

FIRST REGULAR SESSION
[TRULY AGREED TO AND FINALLY PASSED]
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 709

98TH GENERAL ASSEMBLY

1742S.03T

2015

AN ACT

To repeal sections 195.070, 334.037, 334.104, and 334.747, RSMo, and to enact in lieu thereof eight new sections relating to entities regulated by the department of insurance, financial institutions and professional registration.

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

Section A. Sections 195.070, 334.037, 334.104, and 334.747, RSMo, are repealed and
2 eight new sections enacted in lieu thereof, to be known as sections 195.070, 324.023, 334.037,
3 334.104, 334.747, 374.015, 374.018, and 376.791, to read as follows:

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

7 2. An advanced practice registered nurse, as defined in section 335.016, but not a
8 certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, who holds
9 a certificate of controlled substance prescriptive authority from the board of nursing under
10 section 335.019 and who is delegated the authority to prescribe controlled substances under a
11 collaborative practice arrangement under section 334.104 may prescribe any controlled
12 substances listed in Schedules III, IV, and V of section 195.017, **and may have restricted**
13 **authority in Schedule II. Prescriptions for Schedule II medications prescribed by an**

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

14 **advanced practice registered nurse who has a certificate of controlled substance**
15 **prescriptive authority are restricted to only those medications containing**
16 **hydrocodone.** However, no such certified advanced practice registered nurse shall prescribe
17 controlled substance for his or her own self or family. Schedule III narcotic controlled substance
18 **and Schedule II - hydrocodone** prescriptions shall be limited to a one hundred twenty-hour
19 supply without refill.

20 3. A veterinarian, in good faith and in the course of the veterinarian's professional
21 practice only, and not for use by a human being, may prescribe, administer, and dispense
22 controlled substances and the veterinarian may cause them to be administered by an assistant or
23 orderly under his or her direction and supervision.

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

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

324.023. 1. Notwithstanding any law to the contrary, any board or commission
2 **established under chapters 330, 331, 332, 334, 335, 336, 337, 338, 340, and 345 may, at its**
3 **discretion, issue oral or written opinions addressing topics relating to the qualifications,**
4 **functions, or duties of any profession licensed by the specific board or commission issuing**
5 **such guidance. Any such opinion is for educational purposes only, is in no way binding on**
6 **the licensees of the respective board or commission, and cannot be used as the basis for any**
7 **discipline against any licensee under chapters 330, 331, 332, 334, 335, 336, 337, 338, 340,**
8 **and 345. No board or commission may address topics relating to the qualifications,**
9 **functions, or duties of any profession licensed by a different board or commission.**

10 **2. The recipient of an opinion given under this section shall be informed that the**
11 **opinion is for educational purposes only, is in no way binding on the licensees of the board,**
12 **and cannot be used as the basis for any discipline against any licensee under chapters 330,**
13 **331, 332, 334, 335, 336, 337, 338, 340, and 345.**

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

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

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

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

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

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

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

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

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

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

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

41 (7) A list of all other written practice agreements of the collaborating physician and the
42 assistant physician;

43 (8) The duration of the written practice agreement between the collaborating physician
44 and the assistant physician;

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

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

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

59 (1) Geographic areas to be covered;

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

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

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

70

71 Any rules relating to dispensing or distribution of medications or devices by prescription or
72 prescription drug orders under this section shall be subject to the approval of the state board of
73 pharmacy. Any rules relating to dispensing or distribution of controlled substances by
74 prescription or prescription drug orders under this section shall be subject to the approval of the
75 department of health and senior services and the state board of pharmacy. The state board of
76 registration for the healing arts shall promulgate rules applicable to assistant physicians that shall
77 be consistent with guidelines for federally funded clinics. The rulemaking authority granted in
78 this subsection shall not extend to collaborative practice arrangements of hospital employees
79 providing inpatient care within hospitals as defined in chapter 197 or population-based public
80 health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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

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

93 6. A collaborating physician shall not enter into a collaborative practice arrangement
94 with more than three full-time equivalent assistant physicians. Such limitation shall not apply
95 to collaborative arrangements of hospital employees providing inpatient care service in hospitals
96 as defined in chapter 197 or population-based public health services as defined by 20 CSR
97 2150-5.100 as of April 30, 2008.

98 7. The collaborating physician shall determine and document the completion of at least
99 a one-month period of time during which the assistant physician shall practice with the
100 collaborating physician continuously present before practicing in a setting where the
101 collaborating physician is not continuously present. Such limitation shall not apply to
102 collaborative arrangements of providers of population-based public health services as defined
103 by 20 CSR 2150-5.100 as of April 30, 2008.

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

109 9. No contract or other agreement shall require a physician to act as a collaborating
110 physician for an assistant physician against the physician's will. A physician shall have the right
111 to refuse to act as a collaborating physician, without penalty, for a particular assistant physician.
112 No contract or other agreement shall limit the collaborating physician's ultimate authority over any
113 protocols or standing orders or in the delegation of the physician's authority to any assistant
114 physician, but such requirement shall not authorize a physician in implementing such protocols,
115 standing orders, or delegation to violate applicable standards for safe medical practice
116 established by a hospital's medical staff.

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

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

125 12. (1) An assistant physician with a certificate of controlled substance prescriptive
126 authority as provided in this section may prescribe any controlled substance listed in Schedule
127 III, IV, or V of section 195.017, **and may have restricted authority in Schedule II**, when
128 delegated the authority to prescribe controlled substances in a collaborative practice
129 arrangement. **Prescriptions for Schedule II medications prescribed by an assistant**
130 **physician who has a certificate of controlled substance prescriptive authority are restricted**
131 **to only those medications containing hydrocodone.** Such authority shall be filed with the
132 state board of registration for the healing arts. The collaborating physician shall maintain the
133 right to limit a specific scheduled drug or scheduled drug category that the assistant physician
134 is permitted to prescribe. Any limitations shall be listed in the collaborative practice
135 arrangement. Assistant physicians shall not prescribe controlled substances for themselves or
136 members of their families. Schedule III controlled substances **and Schedule II - hydrocodone**
137 **prescriptions** shall be limited to a five-day supply without refill. Assistant physicians who are
138 authorized to prescribe controlled substances under this section shall register with the federal
139 Drug Enforcement Administration and the state bureau of narcotics and dangerous drugs, and
140 shall include the Drug Enforcement Administration registration number on prescriptions for
141 controlled substances.

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

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

334.104. 1. A physician may enter into collaborative practice arrangements with
2 registered professional nurses. Collaborative practice arrangements shall be in the form of

3 written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health
4 care services. Collaborative practice arrangements, which shall be in writing, may delegate to
5 a registered professional nurse the authority to administer or dispense drugs and provide
6 treatment as long as the delivery of such health care services is within the scope of practice of
7 the registered professional nurse and is consistent with that nurse's skill, training and
8 competence.

9 2. Collaborative practice arrangements, which shall be in writing, may delegate to a
10 registered professional nurse the authority to administer, dispense or prescribe drugs and provide
11 treatment if the registered professional nurse is an advanced practice registered nurse as defined
12 in subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an
13 advanced practice registered nurse, as defined in section 335.016, the authority to administer,
14 dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017,
15 **and Schedule II - hydrocodone**; except that, the collaborative practice arrangement shall not
16 delegate the authority to administer any controlled substances listed in Schedules III, IV, and V
17 of section 195.017, **or Schedule II - hydrocodone** for the purpose of inducing sedation or
18 general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic
19 controlled substance **and Schedule II - hydrocodone** prescriptions shall be limited to a one
20 hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be
21 in the form of written agreements, jointly agreed-upon protocols or standing orders for the
22 delivery of health care services.

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

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

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

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

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

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

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

41 (b) Maintain geographic proximity, except the collaborative practice arrangement may
42 allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar
43 year for rural health clinics as defined by P.L. 95-210, as long as the collaborative practice
44 arrangement includes alternative plans as required in paragraph (c) of this subdivision. This
45 exception to geographic proximity shall apply only to independent rural health clinics,
46 provider-based rural health clinics where the provider is a critical access hospital as provided in
47 42 U.S.C. 1395i-4, and provider-based rural health clinics where the main location of the
48 hospital sponsor is greater than fifty miles from the clinic. The collaborating physician is
49 required to maintain documentation related to this requirement and to present it to the state board
50 of registration for the healing arts when requested; and

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

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

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

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

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

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

72 4. The state board of registration for the healing arts pursuant to section 334.125 and the
73 board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of
74 collaborative practice arrangements. Such rules shall be limited to specifying geographic areas

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

90 5. The state board of registration for the healing arts shall not deny, revoke, suspend or
91 otherwise take disciplinary action against a physician for health care services delegated to a
92 registered professional nurse provided the provisions of this section and the rules promulgated
93 thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action
94 imposed as a result of an agreement between a physician and a registered professional nurse or
95 registered physician assistant, whether written or not, prior to August 28, 1993, all records of
96 such disciplinary licensure action and all records pertaining to the filing, investigation or review
97 of an alleged violation of this chapter incurred as a result of such an agreement shall be removed
98 from the records of the state board of registration for the healing arts and the division of
99 professional registration and shall not be disclosed to any public or private entity seeking such
100 information from the board or the division. The state board of registration for the healing arts
101 shall take action to correct reports of alleged violations and disciplinary actions as described in
102 this section which have been submitted to the National Practitioner Data Bank. In subsequent
103 applications or representations relating to his medical practice, a physician completing forms or
104 documents shall not be required to report any actions of the state board of registration for the
105 healing arts for which the records are subject to removal under this section.

106 6. Within thirty days of any change and on each renewal, the state board of registration
107 for the healing arts shall require every physician to identify whether the physician is engaged in
108 any collaborative practice agreement, including collaborative practice agreements delegating the
109 authority to prescribe controlled substances, or physician assistant agreement and also report to
110 the board the name of each licensed professional with whom the physician has entered into such

111 agreement. The board may make this information available to the public. The board shall track
112 the reported information and may routinely conduct random reviews of such agreements to
113 ensure that agreements are carried out for compliance under this chapter.

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

123 8. A collaborating physician shall not enter into a collaborative practice arrangement
124 with more than three full-time equivalent advanced practice registered nurses. This limitation
125 shall not apply to collaborative arrangements of hospital employees providing inpatient care
126 service in hospitals as defined in chapter 197 or population-based public health services as
127 defined by 20 CSR 2150-5.100 as of April 30, 2008.

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

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

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

147 12. No contract or other agreement shall require any advanced practice registered nurse
148 to serve as a collaborating advanced practice registered nurse for any collaborating physician
149 against the advanced practice registered nurse's will. An advanced practice registered nurse shall
150 have the right to refuse to collaborate, without penalty, with a particular physician.

 334.747. 1. A physician assistant with a certificate of controlled substance prescriptive
2 authority as provided in this section may prescribe any controlled substance listed in schedule
3 III, IV, or V of section 195.017, **and may have restricted authority in Schedule II**, when
4 delegated the authority to prescribe controlled substances in a supervision agreement. Such
5 authority shall be listed on the supervision verification form on file with the state board of
6 healing arts. The supervising physician shall maintain the right to limit a specific scheduled drug
7 or scheduled drug category that the physician assistant is permitted to prescribe. Any limitations
8 shall be listed on the supervision form. **Prescriptions for Schedule II medications prescribed**
9 **by a physician assistant with authority to prescribe delegated in a supervision agreement**
10 **are restricted to only those medications containing hydrocodone.** Physician assistants shall
11 not prescribe controlled substances for themselves or members of their families. Schedule III
12 controlled substances **and Schedule II - hydrocodone prescriptions** shall be limited to a
13 five-day supply without refill. Physician assistants who are authorized to prescribe controlled
14 substances under this section shall register with the federal Drug Enforcement Administration
15 and the state bureau of narcotics and dangerous drugs, and shall include the Drug Enforcement
16 Administration registration number on prescriptions for controlled substances.

17 2. The supervising physician shall be responsible to determine and document the
18 completion of at least one hundred twenty hours in a four-month period by the physician assistant
19 during which the physician assistant shall practice with the supervising physician on-site prior
20 to prescribing controlled substances when the supervising physician is not on-site. Such
21 limitation shall not apply to physician assistants of population-based public health services as
22 defined in 20 CSR 2150-5.100 as of April 30, 2009.

23 3. A physician assistant shall receive a certificate of controlled substance prescriptive
24 authority from the board of healing arts upon verification of the completion of the following
25 educational requirements:

26 (1) Successful completion of an advanced pharmacology course that includes clinical
27 training in the prescription of drugs, medicines, and therapeutic devices. A course or courses
28 with advanced pharmacological content in a physician assistant program accredited by the
29 Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its
30 predecessor agency shall satisfy such requirement;

31 (2) Completion of a minimum of three hundred clock hours of clinical training by the
32 supervising physician in the prescription of drugs, medicines, and therapeutic devices;

33 (3) Completion of a minimum of one year of supervised clinical practice or supervised
34 clinical rotations. One year of clinical rotations in a program accredited by the Accreditation
35 Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor
36 agency, which includes pharmacotherapeutics as a component of its clinical training, shall satisfy
37 such requirement. Proof of such training shall serve to document experience in the prescribing
38 of drugs, medicines, and therapeutic devices;

39 (4) A physician assistant previously licensed in a jurisdiction where physician assistants
40 are authorized to prescribe controlled substances may obtain a state bureau of narcotics and
41 dangerous drugs registration if a supervising physician can attest that the physician assistant has
42 met the requirements of subdivisions (1) to (3) of this subsection and provides documentation
43 of existing federal Drug Enforcement Agency registration.

**374.015. 1. For purposes of this section, "insurer" shall mean any person,
2 reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other
3 legal entity engaged in the business of insurance including producers, adjusters and
4 third-party administrators, health services corporations, health maintenance organizations,
5 health carriers, prepaid limited health care service plans, dental, optometric, and other
6 similar health service plans. "Insurer" shall also include all companies organized,
7 incorporated, or doing business under the provisions of chapters 325, 354, and 374 to 385.**

8 **2. For purposes of this section, "bulletin" shall mean an informal written
9 communication to inform or educate the insurance industry and the general public about
10 a regulatory topic or issue. A bulletin is informational in nature and is not an evaluation
11 of specific facts and circumstances.**

12 **3. Notwithstanding any law to the contrary, the director may at his or her
13 discretion issue bulletins addressing the business of insurance in this state.**

14 **4. Bulletins do not have the force or effect of law and shall not be considered
15 statements of general applicability that would require promulgation by rule.**

16 **5. Such bulletins shall not be binding on the department or an insurer. The
17 director may revise or withdraw any previously issued bulletin; however such revision or
18 withdrawal shall be prospective in nature. The effective date for such bulletin which was
19 withdrawn or revised shall be ninety days after the date the revision or withdrawal notice
20 is published and, where applicable, shall apply to new policies issued and policies that
21 renew on or after that date.**

**374.018. 1. For purposes of this section, "no-action letter" shall mean a letter that
2 states the intention of the department to not take enforcement actions under section
3 374.046 with respect to the requesting insurer, based on the specific facts then presented
4 and applicable law, as of the date a no-action letter is issued.**

5 **2. For purposes of this section, "insurer" shall mean all insurance companies**
6 **organized, incorporated, or doing business under the provisions of chapters 354, 376, 379,**
7 **or 380.**

8 **3. Notwithstanding any law to the contrary, the director may at his or her**
9 **discretion issue no-action letters addressing the business of insurance in this state.**

10 **4. No-action letters shall not be considered statements of general applicability that**
11 **would require promulgation by rule.**

12 **5. Insurers who seek guidance may submit a written request for a no-action letter**
13 **to the department.**

14 **6. An insurer is under an affirmative obligation to make full, true, and accurate**
15 **disclosure of all information related to the activities for which the no-action letter is**
16 **requested. Each request shall be accompanied by all relevant supplementary information**
17 **including, but not limited to, background information regarding the request, policies,**
18 **procedures, and applicable marketing materials. Each request shall also include complete**
19 **copies of documents, and shall identify all provisions of law applicable to the request.**

20 **7. The insurer requesting the no-action letter shall provide the department with**
21 **any additional information or documents the department requests for its review of the**
22 **matter.**

23 **8. The insurer may withdraw the request for a no-action letter prior to the issuance**
24 **of the no-action letter.**

25 **9. The department shall act on the no-action letter request within ninety days after**
26 **it receives all information necessary to complete its review.**

27 **10. At the completion of its review of a request for a no-action letter the department**
28 **shall do one of the following:**

29 **(1) Issue a no-action letter;**

30 **(2) Decline to issue a no-action letter; or**

31 **(3) Take such other action as the department considers appropriate.**

32 **11. A no-action letter shall be effective as of the date it is issued.**

33 **12. As long as there is no change in any material fact or law or the discovery of a**
34 **material misrepresentation or omission made by the insurer, the department is estopped**
35 **from bringing any enforcement action under section 374.046 against the requesting insurer**
36 **concerning the specific conduct that is the subject of the no-action letter issued by the**
37 **department. However, this estoppel shall not apply to those enforcement actions related**
38 **to the financial condition of the insurer. The determination of materiality shall be in the**
39 **sole discretion of the director.**

40 **13. A no-action letter request shall not be a public record as defined in chapter 610**
41 **until the date of issuance by the department of a response to the no-action letter**
42 **request. The request for a no-action letter and the department's response shall, after the**
43 **date of issuance by the department, be considered a public record as defined in chapter**
44 **610. Upon request of the insurer, information submitted with a request for a no-action**
45 **letter as required under this section that contains proprietary or trade secret information**
46 **as defined in sections 417.450 to 417.467 shall not be considered a public record.**

376.791. 1. The provisions of subdivisions (4) and (5) of subsection 2 of section
2 **376.777 shall not apply to any individual health insurance coverage. The term "individual**
3 **health insurance coverage" shall have the meaning assigned to it in section 376.450.**

4 **2. The director shall promulgate rules and regulations to implement and**
5 **administer the provisions of this section prior to January 1, 2016. Any rule or portion of**
6 **a rule, as that term is defined in section 536.010 that is created under the authority**
7 **delegated in this section shall become effective only if it complies with and is subject to all**
8 **of the provisions of chapter 536, and, if applicable, section 536.028. This section and**
9 **chapter 536 are nonseverable and if any of the powers vested with the general assembly**
10 **pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul**
11 **a rule are subsequently held unconstitutional, then the grant of rulemaking authority and**
12 **any rule proposed or adopted after August 28, 2015, shall be invalid and void.**

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