet, or necklace of a single color, form, and design as described by rule of the department that signifies that the patient's attending physician **or advanced practice registered nurse** has issued an outside the hospital do-not-resuscitate order for the patient and has documented the grounds for the order in the patient's medical file;

(8) "Outside the hospital do-not-resuscitate order" or "outside the hospital DNR order", a written physician's **or advanced practice registered nurse's** order signed by the patient and the attending physician **or advanced practice registered nurse**, or the patient's representative and the attending physician **or advanced practice registered nurse**, in a form promulgated by rule of the department which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest;

(9) "Outside the hospital do-not-resuscitate protocol" or "outside the hospital DNR protocol", a standardized method or procedure promulgated by rule of the department for the withholding or withdrawal of cardiopulmonary resuscitation by emergency medical services personnel from a patient in the event of cardiac or respiratory arrest;

(10) "Patient", a person eighteen years of age or older who is not incapacitated, as defined in section 475.010, and who is otherwise competent to give informed

consent to an outside the hospital do-not-resuscitate order at the time such order is issued, and who, with his or her attending physician **or advanced practice registered nurse**, has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621. A person who has a patient's representative shall also be a patient for the purposes of sections 190.600 to 190.621, if the person or the person's patient's representative has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621;

(11) "Patient's representative":

(a) An attorney in fact designated in a durable power of attorney for health care for a patient determined to be incapacitated under sections 404.800 to 404.872; or

(b) A guardian or limited guardian appointed under chapter 475 to have responsibility for an incapacitated patient.

190.603. 1. A patient or patient's representative and the patient's attending physician **or advanced practice registered nurse** may execute an outside the hospital do-not-resuscitate order. An outside the hospital do-not-resuscitate order shall not be effective unless it is executed by the patient or patient's representative and the patient's attending physician **or advanced practice registered nurse**, and it is in the form promulgated by rule of the department.

2. If an outside the hospital do-not-resuscitate order has been executed, it shall be maintained as the first page of a patient's medical record in a health care facility unless otherwise specified in the health care facility's policies and procedures.

3. An outside the hospital do-not-resuscitate order shall be transferred with the patient when the patient is transferred from one health care facility to another health care facility. If the patient is transferred outside of a hospital, the outside the hospital DNR form shall be provided to any other facility, person, or agency responsible for the medical care of the patient or to the patient or patient's representative.

190.606. The following persons and entities shall not be subject to civil, criminal, or administrative liability and are not guilty of unprofessional conduct for the following acts or omissions that follow discovery of an outside the hospital do-not-resuscitate identification upon a patient, or upon being presented with an outside the hospital do-not-resuscitate order from Missouri, another state, the District of Columbia, or a territory of the United States; provided that the acts or omissions are done in good faith and in accordance with the provisions of sections 190.600 to 190.621 and the provisions of an outside the hospital do-not-resuscitate order executed under sections 190.600 to 190.621:

(1) Physicians, persons under the direction or authorization of a physician, **advanced practice registered nurses**, emergency medical services personnel, or health care facilities that cause or participate in the withholding or withdrawal of cardiopulmonary resuscitation from such patient; and

(2) Physicians, persons under the direction or authorization of a physician, **advanced practice registered nurses**, emergency medical services personnel, or health care facilities that provide cardiopulmonary resuscitation to

such patient under an oral or written request communicated to them by the patient or the patient's representative.

190.609. 1. An outside the hospital do-not-resuscitate order shall only be effective when the patient has not been admitted to or is not being treated within a hospital.

2. An outside the hospital do-not-resuscitate order and the outside the hospital do-not-resuscitate protocol shall not authorize the withholding or withdrawing of other medical interventions, such as intravenous fluids, oxygen, or therapies other than cardiopulmonary resuscitation. Outside the hospital do-not-resuscitate orders and the outside the hospital do-not-resuscitate protocol shall not authorize the withholding or withdrawing of therapies deemed necessary to provide comfort care or alleviate pain. Any authorization for withholding or withdrawing interventions or therapies that is inconsistent with sections 190.600 to 190.621 and is found or included in any outside the hospital do-not-resuscitate order or in the outside the hospital do-not-resuscitate protocol shall be null, void, and of no effect. Nothing in this section shall prejudice any other lawful directives concerning such medical interventions and therapies.

3. An outside the hospital do-not-resuscitate order shall not be effective during such time as the patient is pregnant; provided, however, that physicians, persons under the direction or authorization of a physician, **advanced practice registered nurses**, emergency medical services personnel, and health care facilities shall not be subject to civil, criminal, or administrative liability and are not guilty of unprofessional conduct if, while acting in accordance with the provisions of sections 190.600 to

190.621 and the provisions of an outside the hospital do-not-resuscitate order executed under sections 190.600 to 190.621, such persons and entities:

(1) Comply with an outside the hospital do-not-resuscitate order and withdraw or withhold cardiopulmonary resuscitation from a pregnant patient while believing in good faith that the patient is not pregnant; or

(2) Despite the presence of an outside the hospital do-not-resuscitate order, provide cardiopulmonary resuscitation to a nonpregnant patient while believing in good faith that the patient is pregnant.

190.612. 1. Emergency medical services personnel are authorized to comply with the outside the hospital do-not-resuscitate protocol when presented with an outside the hospital do-not-resuscitate identification or an outside the hospital do-not-resuscitate order. However, emergency medical services personnel shall not comply with an outside the hospital do-not-resuscitate order or the outside the hospital do-not-resuscitate protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated.

2. Emergency medical services personnel are authorized to comply with the outside the hospital do-not-resuscitate protocol when presented with an outside the hospital do-not-resuscitate order from another state, the District of Columbia, or a territory of the United States if such order is on a standardized written form:

(1) Signed by the patient or the patient's representative and a physician **or advanced practice registered nurse** who is licensed to practice in the other

state, the District of Columbia, or the territory of the United States; and

(2) Such form has been previously reviewed and approved by the department of health and senior services to authorize emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of a cardiac or respiratory arrest.

Emergency medical services personnel shall not comply with an outside the hospital do-not-resuscitate order from another state, the District of Columbia, or a territory of the United States or the outside the hospital do-not-resuscitate protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated.

3. If a physician, **advanced practice registered nurse**, or a health care facility other than a hospital admits or receives a patient with an outside the hospital do-not-resuscitate identification or an outside the hospital do-not-resuscitate order, and the patient or patient's representative has not expressed or does not express to the physician, **advanced practice registered nurse**, or health care facility the desire to be resuscitated, and the physician, **advanced practice registered nurse**, or health care facility is unwilling or unable to comply with the outside the hospital do-not-resuscitate order, the physician, **advanced practice registered nurse**, or health care facility shall take all reasonable steps to transfer the patient to another physician, **advanced practice registered nurse**, or health care facility where the outside the hospital do-not-resuscitate order will be complied with.

190.615. 1. A patient's death resulting from the withholding or withdrawal in good faith of cardiopulmonary resuscitation under an outside the hospital do-not-resuscitate order is not, for any purpose, a suicide or homicide.

2. The possession of an outside the hospital do-not-resuscitate identification or execution of an outside the hospital do-not-resuscitate order does not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor does it modify the terms of an existing policy of life insurance. Notwithstanding any term of a policy to the contrary, a policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawal of cardiopulmonary resuscitation from an insured patient possessing an outside the hospital do-not-resuscitate identification or outside the hospital do-not-resuscitate order.

3. A physician, **advanced practice registered nurse**, health care facility, or other health care provider or a health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not require a patient to possess an outside the hospital do-not-resuscitate identification or execute an **[**out of**]outside the** hospital do-not-resuscitate order as a condition for being insured for or receiving health care services.

4. Sections 190.600 to 190.621 do not prejudice any right that a patient has to effect the obtaining, withholding, or withdrawal of medical care in any lawful manner apart from sections 190.600 to 190.621. In that respect, the rights of patients authorized under sections 190.600 to 190.621 are cumulative.

5. The provisions of sections 190.600 to 190.621 shall not be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to shorten or end life.

191.940. 1. This section shall be known and may be cited as the "Postpartum Depression Care Act".

2. As used in this section, the following terms shall mean:

(1) "Ambulatory surgical center", the same meaning as defined in section 197.200;

(2) "Health care provider", a physician licensed under chapter 334, an assistant physician or physician assistant licensed under chapter 334 and in a collaborative practice arrangement with a collaborating physician, and an advanced practice registered nurse licensed under chapter 335 **[**and in a collaborative practice arrangement with a collaborating physician**]**;

(3) "Hospital", the same meaning as defined in section 197.020;

(4) "Postnatal care", an office visit to a licensed health care provider occurring after pregnancy for the infant or birth mother;

(5) "Questionnaire", an assessment tool designed to detect the symptoms of postpartum depression or related mental health disorders, such as the Edinburgh Postnatal Depression Scale, the Postpartum Depression Screening Scale, the Beck Depression Inventory, the Patient Health Questionnaire, or other validated assessment methods.

3. All hospitals and ambulatory surgical centers that provide labor and delivery services shall, prior to discharge following pregnancy, provide pregnant women and, if possible, fathers and other family members with complete

information about postpartum depression, including its symptoms, methods of treatment, and available resources. The department of health and senior services, in cooperation with the department of mental health, shall provide written information that hospitals and ambulatory surgical centers may use and shall include such information on its website.

4. It is the intent of the general assembly to encourage health care providers providing postnatal care to women and pediatric care to infants to invite women to complete a questionnaire designed to detect the symptoms of postpartum depression and to review the completed questionnaire in accordance with the formal opinions and recommendations of the American College of Obstetricians and Gynecologists to ensure the health, well-being, and safety of the woman and the infant.

191.1145. 1. As used in sections 191.1145 and 191.1146, the following terms shall mean:

(1) "Asynchronous store-and-forward transfer", the collection of a patient's relevant health information and the subsequent transmission of that information from an originating site to a health care provider at a distant site without the patient being present;

(2) "Clinical staff", any health care provider licensed in this state;

(3) "Distant site", a site at which a health care provider is located while providing health care services by means of telemedicine;

(4) "Health care provider", as that term is defined in section 376.1350;

(5) "Originating site", a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine. For the purposes of

asynchronous store-and-forward transfer, originating site shall also mean the location at which the health care provider transfers information to the distant site;

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

2. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person. This section shall not be construed to prohibit a health carrier, as defined in section 376.1350, from reimbursing nonclinical staff for services otherwise allowed by law.

3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

4. Nothing in subsection 3 of this section shall apply to:

(1) Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or

(3) Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician **or advanced practice registered nurse** in this state.

5. Nothing in this section shall be construed to alter the scope of practice of any health care provider or to authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient.

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335.

191.1146. 1. Physicians licensed under chapter 334 **and advanced practice registered nurses, as defined in section 335.016,** who use telemedicine shall ensure that a properly established **[**physician-patient**]provider-patient** relationship exists with the person who receives the

telemedicine services. The **[**physician-patient**]provider-patient** relationship may be established by:

(1) An in-person encounter through a medical interview and physical examination;

(2) Consultation with another physician **or advanced practice registered nurse**, or that physician's **or advanced practice registered nurse's** delegate, who has an established relationship with the patient and an agreement with the physician **or advanced practice registered nurse** to participate in the patient's care; or

(3) A telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

2. In order to establish a **[**physician-patient**]provider-patient** relationship through telemedicine:

(1) The technology utilized shall be sufficient to establish an informed diagnosis as though the medical interview and physical examination has been performed in person; and

(2) Prior to providing treatment, including issuing prescriptions or physician certifications under Article XIV of the Missouri Constitution, a physician **or advanced practice registered nurse** who uses telemedicine shall interview the patient, collect or review relevant medical history, and perform an examination sufficient for the diagnosis and treatment of the patient. A questionnaire completed by the patient, whether via the internet or telephone, does not constitute an acceptable medical interview and examination for the provision of treatment by telehealth.

193.015. As used in sections 193.005 to 193.325, unless the context clearly indicates otherwise, the following terms shall mean:

(1) "Advanced practice registered nurse", a person **who is** licensed **[**to practice as an advanced practice registered nurse under chapter 335, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334**]under the provisions of chapter 335 to engage in the practice of advanced practice nursing**;

(2) "Assistant physician", as such term is defined in section 334.036, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(3) "Dead body", a human body or such parts of such human body from the condition of which it reasonably may be concluded that death recently occurred;

(4) "Department", the department of health and senior services;

(5) "Final disposition", the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus;

(6) "Institution", any establishment, public or private, which provides inpatient or outpatient medical, surgical, or diagnostic care or treatment or nursing, custodian, or domiciliary care, or to which persons are committed by law;

(7) "Live birth", the complete expulsion or extraction from its mother of a child, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other evidence of life such as beating

of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

(8) "Physician", a person authorized or licensed to practice medicine or osteopathy pursuant to chapter 334;

(9) "Physician assistant", a person licensed to practice as a physician assistant pursuant to chapter 334, and who has been delegated tasks outlined in section 193.145 by a physician with whom they have entered into a collaborative practice arrangement under chapter 334;

(10) "Spontaneous fetal death", a noninduced death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles;

(11) "State registrar", state registrar of vital statistics of the state of Missouri;

(12) "System of vital statistics", the registration, collection, preservation, amendment and certification of vital records; the collection of other reports required by sections 193.005 to 193.325 and section 194.060; and activities related thereto including the tabulation, analysis and publication of vital statistics;

(13) "Vital records", certificates or reports of birth, death, marriage, dissolution of marriage and data related thereto;

(14) "Vital statistics", the data derived from certificates and reports of birth, death, spontaneous fetal death, marriage, dissolution of marriage and related reports.

195.070. 1. A physician, podiatrist, dentist, a registered optometrist certified to administer pharmaceutical agents as provided in section 336.220, or an assistant physician in accordance with section 334.037 or a physician assistant in accordance with section 334.747 in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances or he or she may cause the same to be administered or dispensed by an individual as authorized by statute.

2. An advanced practice registered nurse, as defined in section 335.016, but not a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds a certificate of controlled substance prescriptive authority from the board of nursing under section 335.019 **[**and who is delegated the authority to prescribe controlled substances under a collaborative practice arrangement under section 334.104**]** may prescribe any controlled substances listed in Schedules **[**III, IV, and**]II to** V of section 195.017**[**, and may have restricted authority in Schedule II. Prescriptions for Schedule II medications prescribed by an advanced practice registered nurse who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. However, no such certified advanced practice registered nurse shall prescribe controlled substance for his or her own self or family. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill**]**.

3. A veterinarian, in good faith and in the course of the veterinarian's professional practice only, and not for

use by a human being, may prescribe, administer, and dispense controlled substances and the veterinarian may cause them to be administered by an assistant or orderly under his or her direction and supervision.

4. A practitioner shall not accept any portion of a controlled substance unused by a patient, for any reason, if such practitioner did not originally dispense the drug, except:

(1) When the controlled substance is delivered to the practitioner to administer to the patient for whom the medication is prescribed as authorized by federal law. Practitioners shall maintain records and secure the medication as required by this chapter and regulations promulgated pursuant to this chapter; or

(2) As provided in section 195.265.

5. An individual practitioner shall not prescribe or dispense a controlled substance for such practitioner's personal use except in a medical emergency.

195.100. 1. It shall be unlawful to distribute any controlled substance in a commercial container unless such container bears a label containing an identifying symbol for such substance in accordance with federal laws.

2. It shall be unlawful for any manufacturer of any controlled substance to distribute such substance unless the labeling thereof conforms to the requirements of federal law and contains the identifying symbol required in subsection 1 of this section.

3. The label of a controlled substance in Schedule II, III or IV shall, when dispensed to or for a patient, contain a clear, concise warning that it is a criminal offense to transfer such narcotic or dangerous drug to any person other than the patient.

4. Whenever a manufacturer sells or dispenses a controlled substance and whenever a wholesaler sells or dispenses a controlled substance in a package prepared by him or her, the manufacturer or wholesaler shall securely affix to each package in which that drug is contained a label showing in legible English the name and address of the vendor and the quantity, kind, and form of controlled substance contained therein. No person except a pharmacist for the purpose of filling a prescription under this chapter, shall alter, deface, or remove any label so affixed.

5. Whenever a pharmacist or practitioner sells or dispenses any controlled substance on a prescription issued by a physician, physician assistant, dentist, podiatrist, veterinarian, or advanced practice registered nurse, the pharmacist or practitioner shall affix to the container in which such drug is sold or dispensed a label showing his or her own name and address of the pharmacy or practitioner for whom he or she is lawfully acting; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the physician, physician assistant, dentist, podiatrist, advanced practice registered nurse, or veterinarian by whom the prescription was written; the name of the collaborating physician if the prescription is written by **[**an advanced practice registered nurse or**]** a physician assistant, and such directions as may be stated on the prescription. No person shall alter, deface, or remove any label so affixed.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the

services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for

mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section **[**301**]1396**, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his **or her** plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he **or she** is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(9) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(10) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 **(42 U.S.C. Sections 1396a and 1396d), as amended**, and federal regulations promulgated thereunder;

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions or any abortifacient

drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(14) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her **[**physician**]provider** on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a **[**physician**]provider** in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who

would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a **[**physician**]provider**, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a **[**physician**]provider**, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal **[**physician**]provider**. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as

to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section **[**301**]1396, et seq.**, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the

auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse **[**with a collaborative practice agreement**]** to the extent that such services are provided in accordance with **[**chapters 334 and**]chapter** 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that

patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating **[**physician**]provider**;

(25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and

compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical,

psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective

date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to

provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and

intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

334.037. 1. A physician may enter into collaborative practice arrangements with assistant physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to an assistant physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the assistant physician and is consistent with that assistant physician's skill, training, and competence and the skill and training of the collaborating physician.

2. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the assistant physician;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the assistant physician to prescribe;

(3) A requirement that there shall be posted at every office where the assistant physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an assistant physician and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the assistant physician;

(5) The manner of collaboration between the collaborating physician and the assistant physician, including how the collaborating physician and the assistant physician shall:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by Pub. L. 95-210 (42 U.S.C. Section 1395x), as amended, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the assistant physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled

substances the physician authorizes the assistant physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice **[**agreements**]arrangements** of the collaborating physician and the assistant physician;

(8) The duration of the written practice **[**agreement**]arrangement** between the collaborating physician and the assistant physician;

(9) A description of the time and manner of the collaborating physician's review of the assistant physician's delivery of health care services. The description shall include provisions that the assistant physician shall submit a minimum of ten percent of the charts documenting the assistant physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the assistant physician prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

3. The state board of registration for the healing arts under section 334.125 shall promulgate rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules shall specify:

(1) Geographic areas to be covered;

(2) The methods of treatment that may be covered by collaborative practice arrangements;

(3) In conjunction with deans of medical schools and primary care residency program directors in the state, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the assistant physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; and

(4) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances.

Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. The state board of registration for the healing arts shall promulgate rules applicable to assistant physicians that shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined in chapter 197 or population-

based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

4. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to an assistant physician provided the provisions of this section and the rules promulgated thereunder are satisfied.

5. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each assistant physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

6. A collaborating physician shall not enter into a collaborative practice arrangement with more than six full-time equivalent assistant physicians**[**,**]or** full-time equivalent physician assistants**[**, or full-time equivalent advance practice registered nurses**]**, or any combination thereof. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008**[**, or to a certified registered nurse anesthetist providing anesthesia services under the

supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104**]**.

7. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the assistant physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. No rule or regulation shall require the collaborating physician to review more than ten percent of the assistant physician's patient charts or records during such one-month period. Such limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

8. No **[**agreement**]arrangement** made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

9. No contract or other **[**agreement**]arrangement** shall require a physician to act as a collaborating physician for an assistant physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No contract or other **[**agreement**]arrangement** shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's

authority to any assistant physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

10. No contract or other **[**agreement**]arrangement** shall require any assistant physician to serve as a collaborating assistant physician for any collaborating physician against the assistant physician's will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

11. All collaborating physicians and assistant physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and assistant physicians.

12. (1) An assistant physician with a certificate of controlled substance prescriptive authority as provided in this section may prescribe any controlled substance listed in Schedule III, IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for Schedule II medications prescribed by an assistant physician who has a certificate of controlled substance prescriptive authority are restricted to only those medications containing hydrocodone. Such authority shall be filed with the state board of registration for the healing arts. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe. Any

limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician. Assistant physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

(2) The collaborating physician shall be responsible to determine and document the completion of at least one hundred twenty hours in a four-month period by the assistant physician during which the assistant physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to assistant physicians of population-based public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009, or assistant physicians providing opioid addiction treatment.

(3) An assistant physician shall receive a certificate of controlled substance prescriptive authority from the state board of registration for the healing arts upon verification of licensure under section 334.036.

13. Nothing in this section or section 334.036 shall be construed to limit the authority of hospitals or hospital medical staff to make employment or medical staff credentialing or privileging decisions.

334.104. 1. A physician may enter into collaborative practice arrangements with registered professional nurses. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements**[**, which shall be in writing,**]** may delegate to a registered professional nurse **who is not an advanced practice registered nurse, as defined in section 335.016,** the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the registered professional nurse and is consistent with that nurse's skill, training and competence.

2. **[**Collaborative practice arrangements, which shall be in writing, may delegate to a registered professional nurse the authority to administer, dispense or prescribe drugs and provide treatment if the registered professional nurse is an advanced practice registered nurse as defined in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an advanced practice registered nurse, as defined in section 335.016, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general

anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services. An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.

3. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the advanced practice registered nurse;

(2) A list of all other offices or locations besides those listed in subdivision (1) of this subsection where the collaborating physician authorized the advanced practice registered nurse to prescribe;

(3) A requirement that there shall be posted at every office where the advanced practice registered nurse is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by an advanced practice registered nurse and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the advanced practice registered nurse;

(5) The manner of collaboration between the collaborating physician and the advanced practice registered nurse, including how the collaborating physician and the advanced practice registered nurse will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, except the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of this subdivision. This exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics where the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics where the main location of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician is required to maintain documentation related to this requirement and to present it to the state board of registration for the healing arts when requested; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(6) A description of the advanced practice registered nurse's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the nurse to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(7) A list of all other written practice agreements of the collaborating physician and the advanced practice registered nurse;

(8) The duration of the written practice agreement between the collaborating physician and the advanced practice registered nurse;

(9) A description of the time and manner of the collaborating physician's review of the advanced practice registered nurse's delivery of health care services. The description shall include provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the charts documenting the advanced practice registered nurse's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days; and

(10) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the advanced practice registered nurse prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of this subsection.

4. The state board of registration for the healing arts pursuant to section 334.125 and the board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be covered, the methods of treatment that may be covered by collaborative practice arrangements and the requirements for review of services provided pursuant to collaborative

practice arrangements including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the department of health and senior services and the state board of pharmacy. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of nursing may separately promulgate rules relating to collaborative practice arrangements. Such jointly promulgated rules shall be consistent with guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not extend to collaborative practice arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

5. The state board of registration for the healing arts shall not deny, revoke, suspend or otherwise take disciplinary action against a physician for health care services delegated to a registered professional nurse provided the provisions of this section and the rules promulgated thereunder are satisfied.**]** Upon the written request of a physician subject to a disciplinary action imposed as a result of an agreement between a physician and a registered professional nurse or registered physician assistant, whether written or not, prior to August 28, 1993,

all records of such disciplinary licensure action and all records pertaining to the filing, investigation or review of an alleged violation of this chapter incurred as a result of such an agreement shall be removed from the records of the state board of registration for the healing arts and the division of professional registration and shall not be disclosed to any public or private entity seeking such information from the board or the division. The state board of registration for the healing arts shall take action to correct reports of alleged violations and disciplinary actions as described in this section which have been submitted to the National Practitioner Data Bank. In subsequent applications or representations relating to his **or her** medical practice, a physician completing forms or documents shall not be required to report any actions of the state board of registration for the healing arts for which the records are subject to removal under this section.

[6.**]3.** Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice **[**agreement**]arrangement,** including collaborative practice **[**agreements**]arrangements** delegating the authority to prescribe controlled substances, or physician assistant **[**agreement**]collaborative practice arrangement** and also report to the board the name of each licensed professional with whom the physician has entered into such **[**agreement**]arrangement**. The board **[**may**]shall** make this information available to the public. The board shall track the reported information and may routinely conduct random reviews of such **[**agreements**]arrangements** to ensure that

[agreements**]arrangements** are carried out for compliance under this chapter.

[7. Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed. Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative practice arrangement under this section, except that the collaborative practice arrangement may not delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of section 195.017, or Schedule II - hydrocodone.

8. A collaborating physician shall not enter into a collaborative practice arrangement with more than six full-time equivalent advanced practice registered nurses, full-time equivalent licensed physician assistants, or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of this section.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the advanced practice registered nurse shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

10. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

11.**]4.** No contract or other **[**agreement**]arrangement** shall require a physician to act as a collaborating physician for **[**an advanced practice**]a** registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular **[**advanced practice**]** registered nurse. **[**No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12.**]5.** No contract or other **[**agreement**]arrangement** shall require any **[**advanced practice**]** registered nurse to serve as a collaborating **[**advanced practice**]** registered nurse for any collaborating physician against the **[**advanced practice**]** registered nurse's will. **[**An advanced practice**]A** registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician. **Any refusal to collaborate shall not violate applicable standards for the provision of safe practice and patient care.**

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, or the internet, a physician **or advanced practice registered nurse** shall establish a valid **[**physician-patient**]provider-patient** relationship as described in section 191.1146. This relationship shall include:

(1) Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

(5) Maintaining the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice **[**agreement**]arrangement** as **[**defined**]described** in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) Conjunction with an assistant physician licensed under section 334.036;

(7) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(8) On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician or such physician's on-call designee, **[**or**]** an advanced practice registered nurse, **or** a physician assistant**[**,**]** or an assistant physician in a collaborative practice arrangement with **[**such**]a** physician, may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing

[physician-patient**]patient** relationship exists between such **[**physician**]health care provider** and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

334.735. 1. As used in sections 334.735 to 334.749, the following terms mean:

(1) "Applicant", any individual who seeks to become licensed as a physician assistant;

(2) "Certification" or "registration", a process by a certifying entity that grants recognition to applicants meeting predetermined qualifications specified by such certifying entity;

(3) "Certifying entity", the nongovernmental agency or association which certifies or registers individuals who have completed academic and training requirements;

(4) "Collaborative practice arrangement", written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of health care services;

(5) "Department", the department of commerce and insurance or a designated agency thereof;

(6) "License", a document issued to an applicant by the board acknowledging that the applicant is entitled to practice as a physician assistant;

(7) "Physician assistant", a person who has graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor agency, prior to 2001, or the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied

Health Education Programs, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

(8) "Recognition", the formal process of becoming a certifying entity as required by the provisions of sections 334.735 to 334.749.

2. The scope of practice of a physician assistant shall consist only of the following services and procedures:

(1) Taking patient histories;

(2) Performing physical examinations of a patient;

(3) Performing or assisting in the performance of routine office laboratory and patient screening procedures;

(4) Performing routine therapeutic procedures;

(5) Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;

(6) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a collaborating physician;

(7) Assisting the supervising physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological services, and ordering of therapies, using procedures reviewed and approved by a licensed physician;

(8) Assisting in surgery; and

(9) Performing such other tasks not prohibited by law under the collaborative practice arrangement with a licensed physician as the physician assistant has been trained and is proficient to perform.

3. Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe any drug, medicine, device or therapy unless pursuant to a collaborative practice arrangement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a collaborative practice arrangement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

(1) A physician assistant shall only prescribe controlled substances in accordance with section 334.747;

(2) The types of drugs, medications, devices or therapies prescribed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the collaborating physician;

(3) All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the supervising physician;

(4) A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request,

receive and sign for noncontrolled professional samples and may distribute professional samples to patients; and

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the collaborating physician is not qualified or authorized to prescribe.

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician collaboration or in any location where the collaborating physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a patient independently or directly for any services or procedure by the physician assistant; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with a third-party plan or the department of social services as a MO HealthNet or Medicaid provider while acting under a collaborative practice arrangement between the physician and physician assistant.

6. The licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, collaboration, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing

may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

7. At all times the physician is responsible for the oversight of the activities of, and accepts responsibility for, health care services rendered by the physician assistant.

8. A physician may enter into collaborative practice arrangements with physician assistants. Collaborative practice arrangements, which shall be in writing, may delegate to a physician assistant the authority to prescribe, administer, or dispense drugs and provide treatment which is within the skill, training, and competence of the physician assistant. Collaborative practice arrangements may delegate to a physician assistant, as defined in section 334.735, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone. Schedule III narcotic controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of a written arrangement, jointly agreed-upon protocols, or standing orders for the delivery of health care services.

9. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the physician assistant;

(2) A list of all other offices or locations, other than those listed in subdivision (1) of this subsection, where the collaborating physician has authorized the physician assistant to prescribe;

(3) A requirement that there shall be posted at every office where the physician assistant is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by a physician assistant and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the physician assistant;

(5) The manner of collaboration between the collaborating physician and the physician assistant, including how the collaborating physician and the physician assistant will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(b) Maintain geographic proximity, as determined by the board of registration for the healing arts; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency of the collaborating physician;

(6) A list of all other written collaborative practice arrangements of the collaborating physician and the physician assistant;

(7) The duration of the written practice arrangement between the collaborating physician and the physician assistant;

(8) A description of the time and manner of the collaborating physician's review of the physician assistant's delivery of health care services. The description shall include provisions that the physician assistant shall submit a minimum of ten percent of the charts documenting the physician assistant's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days. Reviews may be conducted electronically;

(9) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the physician assistant prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (8) of this subsection; and

(10) A statement that no collaboration requirements in addition to the federal law shall be required for a physician-physician assistant team working in a certified community behavioral health clinic as defined by Pub.L. 113-93, or a rural health clinic under the federal Rural Health Services Act, Pub.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section **[**1395 of the Public Health Service Act**]1395x**, as amended.

10. The state board of registration for the healing arts under section 334.125 may promulgate rules regulating the use of collaborative practice arrangements.

11. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a physician assistant, provided that the provisions of this section and the rules promulgated thereunder are satisfied.

12. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each physician assistant with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that the arrangements are carried out in compliance with this chapter.

13. The collaborating physician shall determine and document the completion of a period of time during which the physician assistant shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2009.

14. No contract or other arrangement shall require a physician to act as a collaborating physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other **[**agreement**]arrangement** shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant. No contract or other arrangement shall require any physician assistant to collaborate with any physician against the physician assistant's will. A physician assistant shall have the right to refuse to collaborate, without penalty, with a particular physician.

15. Physician assistants shall file with the board a copy of their collaborating physician form.

16. No physician shall be designated to serve as a collaborating physician for more than six full-time equivalent licensed physician assistants**[**, full-time equivalent advanced practice registered nurses,**]** or full-time equivalent assistant physicians, or any combination thereof. This limitation shall not apply to physician assistant collaborative practice arrangements of hospital employees providing inpatient care service in hospitals as defined in chapter 197**[**, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of section 334.104**]**.

17. No arrangement made under this section shall supercede current hospital licensing regulations governing

hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital, as defined in section 197.020, if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

334.810. 1. The "practice of respiratory care" includes, but is not limited to:

(1) The administration of pharmacologic, diagnostic and therapeutic agents related to respiratory care to implement a disease prevention, diagnostic, treatment or pulmonary rehabilitative regimen prescribed by a physician **or advanced practice registered nurse** or by clinical protocols pertaining to the practice of respiratory care;

(2) Observing, examining, monitoring, assessment and evaluation of signs, symptoms and general physical response to respiratory care procedures, including whether such are abnormal, and implementation of changes in procedures based on observed abnormalities, appropriate clinical protocols or pursuant to a prescription by a physician licensed under chapter 334**[**,**]** or **[**a person acting under a collaborative practice agreement as authorized by section 334.104**]by an advanced practice registered nurse, as defined in section 335.016**; or

(3) The initiation of emergency procedures under the regulations of the board or as otherwise permitted in sections 334.800 to 334.930.

2. The practice of respiratory care is not limited to the hospital setting but shall always be performed under the prescription, order or protocol of a licensed physician **or advanced practice registered nurse** and includes the diagnostic and therapeutic use of the following:

(1) Administration of medical gases, except for the purpose of anesthesia;

(2) Administration of pharmacologic agents related to, or in conjunction with, respiratory care procedures;

(3) Aerosolized medications and humidification;

(4) Arterial blood gas puncture or sample collection;

(5) Bronchopulmonary hygiene;

(6) Cardiopulmonary resuscitation;

(7) Environmental control mechanisms and therapy;

(8) Initiation, monitoring, modification of ventilator controls, and discontinuance or withdrawal of continuous mechanical ventilation;

(9) Intubation/extubation of endotracheal tubes, tracheostomy tubes and transtracheal catheters;

(10) Insertion of artificial airways and the maintenance of natural and artificial airways;

(11) Mechanical or physiological ventilatory support;

(12) Point-of-care diagnostic testing;

(13) Specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment and research of pulmonary abnormalities, including measurement of ventilatory volumes, pressures, flows, collection of specimens of blood and mucus, measurement and reporting of blood gases, expired and inspired gas samples and pulmonary function testing;

(14) Diagnostic monitoring or therapeutic intervention for oxygen desaturation, aberrant ventilatory patterns and related sleep disorders including obstructive and central apnea; and

(15) Other related physiologic measurements of the cardiopulmonary system.

3. The practice of respiratory care may also include, with special training, the following:

(1) Insertion and maintenance of peripheral arterial or venous lines and hemodynamic monitoring;

(2) Assistance with diagnostic or performing therapeutic bronchoscopy;

(3) Extracorporeal Membrane Oxygenation (ECMO), limited to the intensive care setting, and delivered under the supervision of a Certified Clinical Perfusionist (CCP, as defined by the American Board of Cardiovascular Perfusion, an allied medical professional whose expertise is the science of extracorporeal life support) and a licensed physician;

(4) Air or ground ambulance transport;

(5) Hyperbaric oxygenation therapy;

(6) Electrophysiologic monitoring; or

(7) Other diagnostic testing or special procedures.

4. The state board of registration for the healing arts pursuant to section 334.125, and the board of respiratory care, created pursuant to section 334.830, may jointly promulgate rules defining additional procedures recognized as proper to be performed by respiratory care practitioners. In order to take effect, such rules shall be approved by a majority vote of a quorum of each board. Neither the state board of registration for the healing arts nor the board of respiratory care may separately promulgate rules relating to the practice of respiratory care.

335.016. As used in this chapter, unless the context clearly requires otherwise, the following words and terms mean:

(1) "Accredited", the official authorization or status granted by an agency for a program through a voluntary process;

(2) "Advanced practice registered nurse" **or "APRN"**, a **[**nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist. The board shall promulgate rules specifying which nationally recognized professional organization certifications are to be recognized for the purposes of this section. Advanced practice nurses and only such individuals may use the title "Advanced Practice Registered Nurse" and the abbreviation "APRN"**]person who is licensed under the provisions of this chapter to engage in the practice of advanced practice nursing as a certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist**;

(3) "Approval", official recognition of nursing education programs which meet standards established by the board of nursing;

(4) "Board" or "state board", the state board of nursing;

(5) "Certified clinical nurse specialist", a registered nurse who is currently certified as a clinical nurse specialist by a nationally recognized certifying board approved by the board of nursing;

(6) "Certified nurse midwife", a registered nurse who is currently certified as a nurse midwife by the American **[**College of Nurse Midwives**]Midwifery Certification Board**, or

other nationally recognized certifying body approved by the board of nursing;

(7) "Certified nurse practitioner", a registered nurse who is currently certified as a nurse practitioner by a nationally recognized certifying body approved by the board of nursing;

(8) "Certified registered nurse anesthetist", a registered nurse who is currently certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists, the **[**Council on Recertification of Nurse Anesthetists**]National Board of Certification and Recertification for Nurse Anesthetists**, or other nationally recognized certifying body approved by the board of nursing;

(9) "Executive director", a qualified individual employed by the board as executive secretary or otherwise to administer the provisions of this chapter under the board's direction. Such person employed as executive director shall not be a member of the board;

(10) "Inactive **[**nurse**]license status**", as defined by rule pursuant to section 335.061;

(11) "Lapsed license status", as defined by rule under section 335.061;

(12) "Licensed practical nurse" or "practical nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of practical nursing;

(13) "Licensure", the issuing of a license **[**to practice professional or practical nursing**]** to candidates who have met the **[**specified**]** requirements **specified under this chapter, authorizing the person to engage in the practice of advanced practice, professional, or practical nursing**, and the recording of the names of those persons as

holders of a license to practice **advanced practice,** professional, or practical nursing;

(14) **"Practice of advanced practice nursing", the performance for compensation of activities and services consistent with the required education, training, certification, demonstrated competencies, and experiences of an advanced practice registered nurse;**

(15) "Practice of practical nursing", the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposes of this chapter, the term "direction" shall mean guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a registered professional nurse, including, but not limited to, oral, written, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse, such care may be delivered by a licensed practical nurse without direct physical oversight;

[(15)**](16) "Practice of** professional nursing", the performance for compensation of any act **or action** which requires substantial specialized education, judgment and skill based on knowledge and application of principles

derived from the biological, physical, social, **behavioral**, and nursing sciences, including, but not limited to:

(a) Responsibility for the **promotion and** teaching of health care and the prevention of illness to the patient and his or her family;

(b) Assessment, **data collection**, nursing diagnosis, nursing care, **evaluation**, and counsel of persons who are ill, injured, or experiencing alterations in normal health processes;

(c) The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments;

(d) The coordination and assistance in the **determination and** delivery of a plan of health care with all members of a health team;

(e) The teaching and supervision of other persons in the performance of any of the foregoing;

[(16) A**](17)** "Registered professional nurse" or "registered nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of professional nursing;

[(17)**](18)** "Retired license status", any person licensed in this state under this chapter who retires from such practice. Such person shall file with the board an affidavit, on a form to be furnished by the board, which states the date on which the licensee retired from such practice, an intent to retire from the practice for at least two years, and such other facts as tend to verify the retirement as the board may deem necessary; but if the licensee thereafter reengages in the practice, the licensee shall renew his or her license with the board as provided by this chapter and by rule and regulation.

335.019. **1. An advanced practice registered nurse's prescriptive authority shall include authority to:**

(1) Prescribe, dispense, and administer medications and nonscheduled legend drugs, as defined in section 338.330, within such APRN's practice and specialty; and

(2) Notwithstanding any other provision of this chapter to the contrary, receive, prescribe, administer, and provide nonscheduled legend drug samples from pharmaceutical manufacturers to patients at no charge to the patient or any other party.

2. The board of nursing may grant a certificate of controlled substance prescriptive authority to an advanced practice registered nurse who**[**:

(1)**]** submits proof of successful completion of an advanced pharmacology course that shall include **[**preceptorial experience in**]** the prescription of drugs, medicines, and therapeutic devices**[**; and

(2) Provides documentation of a minimum of three hundred clock hours preceptorial experience in the prescription of drugs, medicines, and therapeutic devices with a qualified preceptor; and

(3) Provides evidence of a minimum of one thousand hours of practice in an advanced practice nursing category prior to application for a certificate of prescriptive authority. The one thousand hours shall not include clinical hours obtained in the advanced practice nursing education program. The one thousand hours of practice in an advanced practice nursing category may include transmitting a prescription order orally or telephonically or to an inpatient medical record from protocols developed in collaboration with and signed by a licensed physician; and

(4) Has a controlled substance prescribing authority delegated in the collaborative practice arrangement under section 334.104 with a physician who has an unrestricted federal Drug Enforcement Administration registration number and who is actively engaged in a practice comparable in scope, specialty, or expertise to that of the advanced practice registered nurse**].**

3. The board of nursing may grant a certificate of controlled substance prescriptive authority to an advanced practice registered nurse, except not to a certified registered nurse anesthetist, to administer, dispense, or prescribe controlled substances listed in Schedules II to V of section 195.017.

4. Advanced practice registered nurses, except for certified registered nurse anesthetists, shall not administer any controlled substances listed in Schedules II to V of section 195.017 for the purpose of inducing general anesthesia for procedures that are outside the advanced practice registered nurse's scope of practice.

5. Notwithstanding any provision of law to the contrary, a certified registered nurse anesthetist shall be permitted to provide anesthesia services without a certificate of controlled substance prescriptive authority, provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed.

335.036. 1. The board shall:

(1) Elect for a one-year term a president and a secretary, who shall also be treasurer, and the board may appoint, employ and fix the compensation of a legal counsel and such board personnel as defined in subdivision (4) of subsection 11 of section 324.001 as are necessary to

administer the provisions of sections 335.011 to **[**335.096**]335.099;**

(2) Adopt and revise such rules and regulations as may be necessary to enable it to carry into effect the provisions of sections 335.011 to **[**335.096**]335.099;**

(3) Prescribe minimum standards for educational programs preparing persons for licensure **as a registered nurse or licensed practical nurse** pursuant to the provisions of sections 335.011 to **[**335.096**]335.099;**

(4) Provide for surveys of such programs every five years and in addition at such times as it may deem necessary;

(5) Designate as "approved" such programs as meet the requirements of sections 335.011 to **[**335.096**]335.099** and the rules and regulations enacted pursuant to such sections; and the board shall annually publish a list of such programs;

(6) Deny or withdraw approval from educational programs for failure to meet prescribed minimum standards;

(7) Examine, license, and cause to be renewed the licenses of duly qualified applicants;

(8) Cause the prosecution of all persons violating provisions of sections 335.011 to **[**335.096**]335.099,** and may incur such necessary expenses therefor;

(9) Keep a record of all the proceedings; and make an annual report to the governor and to the director of the department of commerce and insurance.

2. The board shall set the amount of the fees which this chapter authorizes and requires by rules and regulations. The fees shall be set at a level to produce revenue which shall not substantially exceed the cost and expense of administering this chapter.

3. All fees received by the board pursuant to the provisions of sections 335.011 to **[**335.096**]335.099** shall be

deposited in the state treasury and be placed to the credit of the state board of nursing fund. All administrative costs and expenses of the board shall be paid from appropriations made for those purposes. The board is authorized to provide funding for the nursing education incentive program established in sections 335.200 to 335.203.

4. The provisions of section 33.080 to the contrary notwithstanding, money in this fund shall not be transferred and placed to the credit of general revenue until the amount in the fund at the end of the biennium exceeds two times the amount of the appropriation from the board's funds for the preceding fiscal year or, if the board requires by rule, permit renewal less frequently than yearly, then three times the appropriation from the board's funds for the preceding fiscal year. The amount, if any, in the fund which shall lapse is that amount in the fund which exceeds the appropriate multiple of the appropriations from the board's funds for the preceding fiscal year.

5. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this chapter shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. All rulemaking authority delegated prior to August 28, 1999, is of no force and effect and repealed. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with all applicable provisions of law. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held

unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 1999, shall be invalid and void.

335.046. 1. An applicant for a license to practice as a registered professional nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain the applicant's statements showing the applicant's education and other such pertinent information as the board may require. The applicant shall be of good moral character and have completed at least the high school course of study, or the equivalent thereof as determined by the state board of education, and have successfully completed the basic professional curriculum in an accredited or approved school of nursing and earned a professional nursing degree or diploma. Each application shall contain a statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration. Applicants from non-English-speaking lands shall be required to submit evidence of proficiency in the English language. The applicant must be approved by the board and shall pass an examination as required by the board. The board may require by rule as a requirement for licensure that each applicant shall pass an oral or practical examination. Upon successfully passing the examination, the board may issue to the applicant a license to practice nursing as a registered professional nurse. The applicant for a license to practice registered professional nursing shall pay a license fee in such amount as set by the board. The fee shall be uniform

for all applicants. Applicants from foreign countries shall be licensed as prescribed by rule.

2. An applicant for license to practice as a licensed practical nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain the applicant's statements showing the applicant's education and other such pertinent information as the board may require. Such applicant shall be of good moral character, and have completed at least two years of high school, or its equivalent as established by the state board of education, and have successfully completed a basic prescribed curriculum in a state-accredited or approved school of nursing, earned a nursing degree, certificate or diploma and completed a course approved by the board on the role of the practical nurse. Each application shall contain a statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration. Applicants from non-English-speaking countries shall be required to submit evidence of their proficiency in the English language. The applicant must be approved by the board and shall pass an examination as required by the board. The board may require by rule as a requirement for licensure that each applicant shall pass an oral or practical examination. Upon successfully passing the examination, the board may issue to the applicant a license to practice as a licensed practical nurse. The applicant for a license to practice licensed practical nursing shall pay a fee in such amount as may be set by the board. The

fee shall be uniform for all applicants. Applicants from foreign countries shall be licensed as prescribed by rule.

3. **(1) An applicant for a license to practice as an advanced practice registered nurse shall submit to the board a written application on forms furnished to the applicant. The original application shall contain:**

(a) Statements showing the applicant's education and other such pertinent information as the board may require; and

(b) A statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing same, subject to the penalties of making a false affidavit or declaration.

(2) The applicant for a license to practice as an advanced practice registered nurse shall pay a fee in such amount as may be set by the board. The fee shall be uniform for all applicants.

(3) An applicant shall:

(a) Hold a current registered professional nurse license or privilege to practice, shall not be currently subject to discipline or any restrictions, and shall not hold an encumbered license or privilege to practice as a registered professional nurse or advanced practice registered nurse in any state or territory;

(b) Have completed an accredited graduate-level advanced practice registered nurse program and achieved at least one certification as a clinical nurse specialist, nurse midwife, nurse practitioner, or registered nurse anesthetist, with at least one population focus prescribed by rule of the board;

(c) Be currently certified by a national certifying body recognized by the Missouri state board of nursing in the advanced practice registered nurse role; and

(d) Have a population focus on his or her certification, corresponding with his or her educational advanced practice registered nurse program.

(4) Any person holding a document of recognition to practice nursing as an advanced practice registered nurse in this state that is current on August 28, 2023, shall be deemed to be licensed as an advanced practice registered nurse under the provisions of this section and shall be eligible for renewal of such license under the conditions and standards prescribed in this chapter and as prescribed by rule.

4. Upon refusal of the board to allow any applicant to **[**sit for**]take** either the registered professional nurses' examination or the licensed practical nurses' examination, **[**as the case may be,**]or upon refusal to issue an advanced practice registered nurse license,** the board shall comply with the provisions of section 621.120 and advise the applicant of his or her right to have a hearing before the administrative hearing commission. The administrative hearing commission shall hear complaints taken pursuant to section 621.120.

[4.**]5.** The board shall not deny a license because of sex, religion, race, ethnic origin, age or political affiliation.

335.049. 1. Any advanced practice registered nurse actively practicing in a direct or indirect patient care setting shall:

(1) Report to the board the mailing address or addresses of his or her current practice location or locations;

(2) Notify the board within thirty days of any change in practice setting; and

(3) Notify the board within thirty days of any change in a mailing address of any of his or her practice locations.

2. Advanced practice registered nurses shall maintain an adequate and complete patient record for each patient that is retained on paper, microfilm, electronic media, or other media that is capable of being printed for review by the board. An adequate and complete patient record shall include documentation of the following information:

(1) Identification of the patient, including name, birth date, address, and telephone number;

(2) The date or dates the patient was seen;

(3) The current status of the patient, including the reason for the visit;

(4) Observation of pertinent physical findings;

(5) Assessment and clinical impression of diagnosis;

(6) Plan for care and treatment or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the advanced practice registered nurse shall include in the patient record the medication and dosage of any medication prescribed, dispensed, or administered; and

(7) Any informed consent for office procedures.

3. Patient records remaining under the care, custody, and control of the advanced practice registered nurse shall be maintained by the advanced practice registered nurse or his or her designee for a minimum of seven years from the date on which the last professional service was provided.

4. Any correction, addition, or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the advanced practice registered nurse shall be clearly marked and identified as such. The date, time, and name of the person making the correction, addition, or change, as well as the reason for the correction, addition, or change, shall be included.

5. Advanced practice registered nurses shall ensure that medical records are completed within thirty days following each patient encounter.

335.051. 1. The board shall issue a license to practice nursing as **[**either**]an advanced practice registered nurse**, a registered professional nurse, or a licensed practical nurse without examination to an applicant who has duly become licensed as **[**a**]an advanced practice registered nurse**, registered nurse, or licensed practical nurse pursuant to the laws of another state, territory, or foreign country if the applicant meets the qualifications required of **advanced practice registered nurses**, registered nurses, or licensed practical nurses in this state at the time the applicant was originally licensed in the other state, territory, or foreign country.

2. Applicants from foreign countries shall be licensed as prescribed by rule.

3. Upon application, the board shall issue a temporary permit to an applicant pursuant to subsection 1 of this section for a license as **[**either**]an advanced practice registered nurse**, a registered professional nurse, or a licensed practical nurse who has made a prima facie showing that the applicant meets all of the requirements for such a license. The temporary permit shall be effective only until

the board shall have had the opportunity to investigate his **or her** qualifications for licensure pursuant to subsection 1 of this section and to notify the applicant that his or her application for a license has been either granted or rejected. In no event shall such temporary permit be in effect for more than twelve months after the date of its issuance nor shall a permit be reissued to the same applicant. No fee shall be charged for such temporary permit. The holder of a temporary permit which has not expired, or been suspended or revoked, shall be deemed to be the holder of a license issued pursuant to section 335.046 until such temporary permit expires, is terminated or is suspended or revoked.

335.056. **1.** The license of every person licensed under the provisions of **[**sections 335.011 to 335.096**]this chapter** shall be renewed as provided. An application for renewal of license shall be mailed to every person to whom a license was issued or renewed during the current licensing period. The applicant shall complete the application and return it to the board by the renewal date with a renewal fee in an amount to be set by the board. The fee shall be uniform for all applicants. The certificates of renewal shall render the holder thereof a legal practitioner of nursing for the period stated in the certificate of renewal. Any person who practices nursing as **an advanced practice registered nurse**, a registered professional nurse, or **[**as**]** a licensed practical nurse during the time his **or her** license has lapsed shall be considered an illegal practitioner and shall be subject to the penalties provided for violation of the provisions of sections 335.011 to **[**335.096**]335.099.**

2. The renewal of advanced practice registered nurse licenses and registered professional nurse licenses shall occur at the same time, as prescribed by rule. Failure to renew and maintain the registered professional nurse license or privilege to practice or failure to provide the required fee and evidence of active certification or maintenance of certification as prescribed by rules and regulations shall result in expiration of the advanced practice registered nurse license.

335.076. 1. Any person who holds a license to practice professional nursing in this state may use the title "Registered Professional Nurse" and the abbreviation **[**"R.N."**]"RN"**. No other person shall use the title "Registered Professional Nurse" or the abbreviation **[**"R.N."**]"RN"**. No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a registered professional nurse.

2. Any person who holds a license to practice practical nursing in this state may use the title "Licensed Practical Nurse" and the abbreviation **[**"L.P.N."**]"LPN"**. No other person shall use the title "Licensed Practical Nurse" or the abbreviation **[**"L.P.N."**]"LPN"**. No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a licensed practical nurse.

3. Any person who holds a license **[**or recognition**]** to practice advanced practice nursing in this state may use the title "Advanced Practice Registered Nurse", **the designations of "certified registered nurse anesthetist", "certified nurse midwife", "certified clinical nurse specialist", and "certified nurse practitioner"**, and the

[abbreviation**]abbreviations** "APRN", **[**and any other title designations appearing on his or her license**]"CRNA", "CNM", "CNS", and "NP", respectively.** No other person shall use the title "Advanced Practice Registered Nurse" or the abbreviation "APRN". No other person shall assume any title or use any abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is an advanced practice registered nurse.

4. No person shall practice or offer to practice professional nursing, practical nursing, or advanced practice nursing in this state or use any title, sign, abbreviation, card, or device to indicate that such person is a practicing professional nurse, practical nurse, or advanced practice nurse unless he or she has been duly licensed under the provisions of this chapter.

5. In the interest of public safety and consumer awareness, it is unlawful for any person to use the title "nurse" in reference to himself or herself in any capacity, except individuals who are or have been licensed as a registered nurse, licensed practical nurse, or advanced practice registered nurse under this chapter.

6. Notwithstanding any law to the contrary, nothing in this chapter shall prohibit a Christian Science nurse from using the title "Christian Science nurse", so long as such person provides only religious nonmedical services when offering or providing such services to those who choose to rely upon healing by spiritual means alone and does not hold his or her own religious organization and does not hold himself or herself out as a registered nurse, advanced practice registered nurse, nurse practitioner, licensed practical nurse, nurse midwife, clinical nurse specialist,

or nurse anesthetist, unless otherwise authorized by law to do so.

335.086. No person, firm, corporation or association shall:

(1) Sell or attempt to sell or fraudulently obtain or furnish or attempt to furnish any nursing diploma, license, renewal or record or aid or abet therein;

(2) Practice **[**professional or practical**]** nursing as defined by sections 335.011 to **[**335.096**]335.099** under cover of any diploma, license, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) Practice **[**professional nursing or practical**]** nursing as defined by sections 335.011 to **[**335.096**]335.099** unless duly licensed to do so under the provisions of sections 335.011 to **[**335.096**]335.099**;

(4) Use in connection with his **or her** name any designation tending to imply that he **or she** is a licensed **advanced practice registered nurse, a licensed** registered professional nurse, or a licensed practical nurse unless duly licensed so to practice under the provisions of sections 335.011 to **[**335.096**]335.099**;

(5) Practice **[**professional nursing or practical**]** nursing during the time his **or her** license issued under the provisions of sections 335.011 to **[**335.096**]335.099** shall be suspended or revoked; or

(6) Conduct a nursing education program for the preparation of professional or practical nurses unless the program has been accredited by the board.

335.175. 1. No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the

"Utilization of Telehealth by Nurses". [An advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the collaborating physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need.] Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

2. As used in this section, "telehealth" shall have the same meaning as such term is defined in section 191.1145.

[3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under this section. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

4. For purposes of this section, "rural area of need" means any rural area of this state which is located in a

health professional shortage area as defined in section 354.650.]

338.198. Other provisions of law to the contrary notwithstanding, a pharmacist may fill a physician's prescription or the prescription of an advanced practice **registered** nurse [working under a collaborative practice arrangement with a physician,] when it is forwarded to the pharmacist by a registered professional nurse or registered physician's assistant or other authorized agent **of the physician or advanced practice registered nurse.** [The written collaborative practice arrangement shall specifically state that the registered professional nurse or registered physician assistant is permitted to authorize a pharmacist to fill a prescription on behalf of the physician.]

630.175. 1. No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to chapter 632 and no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility, the attending licensed physician, **the attending advanced practice registered nurse**, or in the circumstances specifically set forth in this section, by [an advanced practice registered nurse in a collaborative practice arrangement, or] a physician assistant or an assistant physician with a collaborative practice arrangement[,] with the attending licensed physician that the chosen intervention is imminently necessary to protect the health and safety of the patient, resident, client or others and that it provides the

least restrictive environment. An advanced practice registered nurse **[**in a collaborative practice arrangement**]**, or a physician assistant or an assistant physician with a collaborative practice arrangement**[**,**]** with the attending licensed physician, may make a determination that the chosen intervention is necessary for patients, residents, or clients of facilities or programs operated by the department, in hospitals as defined in section 197.020 that only provide psychiatric care and in dedicated psychiatric units of general acute care hospitals as hospitals are defined in section 197.020. Any determination made by the **[**advanced practice registered nurse,**]** physician assistant**[**,**]** or assistant physician **in a collaborative practice arrangement** shall be documented as required in subsection 2 of this section and reviewed in person by the attending licensed physician if the episode of restraint is to extend beyond:

(1) Four hours duration in the case of a person under eighteen years of age;

(2) Eight hours duration in the case of a person eighteen years of age or older; or

(3) For any total length of restraint lasting more than four hours duration in a twenty-four-hour period in the case of a person under eighteen years of age or beyond eight hours duration in the case of a person eighteen years of age or older in a twenty-four-hour period.

The review shall occur prior to the time limit specified under subsection 6 of this section and shall be documented by the licensed physician under subsection 2 of this section.

2. Every use of physical or chemical restraint, isolation or seclusion and the reasons therefor shall be

made a part of the clinical record of the patient, resident or client under the signature of the head of the facility, **[**or**]** the attending licensed physician, **[**or**]** the **attending** advanced practice registered nurse **[**in a collaborative practice arrangement**]**, or a physician assistant or an assistant physician with a collaborative practice arrangement**[**,**]** with the attending licensed physician.

3. Physical or chemical restraint, isolation or seclusion shall not be considered standard treatment or habilitation and shall cease as soon as the circumstances causing the need for such action have ended.

4. The use of security escort devices, including devices designed to restrict physical movement, which are used to maintain safety and security and to prevent escape during transport outside of a facility shall not be considered physical restraint within the meaning of this section. Individuals who have been civilly detained under sections 632.300 to 632.475 may be placed in security escort devices when transported outside of the facility if it is determined by the head of the facility, **[**or**]** the attending licensed physician, **[**or**]** the **attending** advanced practice registered nurse **[**in a collaborative practice arrangement**]**, or a physician assistant or an assistant physician with a collaborative practice arrangement**[**,**]** with the attending licensed physician that the use of security escort devices is necessary to protect the health and safety of the patient, resident, client, or other persons or is necessary to prevent escape. Individuals who have been civilly detained under sections 632.480 to 632.513 or committed under chapter 552 shall be placed in security escort devices when transported outside of the facility unless it is determined by the head of the facility, **[**or**]** the attending

licensed physician, **[**or**]** the **attending** advanced practice registered nurse **[**in a collaborative practice arrangement**]**, or a physician assistant or an assistant physician with a collaborative practice arrangement**[**,**]** with the attending licensed physician that security escort devices are not necessary to protect the health and safety of the patient, resident, client, or other persons or is not necessary to prevent escape.

5. Extraordinary measures employed by the head of the facility to ensure the safety and security of patients, residents, clients, and other persons during times of natural or man-made disasters shall not be considered restraint, isolation, or seclusion within the meaning of this section.

6. Orders issued under this section by **[**the advanced practice registered nurse in a collaborative practice arrangement, or**]** a physician assistant or an assistant physician with a collaborative practice arrangement**[**,**]** with the attending licensed physician shall be reviewed in person by the attending licensed physician of the facility within twenty-four hours or the next regular working day of the order being issued, and such review shall be documented in the clinical record of the patient, resident, or client.

7. For purposes of this subsection, "division" shall mean the division of developmental disabilities. Restraint or seclusion shall not be used in habilitation centers or community programs that serve persons with developmental disabilities that are operated or funded by the division unless such procedure is part of an emergency intervention system approved by the division and is identified in such person's individual support plan. Direct-care staff that serve persons with developmental disabilities in

habilitation centers or community programs operated or funded by the division shall be trained in an emergency intervention system approved by the division when such emergency intervention system is identified in a consumer's individual support plan.

630.875. 1. This section shall be known and may be cited as the "Improved Access to Treatment for Opioid Addictions Act" or "IATOA Act".

2. As used in this section, the following terms mean:

(1) "Department", the department of mental health;

(2) "IATOA program", the improved access to treatment for opioid addictions program created under subsection 3 of this section.

3. Subject to appropriations, the department shall create and oversee an "Improved Access to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to disseminate information and best practices regarding opioid addiction and to facilitate collaborations to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state. The IATOA program shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.

4. Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

5. For the purposes of the IATOA program, a remote collaborating physician working with an on-site assistant physician**[**,**]or** physician assistant**[**, or advanced practice registered nurse**]** shall be considered to be on-site. An assistant physician**[**,**]or** physician assistant**[**, or advanced practice registered nurse**]** collaborating with a remote physician shall comply with all laws and requirements applicable to assistant physicians**[**,**]or** physician assistants**[**, or advanced practice registered nurses**]** with on-site supervision before providing treatment to a patient.

6. An assistant physician**[**,**]or** physician assistant**[**, or advanced practice registered nurse**]** collaborating with a physician who is waiver-certified for the use of buprenorphine may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician**[**,**]or** physician assistant**[**, or advanced practice registered nurse**]**.

7. The department may develop curriculum and benchmark examinations on the subject of opioid addiction and treatment. The department may collaborate with specialists, institutions of higher education, and medical schools for such development. Completion of such a curriculum and passing of such an examination by an assistant physician, physician assistant, advanced practice registered nurse, or physician shall result in a certificate awarded by the department or sponsoring institution, if any.

8. An assistant physician, physician assistant, or advanced practice registered nurse participating in the IATOA program may also:

(1) Engage in community education;

(2) Engage in professional education outreach programs with local treatment providers;

(3) Serve as a liaison to courts;

(4) Serve as a liaison to addiction support organizations;

(5) Provide educational outreach to schools;

(6) Treat physical ailments of patients in an addiction treatment program or considering entering such a program;

(7) Refer patients to treatment centers;

(8) Assist patients with court and social service obligations;

(9) Perform other functions as authorized by the department; and

(10) Provide mental health services in collaboration with a qualified licensed physician, **except that advanced practice registered nurses may provide mental health services independently, without the collaboration of a qualified licensed physician.**

The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician assistants, or advanced practice registered nurses participating in the IATOA program may perform other actions.

9. When an overdose survivor arrives in the emergency department, the assistant physician, physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the assistant physician, physician assistant,

or advanced practice registered nurse is unavailable, another properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor and provide treatment options and support available to the overdose survivor. The department shall assist recovery coaches in providing treatment options and support to overdose survivors.

10. The provisions of this section shall supersede any contradictory statutes, rules, or regulations. The department shall implement the improved access to treatment for opioid addictions program as soon as reasonably possible using guidance within this section. Further refinement to the improved access to treatment for opioid addictions program may be done through the rules process.

11. The department shall promulgate rules to implement the provisions of the improved access to treatment for opioid addictions act as soon as reasonably possible. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

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