

DEPARTMENT OF REGULATORY AGENCIES

Colorado Medical Board

MEDICAL RULES AND REGULATIONS

3 CCR 713-1

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

1.1 AUTHORITY

These rules and regulations are adopted pursuant to the authority in sections 12-20-204 and 12-240-106(1)(a), C.R.S., and are intended to be consistent with the requirements of the State Administrative Procedures Act, sections 24-4-101, *et seq.* (the "APA"), C.R.S., and the Medical Practice Act, sections 12-240-101, *et seq.* (the "Practice Act"), C.R.S.

1.2 SCOPE AND PURPOSE

These regulations shall govern the process to become licensed as a physician, physician assistant, and anesthesiologist assistant in Colorado.

1.3 APPLICABILITY

The provisions of these regulations shall be applicable to the practice of medicine in Colorado.

1.4 DEFINITIONS [RESERVED]

1.5 RULES AND REGULATIONS RELATING TO THE UNITED STATES MEDICAL LICENSING EXAMINATION, THE COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION-USA, AND THE FEDERAL LICENSURE EXAMINATION

- A. Basis: The authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1) and 12-240-106(1)(a), 12-240-115, and 12-240-110(1)(a), (b) and (c), C.R.S.
- B. Purpose: The purpose of the rules and regulations is to set forth administrative guidelines for eligibility and acceptance of examinations as required by section 12-240-110(1), C.R.S. These Rules are not meant to preclude acceptance of any licensing exam previously approved by the board.
- C. The Board authorizes the following examinations as satisfying the required examinations identified in section 12-240-110(1)(b), C.R.S.
1. The United States Medical Licensing Examination ("USMLE"), administered by the National Board of Medical Examiners;
 2. The Comprehensive Osteopathic Medical Licensing Examination-USA ("COMLEX-USA"), administered by the National Board of Osteopathic Medical Examiners;
 3. The Federal Licensure Examination ("FLEX"), administered by the Federation of State Medical Boards.

- D. Additional examinations approved by the Board, for the purpose of satisfying the required examinations identified in Section 12-240-110(1)(a), C.R.S. include:
1. Medical Council of Canada Qualifying Examination (“MCCQE”), Parts I and II, along with conferral of the Licentiate of the Medical Council of Canada (“LMCC”).
- To be eligible for USMLE Step 3 or COMLEX-USA Level 3, applicant must have:
1. Obtained the degree of Medical Doctor (“M.D.”) or Doctor of Osteopathic Medicine (“D.O.”); and,
 2. Successfully completed both USMLE Steps 1 and 2 or COMLEX-USA Level 1 and 2.
- E. To be eligible to sit for the USMLE Step 3 or COMLEX-USA Level 3, an applicant must be serving in, or have completed, one year of postgraduate training in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (“ACGME”) of the American Medical Association (“AMA”) or the American Osteopathic Association (“AOA”).
- F. An examinee who fails USMLE Step 3 or COMLEX-USA Level 3 may be reexamined at any subsequent examination upon payment of the required fee.
- G. In order to be eligible for licensure, an applicant must successfully complete USMLE Steps 1, 2, and 3 or COMLEX-USA Levels 1, 2, 3, within seven years of the date the applicant first sat for any step of the USMLE or any level of the COMLEX, irrespective of whether the applicant passed said step or level.
1. This paragraph (G) shall not apply to applicants who are enrolled in a Ph.D. degree program from a regionally accredited university simultaneously with an LCME accredited medical degree program or an AOA accredited osteopathic degree program. However, such Ph.D./M.D./D.O. applicants must have successfully completed USMLE Steps 1, 2, and 3 or COMLEX-USA Levels 1, 2, and 3 within ten years of the date the applicant first sat for any step of the USMLE or any level of the COMLEX, irrespective of whether the applicant passed said step or level.
 2. Upon applicant’s showing of good cause, the Board may waive the time requirements set forth in this paragraph (G). Any such waiver shall be based upon the circumstances relating to the particular individual’s application. The decision to grant or deny such a waiver shall be in the sole discretion of the board.
- H. A failure of any USMLE step or COMLEX-USA level, regardless of the jurisdiction in which the examination was administered, shall be considered a failure of that step for purposes of Colorado licensure and shall be considered for purposes of determining compliance with the requirements of paragraph (D) above.
- I. The USMLE examination is designed to supersede and replace the FLEX over time.
1. For those medical students and physicians who may have already successfully completed part of the FLEX or National Board Examination sequence, the Board designates the following combinations of examinations, and passing score for each, which shall be considered comparable to the existing examinations. In order to meet the examination requirement for licensure, the examination sequence combinations illustrated above must be successfully completed no later than January 1, 2000.

NBME Part I (passing score = 75) or USMLE Step 1 (passing score = 75)

NBME Part II (passing score = 75) or USMLE Step 2 (passing score = 75)

NBME Part III (passing score = 75) or USMLE Step 3 (passing score = 75)

Or

FLEX Component 1 (passing score = 75)

plus

USMLE Step 3 (passing score = 75)

Or

NBME Part I (passing score = 75) or USMLE Step 1 (passing score = 75)

plus

NBME Part II (passing score = 75) or USMLE Step 2 (passing score = 75)

plus

FLEX Component 2 (passing score = 75)

2. For those applicants who successfully completed the FLEX, the Board finds the following minimum scores required to meet the requirements of section 12-240-110(1), C.R.S.:

DATE OF EXAM	ACCEPTED SCORES
Before June 1985	75% weighted average; passed in one sitting; no scrambling or replacement of scores.
Between June 1985 and December 1993	75 each component; both components must be passed within 7 years

Effective: 5/30/93; Revised: 1/30/95; Revised: 5/30/95; Revised: 12/1/95; Revised: 9/30/98; Revised 6/30/00; Revised 12/30/00; Revised 11/15/02, Effective 1/30/03; Revised 8/19/10, Effective 10/15/10; Revised 5/22/14, Effective 7/15/14; Revised 8/20/15, Effective 10/15/15

1.6 LICENSURE AND SUPERVISION OF DISTINGUISHED FOREIGN TEACHING PHYSICIANS

- A. Basis: The authority for promulgation of these rules by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-20-204(1), 12-240-106(1)(a), and 12-240-111, C.R.S.
- B. Purpose: These rules have been adopted by the Board to specify standards related to the qualification and supervision of distinguished foreign teaching physicians and to clarify application requirements for this license type.

- C. A physician who meets the conditions set forth in section 12-240-111, C.R.S., of the Medical Practice Act and the qualification standards and application requirements set forth in this Rule may be granted a distinguished foreign teaching physician license to practice medicine in this state at the discretion of the Board. When determining whether an applicant is eligible for this license type, the Board shall in the exercise of its discretion, consider the following Qualification Standards.
1. **QUALIFICATION STANDARDS:** For licensure as a distinguished foreign teaching physician that demonstrate noteworthy and recognized professional attainment.
 - a. The applicant holds a current medical license in good standing in his/her home country or in any other country.
 - b. The applicant's foreign medical education and training meets or exceeds the minimum educational requirements for medical licensure in Colorado.
 - c. The applicant holds Board certification conferred by a regular member board of the American Board of Medical Specialties or the American Osteopathic Association in the applicant's area of medical specialty OR holds Board certification outside of the United States.
 - d. The applicant has undergone extensive clinical post-graduate medical training in the applicant's area of medical specialty.
 - e. The applicant has demonstrated recent clinical experience by being actively and continuously involved in the practice of medicine for at least a two year period immediately preceding the filing of the application and has demonstrated expertise that meets or exceeds the clinical skills required by the faculty position.
 - f. The applicant has demonstrated teaching ability to include prior experience in an academic position, including other visiting professorships or professorships.
 - g. The applicant has published a significant number of peer-reviewed articles or noteworthy research in respected medical publications.
 - h. The applicant's training, skills or talents will contribute uniquely to clinical medicine and medical education in Colorado.
 - i. The applicant demonstrates that s/he will continue to contribute uniquely to clinical medicine and medical education in Colorado during the ensuing period of licensure.
 - j. The applicant's other medical license(s) and health care privileges are unrestricted and have not been subject to discipline by any licensing body or health care entity.
 - k. The applicant is free from prior medical malpractice judgments, settlements, or their equivalent.
 2. **APPLICATION REQUIREMENTS:** An applicant for licensure as a distinguished foreign teaching physician shall:
 - a. Fully and accurately complete the Board's distinguished foreign teaching physician application, initial or renewal, as applicable;

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- b. Pay the Board a licensing fee to be determined and collected pursuant to section 12-20-105, C.R.S.;
 - c. Submit a letter from the Dean's Office of the medical school on whose academic faculty the applicant will serve identifying:
 - (1) The applicant's proposed faculty position, title, and term of appointment;
 - (2) Whether the applicant will serve in the role of professor, associate professor, or assistant professor;
 - (a) If assistant professor, provide the following information:
 - (i) An explanation as to why the applicant does not qualify or satisfy the University guidelines for the rank of associate professor or higher; and
 - (ii) Identification of a supervising physician who shall have a rank of associate professor or above and have a current Colorado medical license in good standing, which is not a distinguished foreign teaching license nor reentry license; and
 - (b) For renewal applicants not designated as associate professor or higher, provide detailed information for the applicant's plans to obtain Colorado medical licensure pursuant to sections 12-240-110 or 12-240-114, C.R.S.;
 - (3) The reasons international recruitment for this academic faculty position was or continues to be necessary, to include if salary was a motivating factor;
 - (4) How the applicant will uniquely enhance or has uniquely enhanced clinical medicine and medical education in this state;
 - (5) How the applicant meets or continues to meet the Qualification Standards defined in this Rule to be eligible for this license type;
 - (6) Additional information which would assist the Board in understanding the reason for this appointment; and
 - (7) For a renewal applicant continued satisfaction of the Qualification Standards defined in this Rule shall be demonstrated by:
 - (a) An updated curriculum vita;
 - (b) An updated list of publications and teaching experience;
 - (c) Continued post-graduate education; and
 - (d) Copies of the applicant's teaching evaluations since the last renewal application.

3. DEFINITIONS: A “medical school in this state” pursuant to section 12-240-111, C.R.S., must be an approved medical college as defined by section 12-240-104(3)(a), C.R.S., located in the state of Colorado.

Adopted: August 17, 2006, Effective: October 30, 2006; Revised: 08/19/10; Effective: 10/15/2010; Revised: 08/16/2012; Effective: 10/15/2012; Repealed by Act of Colorado Legislature: 05/15/2013; Readopted by Emergency Rulemaking on: 05/16/2013; Effective: 05/16/2013; Readopted by Emergency Rulemaking on 08/15/2013; Effective: 08/15/2013; Revised 11/14/2013; Effective: 01/14/2014

1.7 EDUCATION, TRAINING, OR SERVICE GAINED DURING MILITARY SERVICE

- A. Basis: The authority for promulgation of these rules and regulation by the Colorado Medical Board (“Board”) is set forth in sections 12-20-202(4), 12-240-106(1)(a), 12-240-110(1)(d)(I)(C), 12-240-119, 12-240-120(1)(d), 12-240-141, 12-20-202(2), and 24-4-201 et seq., C.R.S.
- B. Purpose: The following rules and regulations have been adopted by the Board to implement the requirements set forth in section 12-20-202(4), C.R.S., and to otherwise streamline licensure for applicants with relevant military education, training, or experience, pursuant to Colorado House Bill 16-1197.
- C. Credit for Military Education, Training, or Experience
 1. An applicant for licensure may submit information about the applicant’s education, training, or experience acquired during military service. It is the applicant’s responsibility to provide timely and complete information for the Board’s review.
 2. In order to meet the requirements for licensure, such education, training, or experience must be substantially equivalent to the required qualifications that are otherwise applicable at the time the application is received by the Board.
 3. The Board will determine, on a case-by-case basis, whether the applicant’s military education, training, or experience meet the requirements for licensure.
 4. Documentation of military experience, education, or training may include, but is not limited to, the applicant’s Certificate of Release or Discharge from Active Duty (DD-214), Verification of Military Experience and Training (DD-2586), military transcript, training records, evaluation reports, or letters from commanding officers describing the applicant’s practice.
- D. Military Experience as Demonstration of Continued Competency for Physician Licensure
 1. The practice of medicine while an applicant is on active military duty shall be credited towards the requirements for demonstrating continued competency for physician licensure, reinstatement, or reactivation of a license.
 2. Applicants with relevant military experience must otherwise comply with statutory requirements and the processes and requirements of Rule 1.8.
- E. Military Experience as Demonstration of Continued Competency for Physician Assistant Licensure
 1. Practice as a physician assistant while an applicant is on active military duty shall be credited towards the requirements for demonstrating continued competency for physician assistant licensure, reinstatement, or reactivation of a license.

2. Applicants with relevant military experience must otherwise comply with statutory requirements and the processes and requirements of Rule 1.9.

1.8 LICENSE RENEWAL AND REINSTATEMENT PROCEDURES, DEMONSTRATION OF CONTINUED COMPETENCY BY PHYSICIAN APPLICANTS FOR LICENSURE PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM, REINSTATEMENT OF AN EXPIRED LICENSE, OR REACTIVATION OF A LICENSE

- A. Basis: The general authority for promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-202, 12-20-204(1), 12-240-106(1)(a), 12-240-110, 12-240-120(1)(d), 12-240-130, and 12-240-141(5), C.R.S.
- B. Purpose: The following rules and regulations have been adopted by the Board to clarify the requirements set forth in sections 12-240-130 and 12-20-202(1) and (2), C.R.S., for the renewal and reinstatement of licenses issued by the Board, and to set forth the process by which a physician may demonstrate qualifications substantially equivalent for licensure by endorsement in this state pursuant to the Occupational Credential Portability Program as set forth in section 12-20-202, C.R.S., reinstatement of an expired license, or reactivation of an existing license. These rules apply to physicians who are applying for licensure by endorsement through the Occupational Credential Portability Program, physicians seeking reactivation of an inactive Colorado license, physicians seeking a reentry license, or physicians seeking the reinstatement of an expired Colorado license who have not established that they have actively practiced medicine for the two year period immediately preceding the filing of the application (hereinafter: "applicant(s)"). This Rule does not apply to physicians applying for licensure in Colorado via the Interstate Medical Licensure Compact.
- C. Renewal
 1. Pursuant to the requirements of sections 12-240-130 and 12-20-202(1), C.R.S., the Board will not renew a licensee's license until the individual has complied with the following requirements:
 - a. The licensee shall pay the Board a registration fee to be determined and collected pursuant to section 12-20-105, C.R.S.;
 - b. The licensee shall fully and accurately complete the Board's renewal questionnaire, which was developed pursuant to section 12-240-130(2), C.R.S.; and
 - c. The licensee shall provide proof that the individual has complied with the financial responsibility requirements set forth in Part 3 of Article 64, Title 13, C.R.S., and Board Rule 1.14.
 2. If a licensee fails to comply with the requirements listed above prior to the date on which the licensee is required to complete the renewal process, the license of such licensee shall expire.
 3. At any point before, during or after the renewal process, a licensee's license may be subject to disciplinary action pursuant to sections 12-240-121 and 12-240-125, C.R.S., or as otherwise provided by Article 240 of Title 12, C.R.S. ("the Medical Practice Act") or other applicable Colorado law.

D. Reinstatement

1. Pursuant to the requirements of sections 12-240-130 and 12-20-202(2), C.R.S., the Board will not reinstate an individual's expired license until the individual submits a Board approved application for reinstatement. The expired license may be reinstated only upon compliance with the following conditions:
 - a. The individual shall pay a reinstatement fee determined by the Board pursuant to section 12-20-105, C.R.S., and
 - b. The individual shall fully and accurately complete all portions of the Board's application for reinstatement, including but not limited to the Board's renewal questionnaire, and
 - c. The individual shall provide proof that they have complied with the financial responsibility requirements set forth in Part 3 of Article 64, Title 13, C.R.S., and Board Rule 1.14.
 - d. If the individual has a matter pending before an Inquiry or Hearings Panel, the Board may defer action on the pending application for reinstatement and proceed with disciplinary action as provided by section 12-240-125, C.R.S. Pursuant to any such disciplinary action, the Board may determine whether to deny or reinstate with or without probationary terms or impose other sanctions as authorized by the Medical Practice Act.
 - e. If the individual has not practiced medicine during the two years preceding the Board's consideration of the licensee's application for reinstatement, and the individual cannot otherwise demonstrate continued competency, the Board's Licensing Panel may exercise discretion to require the individual to undertake a competency assessment or evaluation conducted by a Board-approved program, undertake a period of supervised practice, or complete an educational program, consistent with the requirements of the Medical Practice Act, including but not limited to sections 12-240-119 and 12-20-202(3), C.R.S., and the Board's supporting rules and policies.
 - f. The Board may approve the reinstatement application or may deny the application as set forth in section 12-240-120, C.R.S.

Effective: 06/30/2001, Revised: 02/09/2006; Effective: 03/31/2006; Revised: 08/19/2010; Effective: 10/15/2010; Revised: 08/16/2012; Effective: 10/15/2012

E. LICENSURE BY ENDORSEMENT PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM PURSUANT TO SECTION 12-20-202(3), C.R.S.

1. Definitions:

- a. For the purpose of licensure by endorsement through the occupational credential portability program, “substantially equivalent experience or credentials” means the applicant holds a current, valid, and unrestricted license in another U.S. jurisdiction that requires qualifications substantially equivalent to the qualifications for licensure in this state; the applicant submits written verification they have actively practiced medicine in another jurisdiction for the last year or has otherwise maintained continued competency as determined by the Board; and submits proof satisfactory to the board and attests that they have not been and are not subject to final or pending disciplinary or other action by any state or jurisdiction in which the applicant is or has been previously licensed except that, if the applicant is or has been subject to action, the board may review the action to determine whether the underlying conduct warrants refusal of a license pursuant to section 12-240-120, C.R.S.
- b. For the purpose of licensure by endorsement through the occupational credential portability program, an applicant may demonstrate “continued competency” by establishing that they have maintained an active, continuous, and unrestricted license in another state, have actively practiced medicine for the last year in a jurisdiction with a scope of practice that is substantially similar to the scope of practice for physicians in Colorado, and have not been subject to any disciplinary action during that time period. The active practice of medicine includes the practice of administrative medicine, so long as such practice is not the result of a limitation or restriction by another state licensing board or credentialing entity.

Alternatively, an applicant may demonstrate “continued competency” through participation in numerous professional activities, including but not limited to: maintenance of certification (MOC) activities; successful completion and maintenance of board certification exams for ABME or AOA member boards; category 1 approved CME educational courses with relevance to practice; teaching/lecturing/mentoring activities; non-patient care hospital or organization committee participation, including quality, safety, pharmacy and therapeutics, peer review, tumor board or other clinically relevant activities; clinically applicable research; surveying on behalf of accreditation organizations; reentry to practice programs, or volunteer medical care provided overseas or in other jurisdictions. The Board’s Licensing Panel shall have discretion to consider an applicant’s activities on a case-by-case basis and may determine an applicant has met continued competency through a combination of any of the above activities or other relevant professional activities.

- c. For the purpose of licensure by endorsement through the occupational credential portability program, “substantially similar scope of practice” means the scope of practice for physicians in another state that is substantially similar to the practice of medicine as defined in section 12-240-107, C.R.S.
2. If the Board determines that the applicant has not established continued competency for purposes of complying with section 12-20-202(3), 12-240-110, 12-240-120(1)(d), 12-240-119, or 12-240-141(5), C.R.S., the Board may require an applicant to submit to any competency assessment(s) or evaluation(s) conducted by a program approved by the Board. Although the Board retains the discretion as to the method of determining continued competency based on the applicant’s specific circumstances, a competency assessment or evaluation conducted by a Board-approved program is the Board’s standard operating procedure. The Board also retains discretion as to whether the Applicant has demonstrated his/her/their qualifications are substantially equivalent to the active practice of medicine.

Nothing in this Rule is intended to limit the Board's Licensing Panel from discretion to deny a license or to otherwise offer a restricted license consistent with the authority in the Medical Practice Act, including those circumstances in which an Applicant holds a restricted license in another jurisdiction or has been subject to disciplinary action.

3. If the Board determines that the applicant requires a period of supervised practice and/or the completion of an educational program (hereinafter "training requirements"), the Board at its discretion may either issue the applicant a license subject to probationary terms or a reentry license.

F. REENTRY LICENSE

The Board will consider an applicant to be ineligible for a reentry license if their period of inactive practice resulted from disciplinary action or unprofessional conduct. If a reentry license is issued, such a license is valid only for three years from the date of issue and is not renewable. Failure to complete the training requirements before the end of the three-year period will result in the reentry license being administratively inactivated.

In the discretion of the Board, the physician may be issued a re-entry license for the specific purpose of completing the education and/or training requirements. The re-entry license is valid for a single period of time not greater than three (3) years from the date of issue. Failure to complete the education and/or training requirements before the end of the three-year (3) period for the re-entry license will result in the re-entry license being administratively inactivated.

G. CONVERSION OF REENTRY LICENSE

When an applicant has timely and successfully completed the training requirements, the applicant shall apply to the Licensing Panel of the Board to convert the reentry license to full licensure by submitting a letter to the Licensing Panel with documents that clearly establish timely and successful completion of the training requirements. If the Board determines that the applicant is competent and qualified to practice medicine without supervision, the Board will convert the reentry license to a full license to practice medicine. If the Board determines that the applicant is not competent nor qualified to practice medicine without supervision, the Board may require further assessment, training, or period of supervised practice in its discretion.

H. EXPENSES

All expenses resulting from the assessment and/or any training requirements are the responsibility of the applicant and not of the Board.

I. ADMINISTRATIVE PRACTICE OF MEDICINE

"Administrative medicine" carries the definition set forth in Board Policy 20-06. Administrative medicine shall constitute the active practice of medicine.

When an applicant who practices administrative medicine seeks licensure, the Board shall evaluate the applicant's application to determine whether they meet the criteria for active and unrestricted licensure in Colorado. If the applicant is not subject to a restricted license because of disciplinary action in another jurisdiction, and otherwise meets the criteria for a full, active, and unrestricted license in Colorado, the Licensing Panel may grant the application for a full, active, and unrestricted license.

If the applicant is subject to a restricted license or credentialing because of disciplinary action in another jurisdiction, the Licensing Panel may consider whether to enter into an agreement with the applicant to limit their practice to administrative medicine in the form of a stipulation and final agency order.

J. REINSTATEMENT OR REACTIVATION OF A LICENSE

In support of any application for reinstatement or reactivation of a license to practice medicine, for the purpose of complying with sections 12-20-202(2)(c)(II), 12-240-120(1)(d), or 12-240-141(5), C.R.S., a physician may demonstrate continued competency in accordance with the methods identified in Rule 22.2(A), identified above.

Effective 12/1/95, Revised 8/15/02, Effective 10/30/02, Revised 2/13/03, Effective 4/30/03, Revised 4/14/05, Effective 6/30/05; Revised 2/9/06; Effective 3/31/06; Revised 8/19/10; Effective 10/15/10; Revised 11/17/2011; Effective 1/14/2012

1.9 DEMONSTRATION OF CONTINUED COMPETENCY BY PHYSICIAN ASSISTANT APPLICANTS FOR LICENSURE, LICENSURE PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM, REINSTATEMENT OF AN EXPIRED LICENSE, OR REACTIVATION OF A LICENSE

- A. Basis: The authority for promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-20-204(1), 12-240-119, 12-240-106(1)(a), 12-240-120(1)(d), 12-20-202(2)(c)(II), and 12-240-141(5), C.R.S.
- B. Purpose: The purpose of these rules and regulations is to set forth the process by which a physician assistant may demonstrate continued competency for the purpose of complying with the statutory sections referenced above to obtain a Colorado physician assistant license; demonstrate qualifications substantially equivalent for licensure by endorsement in this state pursuant to the Occupational Credential Portability Program as set forth in section 12-20-202, C.R.S.; demonstrate at least one year of having practiced as a physician assistant in another jurisdiction with a scope of practice substantially similar to the scope of practice in this state for licensure by endorsement pursuant to the Occupational Credential Portability Program as set forth in section 12-20-202, C.R.S.; reinstate an expired license; or reactivate an existing Colorado physician assistant license. The Board finds that due to the significant differences between the nature of physician assistant practice and the nature of physician practice, it is necessary and appropriate to delineate different methods by which physician assistants and physicians shall demonstrate continued competency as required by the Medical Practice Act. The significant differences between the two types of practice include the requirements that all physician assistants must be supervised by a licensed physician in accordance with existing Board rules and regulations. The Board finds, however, that if a physician assistant has ceased clinical practice for two or more years, the nature of the physician assistant/physician supervisory relationship in and of itself cannot compensate for potential knowledge and clinical deficiencies, which may exist due to the lack of practice experience for such an extended period of time.

C. LICENSURE BY ENDORSEMENT PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM PURSUANT TO SECTION 12-20-202(3), C.R.S.

1. For the purpose of licensure by endorsement through the occupational credential portability program, "substantially equivalent experience or credentials" means the applicant holds a current, valid, and unrestricted license in another U.S. jurisdiction that requires qualifications substantially equivalent to the qualifications for licensure in this state; the applicant submits written verification they have actively practiced as a physician assistant in another jurisdiction for the last two years or has otherwise maintained continued competency as determined by the Board; and submits proof satisfactory to the Board and attests that they have not been and are not subject to final or pending disciplinary or other action by any state or jurisdiction in which the applicant is or has been previously licensed except that, if the applicant is or has been subject to action, the Board may review the action to determine whether the underlying conduct warrants refusal of a license pursuant to section 12-240-120, C.R.S.
2. To demonstrate continued competency for purposes of complying with section 12-20-202(3), C.R.S., a physician assistant may:
 - a. Submit proof satisfactory to the Board of active practice as a physician assistant in another jurisdiction for the one-year period immediately preceding the filing of the application. If the physician assistant has practiced as a physician assistant only for a portion of the one-year period immediately preceding the filing of the application, the Board may determine on a case by case basis in its discretion whether the physician assistant has adequately demonstrated continued competency to practice as a physician assistant;
 - a. Submit proof satisfactory to the Board of having held for at least one year a current and valid physician assistant license in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for physician assistants as specified in section 12-240-107, C.R.S.
 - c. Submit to the Board the following: (a) proof satisfactory to the Board that the physician assistant has been out of practice as a physician assistant for less than two years; (b) proof of current certification by the National Commission on Certification of Physician Assistants, Inc. ("NCCPA"); (c) proof of 100 hours of continuing medical education within the past two years, including twenty-five hours of category I continuing medical education in the past twelve months; and (d) a written plan satisfactory to the Board, documenting the nature, extent, and duration of supervision that will be provided by the supervising physician to the physician assistant as the physician assistant makes the transition back into clinical practice; or
 - d. Submit to the Board proof of participation in numerous professional activities, including but not limited to: maintenance of certification (MOC) activities; successful completion of the National Commission on Certification of Physician Assistants (NCCPA); category 1 approved CME educational courses with relevance to practice; teaching/lecturing/mentoring activities; non-patient care hospital or organization committee participation, including quality, safety, pharmacy and therapeutics, peer review, tumor board or other clinically relevant activities; clinically applicable research; surveying on behalf of accreditation organizations; or volunteer medical care provided overseas or in other jurisdictions. The Board's Licensing Panel shall have discretion to consider an applicant's activities on a case-by-case basis and may determine an applicant has met continued competency through a combination of any of the above activities or other relevant professional activities.

D. REENTRY LICENSE

For those physician assistants who have been out of practice as a physician assistant for two or more years, (a) submit to the Board a personalized competency evaluation report prepared by a program approved by the Board, and (b) complete any education and/or training recommended by the program as a result of the evaluation prior to obtaining a license. In the discretion of the Board, the physician assistant may be able to receive a re-entry license prior to completing the education and/or training recommended by the program for the purpose of facilitating the completion of such education and/or training. All expenses resulting from the evaluation and/or any recommended education and/or training are the responsibility of the physician assistant and not of the Board.

The Board will consider an applicant to be ineligible for a reentry license if their period of inactive practice resulted from disciplinary action or unprofessional conduct. If a reentry license is issued, such a license is valid only for three years from the date of issue and is not renewable. Failure to complete the training requirements before the end of the three-year period will result in the reentry license being administratively inactivated.

In the discretion of the Board, the physician assistant may be issued a re-entry license for the specific purpose of completing the education and/or training requirements. The re-entry license is valid for a single period of time not greater than three (3) years from the date of issue. Failure to complete the education and/or training requirements before the end of the three (3) year period for the re-entry license will result in the re-entry license being administratively inactivated.

E. CONVERSION OF REENTRY LICENSE

When an applicant has timely and successfully completed the training requirements, the applicant shall apply to the Licensing Panel of the Board to convert the reentry license to full licensure by submitting a letter to the Licensing Panel with documents that clearly establish timely and successful completion of the training requirements. If the Board determines that the applicant is competent and qualified to practice as a physician assistant, the Board will convert the reentry license to a full license to practice as a physician assistant. If the Board determines that the applicant is not competent nor qualified to practice as a physician assistant, the Board may require further assessment, training, or period of supervised practice in its discretion.

F. EXPENSES

All expenses resulting from the assessment and/or any training requirements are the responsibility of the applicant and not of the Board.

G. REINSTATEMENT OR REACTIVATION OF A LICENSE

In support of any application for reinstatement or reactivation of a license to practice as a physician assistant, for the purpose of complying with sections 12-20-202(2)(c)(II), 12-240-120(1)(d), or 12-240-141(5), C.R.S., a physician assistant may demonstrate continued competency in accordance with the methods identified in Rule 29.2(A)(2), identified above.

H. Where appropriate, the Board may determine that demonstration of continued competency requires an additional or different approach. For example, due to the length of time the physician assistant has been out of practice, the Board may require a written plan documenting the nature, extent, and duration of supervision that will be provided by the supervising physician to the physician assistant as the physician assistant makes the transition back into clinical practice. This written plan may be in addition to the personalized competency evaluation and/or recommended education and/or training. The decision as to the method of determining continued competency shall be at the discretion of the Board.

Adopted 8/15/02, Effective 10/30/02, Revised 2/13/03, Effective 4/30/03, Revised 4/14/05, Effective 6/30/05, Revised 5/17/07, Effective July 30, 2007; Revised 08/19/10; Effective 10/15/10.

1.10 DEMONSTRATION OF CONTINUED COMPETENCY BY ANESTHESIOLOGIST ASSISTANT APPLICANTS FOR LICENSURE, LICENSURE PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM, REINSTATEMENT OF AN EXPIRED LICENSE, OR REACTIVATION OF A LICENSE

- A. Basis: The authority for promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-240-119, 12-20-204(1), 12-240-106(1)(a), 12-240-120(1)(d), 12-20-202(2)(c)(II), and 12-240-141(5), C.R.S.
- B. Purpose: The purpose of these rules and regulations is to set forth the process by which an anesthesiologist assistant may demonstrate continued competency for the purpose of complying with the statutory sections referenced above to obtain a Colorado anesthesiologist assistant license; demonstrate qualifications substantially equivalent for licensure by endorsement in this state pursuant to the Occupational Credential Portability Program as set forth in section 12-20-202, C.R.S.; demonstrate at least one year of having practiced as an anesthesiology assistant in another jurisdiction with a scope of practice substantially similar to the scope of practice in this state for licensure by endorsement pursuant to the Occupational Credential Portability Program as set forth in section 12-20-202, C.R.S.; reinstate an expired license; or reactivate an existing Colorado anesthesiologist assistant license. The Board finds that due to the significant differences between the nature of anesthesiologist assistant practice and the nature of physician practice, it is necessary and appropriate to delineate different methods by which anesthesiologist assistants and physicians shall demonstrate continued competency as required by the Medical Practice Act. The significant differences between the two types of practice include the requirements that anesthesiologist assistants must be supervised by a licensed physician in accordance with existing Board rules and regulations. The Board finds, however, that if an anesthesiologist assistant has ceased clinical practice for two or more years, the nature of the anesthesiologist assistant/physician supervisory relationship in and of itself cannot compensate for potential knowledge and clinical deficiencies, which may exist due to the lack of practice experience for such an extended period of time.
- C. LICENSURE BY ENDORSEMENT PURSUANT TO THE OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM PURSUANT TO SECTION 12-20-202(3), C.R.S.
1. For the purpose of licensure by endorsement through the occupational credential portability program, "substantially equivalent experience or credentials" means the applicant holds a current, valid, and unrestricted license in another U.S. jurisdiction that requires qualifications substantially equivalent to the qualifications for licensure in this state; the applicant submits written verification they have actively practiced as an anesthesiologist assistant in another jurisdiction for the last two years or has otherwise maintained continued competency as determined by the Board; and submits proof satisfactory to the Board and attests that they have not been and are not subject to final or pending disciplinary or other action by any state or jurisdiction in which the applicant is or has been previously licensed except that, if the applicant is or has been subject to action, the Board may review the action to determine whether the underlying conduct warrants refusal of a license pursuant to section 12-240-120, C.R.S.
 2. To demonstrate continued competency for purposes of complying with section 12-20-202(3), C.R.S., an anesthesiologist assistant may:

- a. Submit proof satisfactory to the Board of active practice as an anesthesiologist assistant in another jurisdiction for the one-year period immediately preceding the filing of the application. If the anesthesiologist assistant has practiced as an anesthesiologist assistant for only a portion of the one-year period immediately preceding the filing of the application, the Board may determine on a case-by-case basis in its discretion whether the anesthesiologist assistant has adequately demonstrated continued competency to practice as an anesthesiologist assistant;
- b. Submit proof satisfactory to the Board of having held for at least one year a current and valid anesthesiologist assistant license in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for anesthesiologist assistants as specified in section 12-240-107, C.R.S.
- c. Submit to the Board the following: (a) proof satisfactory to the Board that the anesthesiologist assistant has been out of practice as an anesthesiologist assistant for less than two years; (b) proof of current certification by the National Commission on Certification of Anesthesiologist Assistants ("NCCAA"); (c) CME hours as required by the certifying body; and (d) a written plan satisfactory to the Board, documenting the nature, extent, and duration of supervision that will be provided by the supervising physician to the anesthesiologist assistant as the anesthesiologist assistant makes the transition back into clinical practice; or
- d. Submit to the Board proof of participation in numerous professional activities, including but not limited to: maintenance of certification (MOC) activities; successful completion of National Commission on Certification of Anesthesiologist Assistants (NCCAA); category 1 approved CME educational courses with relevance to practice; teaching/lecturing/mentoring activities; non-patient care hospital or organization committee participation, including quality, safety, pharmacy and therapeutics, peer review, tumor board or other clinically relevant activities; clinically applicable research; surveying on behalf of accreditation organizations; or volunteer medical care provided overseas or in other jurisdictions. The Board's Licensing Panel shall have discretion to consider an applicant's activities on a case-by-case basis and may determine an applicant has met continued competency through a combination of any of the above activities or other relevant professional activities.

D. REENTRY LICENSE

For those anesthesiologist assistants who have been out of practice as an anesthesiologist assistant for two or more years, (a) submit to the Board a personalized competency evaluation report prepared by a program approved by the Board, and (b) complete any education and/or training recommended by the program as a result of the evaluation prior to obtaining a license. In the discretion of the Board, the anesthesiologist assistant may be able to receive a re-entry license prior to completing the education and/or training recommended by the program for the purpose of facilitating the completion of such education and/or training. All expenses resulting from the evaluation and/or any recommended education and/or training are the responsibility of the anesthesiologist assistant and not of the Board.

The Board will consider an applicant to be ineligible for a reentry license if their period of inactive practice resulted from disciplinary action or unprofessional conduct. If a reentry license is issued, such a license is valid only for three years from the date of issue and is not renewable. Failure to complete the training requirements before the end of the three-year period will result in the reentry license being administratively inactivated.

In the discretion of the Board, the anesthesiologist assistant may be issued a re-entry license for the specific purpose of completing the education and/or training requirements. The re-entry license is valid for a single period of time not greater than three (3) years from the date of issue. Failure to complete the education and/or training requirements before the end of the three (3) year period for the re-entry license will result in the re-entry license being administratively inactivated.

E. CONVERSION OF REENTRY LICENSE

When an applicant has timely and successfully completed the training requirements, the applicant shall apply to the Licensing Panel of the Board to convert the reentry license to full licensure by submitting a letter to the Licensing Panel with documents that clearly establish timely and successful completion of the training requirements. If the Board determines that the applicant is competent and qualified to practice as an anesthesiologist assistant, the Board will convert the reentry license to a full license to practice as an anesthesiologist assistant. If the Board determines that the applicant is not competent nor qualified to practice as an anesthesiologist assistant, the Board may require further assessment, training, or period of supervised practice in its discretion.

F. EXPENSES

All expenses resulting from the assessment and/or any training requirements are the responsibility of the applicant and not of the Board.

G. REINSTATEMENT OR REACTIVATION OF A LICENSE

In support of any application for reinstatement or reactivation of a license to practice as an anesthesiologist assistant, for the purpose of complying with sections 12-20-202(2)(c)(II), 12-240-120(1)(d), or 12-240-141(5), C.R.S., an anesthesiologist assistant may demonstrate continued competency in accordance with the methods identified in Rule 29.2(A)(2), identified above.

H. Where appropriate, the Board may determine that demonstration of continued competency requires an additional or different approach. For example, due to the length of time the anesthesiologist assistant has been out of practice, the Board may require a written plan documenting the nature, extent, and duration of supervision that will be provided by the supervising physician to the anesthesiologist assistant as the anesthesiologist assistant makes the transition back into clinical practice. This written plan may be in addition to the personalized competency evaluation and/or recommended education and/or training. The decision as to the method of determining continued competency shall be at the discretion of the Board.

Adopted 5/22/14: Effective 7/15/14.

1.11 MAINTENANCE OF CURRENT ADDRESS

A. Basis: The authority for the promulgation of rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-20-204(1), 12-240-106(1)(a), C.R.S.

B. Purpose: The purpose of this Rule is to provide licensees and staff with clear guidance regarding a licensee's address of record for Board purposes.

- C. A licensee's address for purposes of sending a "30-Day Letter" pursuant to section 12-240-125(4), C.R.S., for purposes of issuing a formal complaint pursuant to section 12-240-125(5), C.R.S., and for all other Board purposes, shall be the mailing address as indicated by the licensee on the application for initial licensure. Licensees shall inform the Board in a clear, explicit, and unambiguous written statement of any name, address, telephone or email change within thirty days of the change. Such information may also be updated by the licensee via electronic means made available by the Board or by any other manner approved by the Board. The mere receipt of correspondence from a licensee showing a new address shall not be sufficient to change an address.
- D. Thereafter, the licensee's last address of record with the Board shall be the address as indicated in the request for the change. In the event that a licensee submits a request for a change of address, but does not indicate between the business and home address where Board correspondence should be sent, the business address shall constitute the address for purposes of this Rule.
- E. In no event will the Board accept a change of address request which requests the address be changed for some, but not all, communications. Also, in no event shall the Board change the address if a licensee indicates that Board correspondence shall be marked "confidential".

Effective: 9/30/98 Revised 4/14/05, Effective 6/30/05; Revised 08/19/10; Effective 10/15/10

1.12 REPORTING REQUIREMENTS OF SECTIONS 12-30-204(8)(f) AND 12-30-206(2)(b)(I), C.R.S., AND OF THE FEDERAL HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986, AS AMENDED

- A. Basis: The authority for promulgation of rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-30-201(1)(a), 12-30-203(1)(b), 12-30-203(3)(a), and 12-30-208(2), C.R.S.
- B. Purpose: These rules have been adopted by the Board to clarify reporting requirements so that the Board is able to effectively and efficiently utilize and allow professional review committees and governing boards, in order to meet the Board's responsibilities under Colorado Revised Statutes, Title 12, Article 240. These Rules will enable the Board to more effectively regulate the conduct of the practice of medicine by encouraging prompt, accurate, and complete reporting by governing boards of authorized entities and their professional review committees.
- C. Reporting to the Board is required:
1. As obligated under:
 - a. The federal "Health Care Quality Improvement Act of 1986", as amended as required by section 12-30-208(2), C.R.S.; and
 - b. The Professional Review of Health Care Providers as required by sections 12-30-204(7)(f) and 12-30-204(10), C.R.S.; and
 - c. The Professional Review of Health Care Providers Act as required by section 12-30-206(2)(b)(I), C.R.S.
 2. In response to a subpoena issued by the Board in accordance to section 12-30-204(11), C.R.S.

- D. Reporting: In order to be considered in compliance with the reporting requirements of this Rule:
1. Reports required under part (A)(1)(a) and (b) of this Rule, must be submitted to the Board within thirty calendar days of the reportable recommendation, finding, or adverse action.
 2. Reports required under part (A)(1)(c) of this Rule, the report must be submitted to the Board no later than the first day of March of each year for the information from the preceding calendar year.
 3. Paper copies of reports must be sent to the Board's office by U.S. mail or via electronic mail to the Program Director of the Colorado Medical Board.
 4. The Board delegates authority to the Program Director of the Colorado Medical Board to receive the reporting information on its behalf and to resolve reporting discrepancies and irregularities directly with the reporting entity.

Adopted: 05/16/2013, Effective: 07/15/2013

1.13 REPORTING REQUIREMENTS FOR CRIMINAL CONVICTIONS

- A. Basis: The authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-20-204(1), and 12-240-106(1)(a), C.R.S.
- B. Purpose: The purpose of these rules and regulations is to establish and clarify requirements surrounding the reporting of criminal convictions that constitute unprofessional conduct pursuant to section 12-240-121, C.R.S., including but not limited to sections 12-240-121(1)(b), (1)(d), (1)(r) and (1)(s), C.R.S.
- C. A licensee, as defined in section 12-20-102(10), C.R.S., means any physician, physician assistant, or anesthesiologist assistant who is licensed by the Board (hereinafter known as "licensee"). Each licensee shall inform the Board, in the manner set forth by the Board, within thirty days of the conviction of the licensee of any of the following:
1. An offense of moral turpitude under the laws of any state or of the United States;
 2. A felony under the laws of any state or of the United States;
 3. A crime that may constitute a violation of the Medical Practice Act, section 12-240-101 *et seq.*, C.R.S.; or
 4. A violation of any federal or state law regulating the possession, distribution, or use of any controlled substance, as defined in section 12-22-303(7), C.R.S. [repealed].
- D. For purposes of this Rule, a "conviction" includes:
1. A guilty verdict;
 2. A plea of guilty accepted by the court or the entry of a guilty plea;
 3. A plea of nolo contendere (no contest) accepted by the court; or
 4. The imposition of a deferred sentence accepted by the court.

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- E. For the purposes of this Rule, “crimes of moral turpitude” include the following felony, misdemeanors, or municipal offenses:
1. Any of the offenses against the person set forth in Title 18, Article 3 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any assault, menacing, or unlawful sexual behavior;
 2. Any of the offenses against property set forth in Title 18, Article 4 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any arson, theft, trespass, or criminal mischief;
 3. Any of the offenses involving fraud set forth in Title 18, Article 5 of the Colorado Revised Statutes;
 4. Computer crime as set forth in Title 18, Article 5.5 of the Colorado Revised Statutes;
 5. Any of the offenses involving the family relations set forth in Title 18, Article 6, Part 4 (wrongs to children), when committed intentionally and knowingly or recklessly; Part 6 (harboring a minor); or Part 8 (domestic violence), of the Colorado Revised Statutes;
 6. Any of the offenses constituting wrongs to at-risk adults set forth in Title 18, Article 6.5 of the Colorado Revised Statutes;
 7. Any of the offenses relating to morals set forth in Title 18, Article 7 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, prostitution, indecent exposure, and criminal invasion of privacy;
 8. Any other offense in any jurisdiction whatsoever that is committed intentionally, knowingly, or recklessly, and involves violence, coercion, threats, cruelty, fraud, deception, or deprivation of legally recognized rights; and
 9. Any conspiracy, solicitation, or criminal attempt to commit any of the above offenses, or participation as an accessory to any of the above offenses.
- F. The conviction of the licensee of any of the above, under the laws of any state or of the United States, is unprofessional conduct and may be grounds for discipline pursuant to section 12-240-121(1)(b), (d) or (r), C.R.S.
- G. The notice to the Board shall include the following information:
1. The court;
 2. The jurisdiction;
 3. The case name;
 4. The case number; and
 5. A description of the matter or a copy of the indictment or charges.
- H. Even after making the initial report described above, the licensee shall inform the Board of the following information within thirty days of each such occurrence:
1. The imposition of sentence for the conviction.

2. The completion of all terms of the sentence for the conviction.
- I. The licensee notifying the Board may submit a written statement with any notice under this Rule to be included in the licensee records.
- J. A licensee's compliance with this Rule does not excuse compliance with any other applicable statute or rule, including those relating to reporting requirements. A licensee's reporting of information pertaining to criminal convictions on an application for initial licensure, renewal or reinstatement, or pursuant to section 12-30-102, C.R.S. (The Michael Skolnik Medical Transparency Act of 2010), does not excuse the licensee from compliance with this Rule.
- K. Failure to comply with this Rule may constitute grounds for disciplinary action.
- L. This Rule shall apply to any conviction or plea as described in Section (A) of this Rule occurring on or after October 1, 2009.

Effective 09/30/2009; Revised 08/19/2010, Effective: 10/15/2010; Revised 5/22/14, Effective 7/15/14

1.14 FINANCIAL RESPONSIBILITY STANDARDS

- A. Basis: The general authority for the promulgation of rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1) and 12-240-106(1)(a), C.R.S., as amended. Specific authority for the promulgation of rules regarding financial liability requirements is set forth in section 13-64-301(1)(a.5), C.R.S.
- B. Purpose: Part 3 of Article 64, Title 13, sets forth financial responsibility requirements to be met by all Colorado licensed physicians and physician assistants who have been practicing for at least three years. However, the Board may, by rule, exempt or establish lesser standards for certain classes of license holders. These Rules have been adopted by the Board in order to exempt from the requirements certain categories of licensees for whom the financial responsibility standards do not serve to enhance the public interest.
- C. Pursuant to the requirements of section 13-64-301(1)(a.5), C.R.S., every physician who holds or desires to obtain a Colorado medical license and every physician assistant who has been practicing for at least three years must maintain commercial professional liability insurance coverage with an insurance company authorized to do business in this state in a minimum indemnity amount of one million dollars per incident and three million dollars annual aggregate per year (or meet alternative responsibility standards which comply with the provisions of sections 13-64-301(1)(c), (d), or (e), C.R.S.); except that this requirement is not applicable to a health care professional who is a public employee under the "Colorado Governmental Immunity Act".
- D. Pursuant to these Rules, a physician or a physician assistant who has been practicing for at least three years whose medical practice falls entirely within one or more of the following categories is exempt from the requirements set forth in paragraph (A), above:
 1. A federal civilian or military physician or physician assistant whose practice is limited solely to that required by his/her federal/military agency.
 2. A physician or physician assistant who is not engaged in the practice of medicine.
 3. A physician or a physician assistant who is covered by individual professional liability coverage (or an alternative which complies with sections 13-64-301(1)(c), (d) or (e), C.R.S.), maintained by an employer/contracting agency in the amounts set forth in paragraph (A), above.

4. A physician or a physician assistant who provides uncompensated health care to patients, or who does not otherwise engage in any compensated patient care in Colorado.
- E. Any physician or physician assistant who has been practicing for at least three years who claims exemption from the financial responsibility requirements must provide such information, as may be requested by the Board in order to establish eligibility for any such exemption.

Effective 8/30/90; Revised 9/30/99; Revised 08/19/10; Effective 10/15/10

1.15 RULES AND REGULATIONS REGARDING THE LICENSURE OF AND PRACTICE BY PHYSICIAN ASSISTANTS

- A. Basis: The authority for promulgation of Rule 1.15 (“these Rules”) by the Colorado Medical Board (“Board”) is set forth in sections 24-4-103, 12-240-106(1)(a), 12-240-107(6) and 12-240-113, C.R.S.
- B. Purpose: The purpose of these rules and regulations is to implement the requirements of sections 12-240-113 and 12-240-107(6), C.R.S., and provide clarification regarding the application of these Rules to various practice settings.
- C. **EXTENT AND MANNER IN WHICH A PHYSICIAN ASSISTANT MAY PERFORM DELEGATED TASKS CONSTITUTING THE PRACTICE OF MEDICINE UNDER PERSONAL AND RESPONSIBLE DIRECTION AND SUPERVISION**
 1. The requirements for a Supervisory Plan or a Practice Agreement applies to all supervising physicians and physician assistants as of August 2, 2019.
 2. Responsibilities of the Physician Assistant
 - a. Compliance with these Rules. A physician assistant and the physician assistant’s supervising physician are responsible for implementing and complying with statutory requirements and the provisions of these Rules.
 - b. License. A physician assistant shall ensure that his or her license to practice as a physician assistant is active and current prior to performing any acts requiring a license.
 - c. Registration. A physician assistant shall ensure that a form in compliance with Section 7.3 of these Rules is on record with the Board.
 - d. Identification As A Physician Assistant. While performing acts defined as the practice of medicine, a physician assistant shall clearly identify himself or herself both visually (e.g. by nameplate or embroidery on a lab coat) and verbally as a physician assistant.
 - e. Chart Note. A physician assistant shall make a chart note for every patient for whom the physician assistant performs any act defined as the practice of medicine in section 12-240-107(1), C.R.S. When a physician assistant consults with any physician about a patient, the physician assistant shall document in the chart note the name of the physician consulted and the date of the consultation.
 - f. Documentation. A physician assistant shall keep such documentation as necessary to assist the supervising physician in performing an adequate performance assessment as set forth below in Section 7.1(C)(6) of these Rules.

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- g. Acute Care Hospital Setting
 - (1) Physician assistants performing delegated medical functions in an acute care hospital setting must comply with the requirements of section 12-240-107(6)(b)(II), C.R.S.
 - (2) For purposes of this section, “reviewing the medical records” means review and signature by the primary supervising physician or a secondary supervising physician.
3. Requirements for and Types of Supervising Physicians and Their Scope and Authority to Delegate
- a. Supervising Physicians must be actively practicing medicine in Colorado by means of a regular and reliable physical presence in Colorado. For purposes of this Rule, to practice medicine based primarily on telecommunication devices or other telehealth technologies does not constitute “actively practicing medicine in Colorado.”
 - b. A supervising physician must perform personal and responsible direction and supervision, which may not be rendered through intermediaries. Section 240-107(6)(b)(II), C.R.S., sets forth a statutory exception to this provision and specific requirements pertaining to delegated medical functions in some acute care hospitals.
 - c. Eight Physician Assistant Limit. Except as otherwise provided in Section 7.1(E) of these Rules, no physician shall be the primary supervising physician for more than eight specific, individual physician assistants. The names of such physician assistants shall appear on the form in compliance with Section 7.3 of these Rules. The primary supervising physician may supervise additional physician assistants other than those who appear on the form in compliance with Section 7.3 of these Rules. In other words, a primary supervising physician may also be a secondary supervising physician, as set forth below, for additional physician assistants so long as such supervision is in compliance with these Rules.
 - d. Primary Supervising Physician. Except as set forth in Section 7.1(B)(5) of these Rules, a physician licensed to practice medicine by the Board and actively practicing medicine in Colorado as defined in Section 7.1(B)(1) may delegate to a physician assistant licensed by the Board the authority to perform acts that constitute the practice of medicine only if a form in compliance with Section 7.3 of these Rules is on record with the Board. The physician(s) whose name appears on the form in compliance with Section 7.3 of these Rules shall be deemed the “primary supervising physician.” The supervisory relationship shall be deemed to be effective for all time periods in which a form in compliance with Section 7.3 of these Rules is on file with the Board.

A physician assistant shall have at least one primary supervising physician for each employer. If the employer is a multi-specialty organization, e.g., a multi-specialty practice, hospital, hospital system or health maintenance organization, the physician assistant shall have a primary supervising physician, duly registered with the Board, per specialty practice area. When performing delegated tasks, the physician assistant’s clinical practice should be consistent with and in the scope of the delegating physician’s education, training, experience, and active practice.
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- e. Secondary Supervising Physician. Other than the supervising physician whose name appears on the form in compliance with Section 7.3 of these Rules, a physician licensed to practice medicine by the Board and actively practicing medicine in Colorado as defined in Section 7.1(B)(1), may delegate to a physician assistant licensed by the Board the authority to perform acts which constitute the practice of medicine only as permitted by Section 7.1(D) of these Rules. Such physician shall be termed a "secondary supervising physician." Secondary physician supervisors do not need to be registered with the Board.
 - f. Delegation of Medical Services. Delegated services must be consistent with the delegating physician's education, training, experience and active practice. Delegated services must be of the type that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. A physician may only delegate services that the physician is qualified and insured to perform and services that the physician has not been restricted from performing. Any services rendered by the physician assistant will be held to the same standard that is applied to the delegating physician.
4. Responsibilities of and Supervision by the Primary Supervising Physician
- a. Compliance with these Rules. Both the supervising physician and the physician assistant are responsible for implementing and complying with the statutory requirements and the provisions of these Rules.
 - b. Responsibility for Actions of a Physician Assistant. A primary supervising physician may supervise and delegate responsibilities to a physician assistant in a manner consistent with the requirements of these Rules. Except as provided in Sections 7.1(C)(2) and 7.1(D) of these Rules, the primary supervising physician may be responsible if a supervised physician assistant commits unprofessional conduct as defined in section 12-240-121(1)(j), C.R.S., or if such physician assistant otherwise violates these Rules. The Board may take into consideration mitigating circumstances in determining whether sanctions involving the primary supervising physician are necessary to protect the public on a case by case basis. A primary supervising physician may be responsible if a supervised physician assistant commits negligence, except as exempted by section 12-240-114.5(5)(c), C.R.S.
 - c. The primary supervising physician shall not be responsible for the conduct of a physician assistant where that physician assistant was acting under the supervision of another primary supervising physician and there is a form in compliance with Section 7.3 of these Rules signed by that other primary supervising physician. The primary supervising physician shall also not be responsible for the conduct of a physician assistant where it is established by documentation or other reliable means that the physician assistant consulted with a secondary supervising physician and that the secondary supervising physician was clearly overseeing, or was otherwise responsible for the conduct of the physician assistant, for an episode of care.
 - d. License Status. Before authorizing a physician assistant to perform any medical service, the supervising physician should verify that the physician assistant has an active and current Colorado license issued by the Board.
 - e. Qualifications. Before authorizing a physician assistant to perform any medical service, the supervising physician is responsible for evaluating the physician assistant's education, training and experience to perform the service safely and competently.

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- f. Performance Evaluation
- (1) A primary supervising physician who supervises a physician assistant shall develop and carry out a periodic Performance Evaluation as required by these Rules and section 12-240-114.5(1)(a), C.R.S. The Performance Evaluation should include domains of competency relevant to the particular practice and utilize more than one modality of assessment to evaluate those domains of competency. The Performance Evaluation should take into account the education, training, experience, competency and knowledge of the individual physician assistant for whatever specialty the physician assistant is engaged.
 - (2) The statutory relationship between the physician and physician assistant is by its nature a team relationship. The purpose of the Performance Evaluation is to enhance the collaborative nature of the team relationship, promote public safety, clarify expectations, and facilitate the professional development of an individual physician assistant.
 - (3) The domains of competency may be dependent upon the type of practice the physician assistant is engaged in and may include but are not limited to:
 - (a) Medical knowledge;
 - (b) Ability to perform an appropriate history and physical examination;
 - (c) Ability to manage, integrate and understand objective data, such as laboratory studies, radiographic studies, and consultations;
 - (d) Clinical judgment, decision-making and assessment of patients;
 - (e) Accurate and appropriate patient management;
 - (f) Communication skills (patient communication and communication with other care providers);
 - (g) Documentation and record keeping;
 - (h) Collaborative practice and professionalism;
 - (i) Procedural and technical skills appropriate to the practice.
 - (4) The modalities of assessment to evaluate domains of competency may include but are not limited to:
 - (a) Co-management of patients;
 - (b) Direct observation;
 - (c) Chart review with identification of charts reviewed;
 - (d) Feedback from patients and other identified providers.
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- (5) A primary supervising physician must maintain accurate records and documentation of the Performance Evaluations, including the initial Performance Evaluation and periodic Performance Evaluations for each physician assistant supervised, and the Supervisory Plans.
- (6) The Board may audit a supervising physician's performance assessment records. Upon request, the supervising physician shall produce records of the performance assessments as required by the Board.

g. Supervisory Plan.

The purpose of the initial Supervisory Plan is to lay the foundation for the ongoing growth and professional development of the physician assistant's clinical practice and abilities and to promote the collaborative relationship between the physician assistant and supervising physician. This initial Supervisory Plan should also be used to address any gaps and/or deficiencies identified in the physician assistant's clinical competencies during the initial performance period.

Elements that **should** be incorporated into the Supervisory Plan may include, but are not limited to:

- (1) Nature of the Clinical Practice (areas of specialty, practice sites, populations served, ambulatory and inpatient expectations, etc.);
- (2) Specific expectations and duties of the physician assistant;
- (3) Expectations around physician(s) support, supervision, consultation and back up;
- (4) Methods and modes of communication, co-management and collaboration;
- (5) Specific clinical instances in which the physician assistant should ask for physician back up;
- (6) Plan for on-going professional education, skill acquisition, gap analysis and career development;
- (7) List of secondary supervisors anticipated to participate in the PA's practice;
- (8) Schedule of performance assessments and anticipated modalities by which the practice will be assessed and domains that will be assessed.
- (9) Other pertinent elements of collaborative, team-based practice applicable to the specific practice or individual physician and physician assistant.

h. Availability of the Supervising Physician

- (1) The supervising physician must provide adequate means for communication with the physician assistant.

- (2) If not physically on site with the physician assistant, the primary or secondary supervising physician must be readily available by telephone, radio, pager, or other telecommunication device.

5. Responsibilities of the Secondary Supervising Physician

- a. If a physician who is not the primary supervising physician consults with a physician assistant regarding a particular patient, the physician is a secondary supervising physician. The physician assistant must document the consultation date and name of all physicians consulted in the patient chart.
- b. Responsibility for Actions of a Physician Assistant. Such supervising physician may be responsible for any action or omission involving the practice of medicine supervised by the secondary supervising physician involving the particular patient. The Board may take into consideration mitigating circumstances in determining whether sanctions involving the secondary supervising physician are necessary to protect the public on a case by case basis.

6. Waiver of Provisions of these Rules

a. Criteria for Obtaining Waivers.

- (1) Upon a showing of good cause, the Board may permit waivers of any provision of these Rules, except waiver of the primary supervision of more than eight physician assistants.
- (2) Factors to be considered in granting such waivers include, but are not limited to: whether the physician assistant is located in an underserved or rural area distant from the supervising physician; the quality of protocols setting out the responsibilities of a physician assistant in the particular practice; any disciplinary history on the part of the supervising physician or the physician assistant; and whether the physician assistants in question work less than a full schedule.
- (3) All such waivers shall be in the sole discretion of the Board. All waivers shall be strictly limited to the terms provided by the Board. No waivers shall be granted if in conflict with state law.

b. Procedure for Obtaining Waivers.

- (1) Applicants for waivers must submit a written application on forms approved by the Board detailing the basis for the waiver request.
- (2) The written request should address the pertinent factors listed in Section 7.1(E)(1)(b) of these Rules and include a copy of any written protocols in place for the supervision of physician assistants.
- (3) Upon receipt of the waiver request and documentation, the matter will be considered at the next available Board meeting.

D. PRESCRIPTION AND DISPENSING OF DRUGS.

1. Prescribing Provisions:

- a. A physician assistant may issue a prescription order for any drug or controlled substance provided that:
 - (1) Each prescription and refill order is entered on the patient's chart.
 - (2) Each written prescription for a controlled substance shall contain, in legible form, the name of the physician assistant and the name, address and telephone number of the supervising physician.
 - (3) For all other written prescriptions issued by a physician assistant, the physician assistant's name and the address of the health facility where the physician assistant is practicing must be imprinted on the prescription.
 - (a) If the health facility is a multi-specialty organization, the name and address of the specialty clinic within the health facility where the physician assistant is practicing must be imprinted on the prescription.
 - (4) Nothing in this Section 7.2 of these Rules shall prohibit a supervising physician from restricting the ability of a supervised physician assistant to prescribe drugs or controlled substances.
 - (5) A physician assistant may not issue a prescription order for any controlled substance unless the physician assistant has received a registration from the United States Drug Enforcement Administration.
 - (6) For the purpose of this Rule electronic prescriptions are considered written prescription orders.
 - b. Physician assistants shall not write or sign prescriptions or perform any services that the supervising physician for that particular patient is not qualified or authorized to prescribe or perform.
2. Obtaining Prescription Drugs or Devices to Prescribe, Dispense, Administer or Deliver
- a. No drug that a physician assistant is authorized to prescribe, dispense, administer or deliver shall be obtained by said physician assistant from a source other than a supervising physician, pharmacist or pharmaceutical representative.
 - b. No device that a physician assistant is authorized to prescribe, dispense, administer or deliver shall be obtained by said physician assistant from a source other than a supervising physician, pharmacist or pharmaceutical representative.

E. REPORTING REQUIREMENTS

1. Supervisory Form.
- a. Any person wishing to form a supervisory relationship in conformance with these Rules shall file with the Board a form as required by the Board.
 - b. The form shall be signed by the primary supervising physician and the physician assistant or assistants for whom the physician intends to be the primary supervising physician.

- c. No primary supervising physician shall be a primary supervising physician for more than eight specific, individual physician assistants.
- d. The names of no more than eight individual physician assistants shall appear on the form in compliance with this Section of these Rules.
- e. The supervisory relationship acknowledged in the form shall be deemed to continue for purposes of these Rules until specifically rescinded by either the physician assistant or the primary supervising physician in writing.

Effective 12/30/83; Revised 05/30/85; Revised 12/30/85; Revised 8/30/92; Revised 11/30/94; Revised 12/1/95; Revised 12/14/95; Revised 3/30/96; Revised 3/30/97; Revised 9/30/97; Revised 3/30/98; Revised 9/30/98; Revised 06/30/00; Revised 12/30/01; Revised 9/30/04; Revised 2/9/06, Effective 3/31/06; Emergency Rule Revised and Effective 7/01/10; Revised 08/19/10, Effective 10/15/10; Revised 11/15/12, Effective 01/14/2013; Revised 5/22/14, Effective 7/15/14; Revised 8/20/15, Effective 10/15/15; Emergency Rule Revised And Effective 8/18/16; Permanent Rule Revised 8/18/16; Effective 10/15/16; Permanent Rule Revised 2/15/18, Effective _____

1.16 LICENSURE OF AND PRACTICE BY ANESTHESIOLOGIST ASSISTANTS

A. Basis: The authority for promulgation of Rule 1.16 ("these Rules") by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-20-204(1), 12-240-106(1)(a), and 12-240-112, C.R.S.

B. Purpose: The purpose of these rules and regulations is to implement the requirements of sections 12-240-107(7) and 12-240-112, C.R.S.

C. QUALIFICATIONS FOR LICENSURE APPLICATION

To apply for a license, an applicant must meet the requirements for licensure as outlined in section 12-240-112(1), C.R.S.

D. EXTENT AND MANNER IN WHICH AN ANESTHESIOLOGIST ASSISTANT MAY PERFORM DELEGATED TASKS CONSTITUTING THE PRACTICE OF MEDICINE UNDER PERSONAL AND RESPONSIBLE DIRECTION AND SUPERVISION

1. Responsibilities of the Anesthesiologist Assistant

a. Compliance with these Rules

- (1) An anesthesiologist assistant and the anesthesiologist assistant's supervising physician are responsible for implementing and complying with statutory requirements and the provisions of these Rules.

b. License

- (1) An anesthesiologist assistant shall ensure that his or her license to practice as an anesthesiologist assistant is active and current prior to performing any acts requiring a license.

c. Registration

- (1) An anesthesiologist assistant shall ensure that a form in compliance with Section (D) of these Rules is on record with the Board.

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- d. Nameplate
 - (1) In addition to the requirements regarding patient disclosure in the Statute, and while performing acts defined as the practice of medicine, an anesthesiologist assistant shall wear a nameplate or photo identification badge with the non-abbreviated title "Anesthesiologist Assistant" clearly visible.
 - e. Chart Note
 - (1) An anesthesiologist assistant shall make a chart note for every patient for whom the anesthesiologist assistant performs any act defined as the practice of medicine in section 12-240-107(1), C.R.S.
 - (2) The chart note at a minimum must include documentation that clearly indicates the times that the anesthesiologist assistant was responsible for the care of a patient (i.e. start of service, end of service, on/off breaks, assuming care to cover a scheduled break, etc.).
 - (3) The Anesthesiologist Assistant shall document in the chart note the name of the supervising Anesthesiologist and the date of the anesthesia service.
 - f. Documentation
 - (1) An anesthesiologist assistant shall keep such documentation as necessary to assist the supervising physician in performing an adequate performance assessment as set forth below in Section (B)(3)(d) of these Rules.
2. Physician Supervisors and Scope and Authority to Delegate
- a. Four Anesthesiologist Assistant Limit
 - (1) No physician shall concurrently supervise more than four specific, individual anesthesiologist assistants at any one time.
 - (2) The names of the supervising physician and the anesthesiologist assistant shall appear within the anesthesia or other medical records for each patient when care is provided by the anesthesiologist assistant.
 - (3) To help ensure compliance with the four anesthesiologist assistant rule, anesthesia records must be maintained in such a way as to clearly show the beginning and end of each anesthesiologist assistant involvement in an anesthetic service.
 - b. Physician Supervisor
 - (1) A physician licensed to practice medicine by the Board and who practices as an anesthesiologist may delegate to an anesthesiologist assistant licensed by the Board the ability to perform acts that constitute the practice of medicine, however, the authority for those acts remains with the supervising physician.
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- (2) The physician whose name appears on the form in compliance with Section (D) of these Rules shall be deemed the “physician supervisor”.
 - (3) The supervisory relationship shall be deemed to be effective for all time periods in which a form in compliance with Section (D) of these Rules is on file.
 - (4) An incorporated group practice may meet the requirements of this Section by submitting to the Board a listing of all its employed anesthesiologist assistants and all of its employed physicians who may act as supervising physicians.
 - (5) During an anesthesia service where a transfer of authority may take place, the transfer from one physician supervisor to another must be clearly indicated in the anesthesia or other medical record.
- c. Delegation of Medical Services
- (1) Delegated services must be consistent with the delegating physician’s education, training, experience and active practice. Delegated services must be of the type that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate.
 - (2) A physician may only delegate services that the physician is qualified and insured to perform and services that the physician has not been legally restricted from performing.
 - (3) Any services rendered by the anesthesiologist assistant will be held to the same standard that is applied to the delegating physician, as defined in section 12-240-107(7), C.R.S.
3. Responsibilities of and Supervision by the Physician Supervisor
- a. Compliance with these Rules
- (1) Both the supervising physician and the anesthesiologist assistant are responsible for implementing and complying with the statutory requirements and the provisions of these Rules.
- b. Liability for Actions of an Anesthesiologist Assistant
- (1) A physician supervisor may supervise and delegate tasks to an anesthesiologist assistant in a manner consistent with the requirements of these Rules.
 - (2) The physician supervisor may be deemed to have violated these Rules if a supervised anesthesiologist assistant commits unprofessional conduct as defined in section 12-240-121(1)(j), C.R.S., or if such anesthesiologist assistant otherwise violates these Rules.

c. Evaluation

- (1) Prior to engaging the services of an anesthesiologist assistant, the hospital, facility, ambulatory surgery center, or office must ascertain that a mechanism exists for obtaining an annual performance review that contains, at a minimum, the requirements outlined in Section (B)(3)(d) of this Rule.
- (2) The performance assessment must be performed by a physician licensed to practice medicine in this State who practices as an anesthesiologist. Whenever possible the evaluation and performance assessment should be conducted by the physician with the most knowledge of the anesthesiologist assistant's performance throughout the year.
- (3) Performance evaluation information may be gathered through direct observation, review of available information, including a review of reports which evidence performance, or a combination of both.
- (4) Facilities required by local, state or federal statute and regulations to have reviews performed by a director of anesthesia services are deemed to have satisfied the evaluation requirements.

d. Performance Assessment

- (1) An anesthesiologist assistant shall have a periodic performance assessment as required by these Rules to assist in evaluating and maintaining the quality of care provided by an anesthesiologist assistant that include, at a minimum:
 - (a) An assessment of the medical competency of the anesthesiologist assistant;
 - (b) A review of selected charts;
 - (c) An assessment of the ability of the anesthesiologist assistant to take a medical history from, and perform an examination of, patients representative of those cared for by the anesthesiologist assistant; and,
 - (d) Maintenance by the facility or employer of accurate records and documentation of the performance assessments for each anesthesiologist assistant supervised.
- (2) The Board may audit an anesthesiologist assistant's performance assessment records.

e. Availability of the physician supervisor.

The supervising physician must provide adequate means for communication with the anesthesiologist assistant and remain immediately available throughout the anesthesia service.

- (1) The Board considers a supervising physician to be immediately available if s/he is in physical proximity that allows the physician to return to re-establish direct contact with the patient in order to meet medical needs and address any urgent or emergent clinical problems.
- (2) These responsibilities may also be met through the coordination among physicians of the same incorporated group practice.

E. ADMINISTRATION OF DRUGS AND CONTROLLED SUBSTANCES

1. An anesthesiologist assistant may not independently write or issue a prescription order for any drug or controlled substance.
 - a. An anesthesiologist assistant may communicate an order from the supervising physician to another licensed practitioner.
 - b. Such communication may be verbal, written or electronic.
2. Once a physician order is entered into the medical record by an anesthesiologist assistant; the supervising physician must review and, if required by the facility or institutional policy, cosign those orders in a timely manner.
3. An anesthesiologist assistant may administer drugs and controlled substances under the supervision of a physician provided that:
 - a. Each administration is entered in the patient's anesthesia or other medical record.
 - b. Nothing in this Section (C) of these Rules shall prohibit a physician supervisor from restricting the ability of a supervised anesthesiologist assistant to administer drugs or controlled substances.
 - c. An anesthesiologist assistant may not issue or communicate an order for any drug or controlled substance outside of the hospital, facility, ambulatory surgery center, or office setting reported pursuant to Section (D) of these Rules.
 - d. Anesthesiologist assistants shall not write or issue prescriptions or perform any services that the supervising physician for that particular patient is not qualified or authorized to prescribe or perform.

F. REPORTING REQUIREMENTS

1. The application for licensure shall include a requirement that anesthesiologist assistants provide the Board with a list of hospitals, facilities, ambulatory surgery centers, and physician offices where they intend to practice medicine under the supervision of a physician.
2. The reporting must be provided in a form established by the Board and completed in conformance with these Rules.

Adopted 02/14/2013, Effective 04/30/2013; Revised 5/22/14, Effective 7/15/14; Revised 5/17/18, Effective

1.17 DELEGATION AND SUPERVISION OF MEDICAL SERVICES TO UNLICENSED PERSONS PURSUANT TO SECTION 12-240-107(3)(I), C.R.S.

- A. Basis: The general authority for promulgation of these Rules by the Colorado Medical Board (“Board”) is set forth in sections 12-20-204(1), 12-240-106(1)(a), and 24-4-103, C.R.S.
- B. Purpose: The following Rules have been adopted by the Board to clarify the requirements of section 12-240-107(3)(I), C.R.S. (the “Delegation Statute”). The Delegation Statute governs the delegation of medical services to, and personal and responsible direction and supervision over, a person who is **not** licensed to practice medicine or otherwise licensed to perform the delegated medical services. This Rule does not govern delegation of medical services to physician assistants, anesthesiologist assistants or those individuals regulated by the Board of Nursing. Such delegation is governed by Rules 1.15 and 1.16, and the Nurse Practice Act, section 12-255-101 *et seq.*, C.R.S., respectively.
- C. Scope of Rules: These Rules apply to the delegation of services constituting the practice of medicine to a person who is not licensed to practice medicine, is not qualified for licensure as a physician, physician assistant or anesthesiologist assistant, and is not otherwise exempt pursuant to section 12-240-107, C.R.S., from holding a license to practice medicine.

D. MEDICAL SERVICES THAT MAY BE DELEGATED UNDER THESE RULES

1. Medical Services

- a. “Medical services” are defined by the Medical Practice Act, section 12-240-107, C.R.S., to include suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition or defect of any person.
- b. “Medical services” also include holding oneself out to the public as being able to diagnose, treat, prescribe for, palliate or prevent any human disease, ailment, pain, injury, deformity, or physical or mental condition. “Medical services” are further defined by section 12-240-107(1), C.R.S.
- c. “Medical Services” includes those acts, other than those acts excluded by subsection (D) of this Section, performed pursuant to physician delegation by unlicensed persons or licensed healthcare professionals.

2. Medical-Aesthetic Services

- a. “Medical-Aesthetic Services” are medical services in the cosmetic or aesthetic field that constitute the practice of medicine. Such Medical-Aesthetic Services include, but are not limited to: (a) the use of a Class IIIb or higher laser, radio-frequency device, intense pulsed light, or other technique that results in the revision, destruction, incision or other structural alteration of human tissue and/or for hair removal; and (b) the performance of injection(s) of any substance into the human body except as may be permitted pursuant to subsection (D) of this Section.
- b. As with all delegated medical services, delegated Medical- Aesthetic Services must be of the type that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. Consequently, delegated Medical-Aesthetic Services should be routine, technical services, the performance of which do not require the special skills of a licensed physician.

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- c. Off-label use of medications or devices when performing delegated Medical-Aesthetic Services is generally prohibited unless:
 - (1) The delegating physician has specifically authorized and delegated the off-label use, and,
 - (2) The off-label use is within generally accepted standards of medical practice.
 - d. Medical-Aesthetic Services must be delivered within a facility appropriate to the delegated service provided and listed on the written agreement as set forth in Appendix A.
3. Use of Lasers
 - a. The revision, destruction, incision, or other structural alteration of human tissue using laser technology is a medical service and constitutes the practice of medicine, as defined in section 12-240-107, C.R.S.
 - b. Use of Class IIIb or higher lasers or pulse light devices as constitutes the practice of medicine.
 4. Acts That Do Not Constitute Medical Services
 - a. The definition of medical services under the Medical Practice Act does not include acting as an intermediary by communicating a physician's message or order to another person, or otherwise carrying out education activities as directed by the physician. Therefore a person who merely acts as an intermediary to communicate a physician's message or order to another person is not subject to these Rules.
 - b. The definition of medical services under the Medical Practice Act does not include gathering data. A person who merely gathers data is not subject to these Rules. For example, performing phlebotomy, measuring vital signs, and gathering historical patient information is not subject to these Rules.
 - c. Tattooing, application of permanent makeup, superficial exfoliative therapies, such as microdermabrasion, other superficial skin treatments, and those services regulated by the Barber and Cosmetologist Practice Act, section 12-105-101, *et seq.*, C.R.S., are not medical services.
 - d. The use of Class I, II, and IIIa medical devices, including Class I, II, and IIIa lasers, does not constitute a medical service.
 - e. Monitoring of medication compliance is not a medical service.
 - f. Medication administration by Qualified Medication Administration Personnel (QMAP) who are regulated by the Colorado Department of Public Health and Environment is not included within the definition of medical services for purposes of this Rule.
 5. Delegated Medical Services Should Not Require Exercise of Medical Judgment
 - a. A physician should not delegate a medical service requiring the exercise of medical judgment by the delegatee.
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- b. Delegated medical services should be limited to routine, technical services that do not require the special skills of a licensed physician.
6. Medical Services that May Not Be Delegated
- a. Prescription Medications
 - (1) Prescribing of drugs may not be delegated under section 12-240-107(3)(I), C.R.S., and these Rules.
 - (2) The ordering of a prescription refill by a delegatee does not constitute “the prescribing of drugs” provided that:
 - (a) The prescription refill is ordered at the same dose and for the same medication as the original prescription for that patient; and
 - (b) The prescription refill is ordered pursuant to a written refill protocol developed and authorized by one or more delegating physicians.
 - b. Non-Prescription Medications
 - (1) The recommendation of marijuana as a therapeutic option may not be delegated under section 12-240-107(3)(I), C.R.S., and these Rules.
- E. RULES GOVERNING INDIVIDUALS WHO CHOOSE TO DELEGATE MEDICAL SERVICES
1. Who May Delegate
- a. Licensed physicians may delegate the performance of medical services to delegates, in conformance with these Rules.
 - b. To delegate a medical service, an eligible delegating physician must be:
 - (1) Qualified by education, training and experience to perform the medical service;
 - (2) Actively performing the medical service as part of his or her medical practice and not exclusively by delegating the service to a delegatee;
 - (3) Insured to perform the medical service; and
 - (4) Actively practicing medicine and available in the community where the delegated medical services occur.
 - (a) To be “available in the community,” a physician must be physically present in the State and able to promptly, personally consult with or otherwise provide follow up care to the patient.
 - (b) A delegating physician may utilize telehealth technologies, where appropriate, to satisfy the requirements for prompt personal consultation or follow-up care, but should not rely exclusively on such telehealth technologies to perform those services.

- (c) Physician assistants or anesthesiologist assistants may delegate medical services to unlicensed healthcare providers who are acting under the direct supervision of the licensed physician assistant or anesthesiologist assistant, where appropriate, within the scope of the physician assistant's or anesthesiologist assistant's delegated medical services.

2. Who May Not Delegate

- a. Delegated services cannot be re-delegated to another party by the delegatee.
- b. A person who holds a physician training license pursuant to section 12-240-128, C.R.S., is not authorized to delegate medical services pursuant to section 12-240-107(3)(l), C.R.S., and these Rules.
- c. Persons with a limited medical license may not delegate pursuant to these Rules any medical services for which the licensee is prohibited from performing.

F. RULES GOVERNING INDIVIDUALS TO WHOM MEDICAL SERVICES ARE DELEGATED ("DELEGATEES")

1. Persons Who May Serve as Delegates

a. Qualified by Education, Training or Experience

- (1) The delegating physician must evaluate and determine that the delegatee has the necessary education, training or experience to perform each delegated medical service.
- (2) As part of his or her evaluation, the delegating physician shall personally assess and review:
 - (a) Copies of diplomas, certificates or professional degrees from bona fide training program(s) appropriate to the specific services delegated; and,
 - (b) Appropriate credentialing by a bona fide agency, Board or institution, if applicable.
 - (c) In any practice which utilizes a credentialing committee or a human resources department for verification of credentials, a delegating physician may rely on a credentialing committee or a human resources department for verification of Section 30.4(A)(1)(b)(1) and (2).
- (3) The delegating physician shall perform over-the-shoulder direct observation of the delegatee's performance of any medical service prior to authorizing the delegatee to perform the medical service outside of the delegating physician's physical presence. A delegating physician may rely on another Colorado Medical Board licensee's evaluation of the delegatee's skill to perform medical services.

- b. In the event that a delegating physician chooses to delegate medical services to a person holding a license, certificate or registration, and the delegated services are beyond the scope of that person's license, certificate or registration, the delegating physician must ensure that the delegatee is qualified by additional education, training or experience beyond that required for the delegatee's license, certificate or registration. Any delegation described in this paragraph must comply with the requirements of this Rule 800.
 - c. These Rules apply to individuals who are certified by a national or private body but who do not have Colorado state licensure, registration or certification.
 - d. Graduates of physician assistant and anesthesiologist assistant programs who have not yet taken the certification examination, and thus, are not qualified for licensure, may perform delegated medical services pursuant to section 12-240-107(3)(l), C.R.S., until such time as they have been notified that they have passed the certification exam and are eligible for a Colorado license. The delegating physician and the unlicensed physician assistant graduate or unlicensed anesthesiologist assistant graduate shall comply with the requirements of these Rules until the physician assistant or anesthesiologist assistant is licensed and subject to Board Rule 1.15 or 1.16.
 - e. Medical aesthetic service instructors at institutions accredited/certified by the Department of Higher Education may serve as delegates provided the instructor possesses the necessary education, training or experience to perform each delegated medical service.
 - (1) The physician may delegate the medical service to such Instructor and students at the aforementioned institution to be performed by the student under the direct supervision of the instructor.
2. The delegating physician and the delegatee shall take appropriate measures to ensure that delegates are identified in a manner that prevents confusion as to the delegates' qualifications and legal authority to provide medical services. Following are examples of situations in which confusion as to the delegates' qualifications and legal authority to provide medical services is likely and in which the physician and the delegatee shall be responsible for taking effective measures to prevent such confusion. This list is illustrative and not exhaustive.
 - a. A delegatee who is a "radiology practitioner assistant" uses the acronym "RPA", which is easily confused with the title of a licensed physician assistant or PA;
 - b. A delegatee uses the word "licensed" as part of a title when the delegatee is not licensed, registered, or certified by the state of Colorado to perform the medical services at issue;
 - c. A delegatee uses the word "doctor" or the abbreviation "Dr." when acting as a delegatee; or
 - d. A delegatee who is an "aesthetician" uses the word "medical" as part of a title, such as "medical aesthetician", when the delegatee is not licensed, registered or certified by the state of Colorado to perform medical services.
 3. Persons Not Eligible to Serve as Delegates

- a. A physician shall not delegate medical services to any person who is otherwise qualified to be licensed by the Board as a physician, physician assistant or anesthesiologist assistant but who is not so licensed, including, but not limited to:
 - (1) Any physician, physician assistant or anesthesiologist assistant with an inactive, expired, revoked, restricted, limited, suspended or surrendered license;
 - (2) Any physician, physician assistant or anesthesiologist assistant (other than those physician assistants or anesthesiologist assistants authorized pursuant to Rule 1.17(F)(1)(d)) who meets all qualifications for licensure but who is not licensed in Colorado; and
 - (3) Any physician, physician assistant or anesthesiologist assistant whose application for licensure in the State of Colorado has been denied unless the denial is pursuant to section 12-240-120(1)(a), C.R.S.
 - b. Medical services shall not be delegated to any person who holds a physician training license pursuant to section 12-240-128, C.R.S.
4. Exceptions
- a. These Rules do not apply to a person performing acts that do not constitute the practice of medicine as defined by section 12-240-107(1), C.R.S.
 - b. These Rules do not apply to health care providers who are licensed, registered or certified by the state of Colorado and who are acting within their scope of practice.
 - c. These Rules do not apply to a registered nurse (also known as a professional nurse or an RN). Services provided by a registered nurse, either as an independent nursing function or a delegated medical function, are governed by the Nurse Practice Act.
 - d. These Rules do not apply to any person who is otherwise exempt pursuant to section 12-240-107, C.R.S. from holding a license to practice medicine and who is acting within the scope of the specific statutory exemption.

G. RULES GOVERNING THE DELEGATING PHYSICIAN'S DELEGATION OF AUTHORITY TO PROVIDE MEDICAL SERVICES.

- 1. Any medical service rendered by the delegatee must conform to the same standard applicable if the delegating physician performed the service personally.

H. RULES GOVERNING THE DELEGATING PHYSICIAN'S REQUIREMENTS FOR SUPERVISION OF DELEGATEES

- 1. The delegating physician must:
 - a. Provide ongoing inspection, evaluation, advice and control;
 - b. Make decisions as to the necessity, type, effectiveness and method of treatment;
 - c. Provide sufficient on-the-spot inspection to determine that the physician's directions are regularly being followed;

- d. Monitor the quality of the services provided by the delegatee; and,
 - e. Provide personal and responsible direction and supervision that is consistent with generally accepted standards of medical practice.
2. The physician's direction and supervision of the delegatee shall be sufficient to limit the need for a delegatee to exercise the judgment required of a physician.
 3. Delegated services must be provided in the context of an appropriate physician/patient relationship.
 4. Ongoing care of a particular patient without direct physician involvement is inappropriate and demonstrates insufficient personal and responsible direction and supervision of a delegatee.
 - a. Factors establishing the presence of an appropriate physician/patient relationship include, but are not limited to, some or all of the following: physician performance of an initial consultation with the patient, direct observation by the physician of delegated services rendered by the delegatee, physician review of care rendered to the patient by the delegatee, physician review of outcomes following the performance of delegated services, and other active physician involvement in the provision, review and documentation of services provided by the delegatee.
 5. Except as otherwise provided in these Rules, a physician must be on the premises and readily available to provide adequate personal and responsible direction and supervision.
 6. Where a delegatee is acting pursuant to specific and detailed written protocols and where adequate written emergency protocols are in place, the presence of the delegating physician on the premises may not be necessary. However, a delegating physician must be physically present in the State and available to promptly, personally attend to the patient. At any time when a delegating physician is not physically present within the State, the delegating physician must identify and provide the contact information to delegates of a covering physician who is physically present in the State and available to promptly, personally attend to the patient.
 7. At least every two weeks, the delegating physician must monitor the quality of the services provided by the delegatee through such means as direct observation, review of care, review of outcomes, review of equipment, review of protocols and procedures and review of charts. The monitoring must occur at the site where the delegated services are performed.
 8. On at least an annual basis, the delegating physician must personally reassess the qualifications and competence of the delegatee to perform the medical services. This reassessment must include, but must not be limited to, over-the-shoulder monitoring of the delegatee's performance of each delegated medical service.
 9. The delegating physician must document the initial assessment and follow-up reassessments of the delegatee's performance of the delegated medical services. Upon request, the delegating physician must provide such documentation to the Board.
 - a. In a hospital or medical practice, a delegating physician may rely on a credentialing committee, human resources, or other documented institutional process/es for verification of this Rule 1.17(H)(6)-(9).

I. DOCUMENTATION REQUIREMENTS

1. Written Procedure Protocols

- a. Written procedure protocols are required to be in place at any time that a delegating physician will not be physically located on the premises where medical services are provided by a delegatee.
- b. The delegating physician shall create a comprehensive written protocol for use by the delegatee for each procedure that the physician delegates to the delegatee. The delegating physician may not rely upon a written protocol created by the delegatee to satisfy this requirement.

2. Written Emergency Protocols

- a. Written emergency protocols are required to be in place at any time that a delegating physician will not be physically located on the premises where medical services are provided by a delegatee.
- b. The delegating physician shall create a comprehensive written emergency protocol for use by the delegatee when medical services result in adverse events. The delegating physician may not rely upon a written protocol created by the delegatee to satisfy this requirement.
- c. As part of a written emergency protocol, the delegatee shall be required to notify the delegating physician of all adverse events.

3. Medical Records

- a. A delegating physician shall assure that there is a timely medical record for all patient contacts with either the delegatee or with the delegating physician. The medical record prepared by a delegatee shall conform to generally accepted standards of medical practice for recordkeeping.
- b. A delegating physician shall review the care provided to every patient who is treated by the delegatee. The delegating physician shall demonstrate that he or she has reviewed the care provided to the patient by reviewing each entry in the patient's medical record. The delegating physician shall initial and date the medical record at the time he or she reviews the record.
- c. A delegating physician shall review the care provided to patients pursuant to his or her delegated authority within fourteen days of the date that the care was provided.
- d. When the delegated medical services by delegatees occur in the context of a same-day encounter with the delegating physician and the delegating physician has been personally involved in the care of the patient, the delegating physician's own documentation of the encounter shall be adequate to meet the requirements for chart review, and the delegating physician need not co-sign any entries made by the delegatee.

4. Written Agreement between Delegating Physician and Delegatee

- a. The delegating physician and the delegatee must have a written agreement documenting and detailing the relationship. This written agreement is attached in Appendix A of these Rules. The written agreement as set forth in Appendix A must be available to the public at the site where the delegated medical services are performed.
 - b. The delegating physician must maintain a list of all delegatees to whom the physician has delegated medical services. The list must include a comprehensive and specific list of the delegated medical services that the physician has authorized the delegatee to perform.
 - c. Where the delegating physician is on-site and able to personally direct the delegatee at least 60% of the time, the requirement for a written agreement may be satisfied through job descriptions, personnel records or other documents that identify the relationship between the delegating physician and delegatee.
5. Documentation that the Delegating Physician or Healthcare Facility Must Maintain
- a. The delegating physician or healthcare facility shall maintain a copy of all documentation required by these Rules, including but not limited to:
 - (1) Appendix A written agreement;
 - (2) Any agreement that the delegating physician enters into, in order to serve as a medical director.
 - b. The delegating physician or healthcare facility is required to maintain all documentation required by these Rules.
 - c. Upon request, the delegating physician is responsible to provide all documentation maintained by the physician or healthcare facility in accordance with these Rules to the Board. The delegating physician may not rely solely on a medical office or other entity to provide the requested documents.
6. Disclosure Requirements to Patients
- a. Delegating physicians shall ensure that delegatees adequately disclose that a medical service will be performed by a delegatee, rather than by the delegating physician. When the delegating physician is not actively involved in the patient encounter, the disclosure shall include: the service the patient is receiving is a medical service; the delegatee of the service is not licensed by the state of Colorado or is acting beyond the scope of his or her Colorado license, certification or registration; the delegatee is providing the service pursuant to the delegated authority of a physician; and, the delegating physician is available personally to consult with them or provide appropriate evaluation or treatment in relation to the delegated medical services. Upon request, the delegating physician must timely and personally provide such consultation, evaluation or treatment, or provide appropriate follow-up care and/or referrals.
 - (1) The disclosure requirements may be made in writing as part of a signed disclosure agreement, an Informed Consent agreement, or a Consent or Agreement to Treat form.

- b. For all delegated medical services occurring in the context of a bona fide physician-patient relationship, the delegating physician and the delegatee shall document the disclosure made to the patient, at the time each medical service is performed.
- c. For all offices at which delegated medical-aesthetic services are provided, the delegating physician shall ensure that each office conspicuously posts, in the office's reception area, a notice with the name and contact information for each delegating physician.
- d. For all offices at which delegated medical-aesthetic services are provided, the delegating physician shall create a written disclosure, identifying the service to be performed, that the performance of the medical service is delegated to an unlicensed person, the name of the unlicensed person/delegatee, and the name and contact information for the delegating physician. The written disclosure shall be signed by the patient prior to receiving the medical service. The patient shall be given a copy of each disclosure and a copy shall be retained within the patient's medical record.
- e. The delegating physician must ensure that each patient receives all information necessary to give appropriate informed consent or consent or agreement for treatment for any medical service and that such informed consent or consent or agreement for treatment is timely documented in the patient's chart.

J. UNPROFESSIONAL CONDUCT

- 1. It is a violation of these Rules for any physician to have delegated medical services without complying with the provisions of these Rules.
- 2. It is a violation of these Rules for a licensee to perform delegated medical services pursuant to these Rules, when such licensee is otherwise restricted from performing such acts.
- 3. It is a violation of these Rules for any person qualified for licensure by this Board and who later applies for licensure by this Board, to have performed delegated medical services or to have delegated medical services pursuant to section 12-240-107(3)(l), C.R.S., prior to licensure in Colorado.
- 4. Any violation of these Rules may be determined to be unprofessional conduct pursuant to section 12-240-121(1)(n), C.R.S.
- 5. To the extent that delegates do not provide delegated medical services within generally accepted standards of medical practice, the delegating physician may be determined to have committed unprofessional conduct pursuant to section 12-240-121(1)(j), C.R.S.
- 6. To the extent that delegates falsify or repeatedly make incorrect essential entries on patient records, or repeatedly fail to make essential entries on patient records, the delegating physician may be determined to have committed unprofessional conduct pursuant to section 12-240-121(1)(v), C.R.S.
- 7. In the event that a delegating physician fails to produce to the Board, upon its request through a 30-day letter, a copy of any document required to be maintained by these Rules, the Board may determine that the delegating physician has committed unprofessional conduct pursuant to section 12-240-121(1)(y), C.R.S.

K. UNLICENSED PRACTICE OF MEDICINE

1. Pursuant to section 12-240-107(2), C.R.S., any person who performs any of the acts constituting the practice of medicine as defined by section 12-240-107(1), C.R.S., and who is not licensed by the Board to practice medicine or exempt from licensure requirements by some provision of section 12-240-107, C.R.S., shall be deemed to be practicing medicine without a license. No person shall be exempt from medical licensure requirements pursuant to section 12-240-107(3)(l), C.R.S., unless such person is acting in conformance with these Rules.
2. A person who practices medicine without a license may be the subject of a cease and desist order pursuant to section 12-240-125, C.R.S. Such person may also be the subject of injunctive proceedings by the Board in the name of the People of the State of Colorado pursuant to section 12-20-406, C.R.S. Such person may also be held criminally liable pursuant to section 12-240-135(1), C.R.S. Finally, such person may be subject to any other enforcement allowed under the law.

Adopted 11/15/02, Effective 1/30/03; Revised 04/14/05, Effective 06/30/05; Revised 10/13/05, Effective 11/30/05, Revised 5/11/06, Effective 7/2/06; Repealed and Readopted 5/22/08, Effective 6/30/08; Revised 08/19/10; Effective 10/15/10; Revised 11/18/2010; Effective 01/14/2011; Emergency-Revised 4/20/17, Effective 4/20/17; Permanent-Revised 4/20/17, Effective 6/14/17

1.18 RESPONSIBILITIES OF A PHYSICIAN WHO ENGAGES IN DRUG THERAPY MANAGEMENT WITH A COLORADO LICENSED PHARMACIST

- A. Basis: The general authority for promulgation of these Rules by the Colorado Medical Board("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), and 24-4-103, C.R.S.
- B. Purpose: The Board has adopted these Rules to delineate the requirements and responsibilities applicable to a licensed physician who enters into an agreement with a Colorado licensed pharmacist to provide "drug therapy management" by protocol as defined in these Rules. Colorado State Board of Pharmacy Rule 17.00.00 ("Pharmaceutical Care, Drug Therapy Management and Practice by Protocol") defines the requirements and responsibilities applicable to a Colorado licensed pharmacist who enters into an agreement with a Colorado licensed physician to provide "drug therapy management" by protocol.
- C. Definitions
 1. "Active, unrestricted license" means a license that is not currently subject to any practice restrictions, terms, or conditions, including but not limited to terms of probation.
 2. "Board" means the Colorado Medical Board unless otherwise specified in these Rules.
 3. "Drug therapy management" means the review and evaluation of drug therapy regimens for patients undertaken by a pharmacist in order to provide drug therapy, monitor progress and modify drug therapy. Drug therapy management may only be undertaken pursuant to an initial diagnosis made by a licensed physician, a valid order for the therapy, and a written agreement, which delineates proper protocols to be used, and the type of interaction that must occur between the pharmacist and the physician. Therapeutic interchange programs in inpatient and group model integrated closed HMO settings that are approved by medical staff committees are not considered drug therapy management for purposes of these Rules. Drug therapy management may include:
 - a. Collecting and reviewing patient drug histories;

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- b. Obtaining and checking vital signs;
 - c. Ordering and evaluating the results of laboratory tests directly related to management of the drug therapy when performed in compliance with the protocol ordered by the physician;
 - d. Modifying drug therapy when appropriate, in compliance with the protocol ordered by the physician; and
 - e. Implementing the drug therapy plan agreed upon between the physician and the pharmacist, using a protocol and managing the therapy according to the protocol.
4. "Protocol" means a specific written plan for a course of medical treatment for a certain disease state containing a written set of specific directions created by the physician, groups of physicians, hospital medical committee, or pharmacy and therapeutics committee.
- D. Eligibility to Enter into a Drug Therapy Management Agreement:
1. A physician may engage in drug therapy management by protocol with a Colorado licensed pharmacist only when the protocol used is within the scope of the physician's current practice and are consistent with the physician's education, training and experience.
 2. Only a physician with an active, unrestricted Colorado license may engage in a drug therapy management agreement with a Colorado licensed pharmacist. Upon a showing of good cause and written request, the Board may allow a physician with a restricted license to engage in drug therapy management with a Colorado licensed pharmacist. Consideration shall be given on a case by case basis. It is anticipated that such waivers would be rare. The decision to grant such a waiver shall be in the sole discretion of the Board.
 3. A physician may engage in a drug therapy management agreement only with a Colorado licensed pharmacist who has an active, unrestricted license to practice pharmacy and who meets the qualifications to provide drug therapy management as determined by the Colorado State Board of Pharmacy and set forth in Pharmacy Board Rule 17.00.30.
- E. Protocol Requirements:
1. The protocol used by a physician and pharmacist engaging in drug therapy management must follow the format of and contain the elements required in Exhibit A, which is attached to these Rules.
 2. The protocol used by a physician and pharmacist engaging in drug therapy management must demonstrate a plan of treatment that constitutes evidence-based medicine. This means that the plan of treatment must be guided by or based on current, objective, and supported scientific evidence as published in scientific literature, rather than anecdotal observations.
 3. The protocol shall be signed and dated by the authorizing physician or chairperson of the authorizing group or committee. Upon request, the physician shall submit the written protocols for drug therapy management to the Board for review.
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4. The protocol shall be reviewed and revised as necessary by the physician, at least annually. The protocol must also be revised in a timely fashion to reflect any changes in the accepted standard of medical care. The protocol developed must allow for the provision of patient care that meets generally accepted standards of medical practice.

F. Requirements for Written Agreements or General Authorization Plans:

1. Physicians who wish to engage in drug therapy management with Colorado licensed pharmacists in an inpatient setting or in a group model integrated closed HMO setting must first execute a general authorization plan. The general authorization plan must identify those physicians and pharmacists who are authorized and who have agreed to participate in drug therapy management in the specified practice setting. The general authorization plans must define the responsibilities of physicians and pharmacists engaging in drug therapy management in order to assure compliance with generally accepted standards of medical practice and with those items set forth in paragraph (D)(2) of these Rules.
2. A physician who wishes to engage in drug therapy management by protocol with a Colorado licensed pharmacist in any other setting must first execute a written agreement containing the following information:
 - a. Pharmacist's name;
 - b. Physician's name;
 - c. Diagnoses relevant to the drug therapy to be managed and other patient conditions relevant to maintenance of the patient's health during drug therapy management;
 - d. Protocol to be employed;
 - e. Functions and activities the pharmacist will perform, and restrictions or limitations on the pharmacist's management;
 - f. Method, content and frequency of reports to the physician;
 - g. Manner in which pharmacist's drug therapy management will be monitored by the physician, including method and frequency;
 - h. A specified time, not to exceed twenty-four hours (excluding Saturdays, Sundays and State holidays), within which the pharmacist must notify the physician or when applicable, the covering physician, of any modifications of drug therapy;
 - i. A provision that allows the physician to override any action taken by the pharmacist when the physician deems it to be necessary;
 - j. An effective date of the agreement and signatures of both parties;
 - k. A provision addressing how drug therapy management will be handled when the patient has more than one physician involved in evaluating or treating the medical condition which is the subject of the agreement. All physicians who are actively involved in the management of the relevant conditions shall be parties to the agreement.

- I. A provision that the pharmacist agrees to maintain liability insurance in the amount of at least \$1,000,000 per occurrence.
 3. Any general authorization plan or written agreement executed in accordance with these Rules must allow any physician or pharmacist to withdraw from the general authorization plan or written agreement within a period of time specified in the agreement.
- G. Record Keeping and Retention of Records
1. A physician who engages in drug therapy management by protocol with a Colorado licensed pharmacist must obtain copies of the pharmacist's records for each patient in a timely manner and must review such records.
 2. The physician's receipt and review of the records are important for the following reasons:
 - a. To assure that the drug therapy management is in compliance with the protocol and with these Rules;
 - b. To assure that the physician's decision to participate in drug therapy management is consistent with generally accepted standards of medical practice;
 - c. To assure that the patient's drug therapy management records are complete; and
 - d. To assure that the physician is providing overall care to the patient that meets generally accepted standards of medical practice.

Adopted 10/13/05, Effective 11/30/05; Revised 08/19/10, Effective 10/15/10; Revised 11/19/15, Effective 1/14/16

1.19 REQUIREMENTS TO BECOME A RECOGNIZED AND ESTABLISHED ACCREDITATION OR REVIEW ORGANIZATION FOR THE PURPOSES OF § 12-240-121(1)(U)(II), C.R.S.

- A. Basis: The general authority for the promulgation of rules and regulations by the Colorado Medical Board is set forth in sections 12-20-204(1) and 12-240-106(1)(a), C.R.S. The specific authority to promulgate this rule appears at section 12-240-121(1)(u)(II), C.R.S.
- B. Purpose: The following Rule is promulgated by the Board to comply with the mandate of section 12-240-121(1)(u)(II), C.R.S., that the Board utilize, in addition to its own expertise, the standards developed by recognized and established accreditation or review organizations which organizations meet requirements established by the Board by rule and regulation.
- C. The Board hereby adopts the criteria set out in section 12-30-204(4), (5) and (6) as the requirements for qualifying as an established accreditation or review organization for the purposes of section 12-240-121(1)(u)(II), C.R.S.

Effective 08/14/95; Revised 08/19/10; Effective 10/15/10

1.20 DESIGNATION OF AUTHORIZED ENTITIES TO CONDUCT PROFESSIONAL REVIEW

- A. Basis: The authority for promulgation of rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 24-4-103, 12-30-201(1)(a), 12-30-204(5), and 12-30-204(6), C.R.S.
- B. Purpose: These Rules have been adopted by the Board to:

1. Establish procedures necessary to designate specialty societies as required by section 12-30-204(5)(e), C.R.S., as authorized entities that are able to establish professional review committees;
 2. Establish procedures necessary to designate organizations authorized to insure physicians and physician assistants as required by section 12-30-204(5)(h), C.R.S., as authorized entities that are able to establish professional review committees; and
 3. Establish procedures necessary to authorize other health care or physician organizations or professional societies as authorized entities that may establish professional review committees as permitted by section 12-30-204(6), C.R.S.
- C. Designations: In order to be designated by the Board as an authorized entity entitled to establish professional review committees, an entity must:
1. Have in place written procedures that are in accordance with Colorado Revised Statutes Title 12, Article 30 and that are approved by the authorized entity's governing board;
 2. Have a governing board that registers with the Division of Professions and Occupations in accordance with section 12-30-206, C.R.S.;
 3. Report to the Medical Board and the Division of Professions and Occupations in accordance with Colorado revised statutes Title 12, Article 30;
 4. Be one of the following entities:
 - a. A medical specialty society or association designated by the Board in accordance with section 12-30-204(5)(e), C.R.S. The Board designates medical specialty societies or associations whose:
 - (1) Members are licensed to practice medicine and residing in the State of Colorado;
 - (2) Members specialize in a distinct and recognizable discipline of medicine. Such specialization may be shown by establishing that such group:
 - (a) Is recognized by the American Board of Medical Specialties, or the Advisory Board for Osteopathic Specialists of the American Osteopathic Association; or
 - (b) Is recognized as a medical specialty society by the Colorado Medical Society, or the Colorado Society of Osteopathic Medicine; or
 - (c) Practices an area of medicine that is materially distinguishable from any other such area.
 - (d) Members are representative of practitioners in that discipline.
 - (e) The society must provide the Board with a description of that society's or association's requirements for membership at the time it seeks designation.

- b. Be, for a corporation authorized to insure persons licensed under Colorado Revised Statutes, Title 12, Article 240, designated by the board in accordance with section 12-30-204(5)(h), C.R.S. The Board designates those corporations that are a professional liability insurer authorized to do business in Colorado under the provisions of section 10-3-105, C.R.S.
- c. A health care or physician organization or professional society designated by the Board in Accordance with section 12-30-204(6), C.R.S. The Board designates health care or physician organization or professional societies whose:
 - (1) Members are licensed in accordance with Colorado revised Statutes, Title 12, Article 240 and reside in the state of Colorado;
 - (2) Members practice in an area of medicine that is materially distinguishable from any other such area or a component medical society chartered by a statewide society or association;
 - (3) Members are representative of practitioners in that discipline; and
 - (4) The health care or physician organization or professional society must provide the Board with a description of those society's or association's requirements for membership at the time it seeks designation.

Effective: 11/30/88; Revised: 12/8/89; Revised: 1/30/90; Revised 08/19/10; Effective 10/15/10; Revised 05/16/2013; Effective XX/XX/XXXX

1.21 DECLARATORY ORDERS

A. STATEMENT OF BASIS AND PURPOSE

These Rules are adopted pursuant to sections 12-20-204(1), 12-240-106(1)(a), and 24-4-105(11), C.R.S., in order to provide for a procedure for entertaining requests for declaratory orders to terminate controversies or to remove uncertainties with regard to the applicability of statutory provisions or rules or orders of the Colorado Medical Board ("Board") to persons petitioning the Board.

- B. Any person may petition the Board for a declaratory order to terminate controversies or to remove uncertainties as to the applicability to the petitioner of any statutory provision or of any rule or order of the Board.
- C. The Board will determine, in its discretion and without notice to petitioner, whether to rule upon any such petition. If the Board determines that it will not rule upon such a petition, the Board shall promptly notify the petitioner of its action and state the reasons for such decision. Any of the following grounds, among others, may be sufficient reason to refuse to entertain a petition.
 - 1. Failure to comply with paragraph (C) of this Rule.
 - 2. A ruling on the petition will not terminate the controversy nor remove uncertainties as to the applicability to petitioner of any statutory provision or rule or order of the Board.
 - 3. The petitioner involves any subject, question or issue which is the subject of, or is involved in, a matter (including a hearing, investigation or complaint) currently pending before the Board or any Panel of the Board, particularly, but not limited to, any such matter directly involving the petitioner.

4. The petition seeks a ruling on a moot or hypothetical question, or will result in an advisory ruling or opinion, having no direct applicability to petitioner.
 5. Petitioner has some other adequate legal remedy, other than an action for declaratory relief pursuant to C.R.C.P. 57, which will terminate the controversy or remove any uncertainty concerning applicability of the statute, rule or order in question.
- D. Any petition filed pursuant to this Rule shall set forth the following:
1. The name and address of the petitioner and whether the petitioner is licensed by the Board as a doctor of medicine, doctor of osteopathy or physician assistant.
 2. The statute, rule or order to which the petition relates.
 3. A concise statement of all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule or order in question applies or potentially applies to the petitioner. Petitioner may also include a concise statement of the legal authorities upon which petitioner relies.
 4. A concise statement of the specific declaratory order sought by petitioner.
- E. If the Board determines that it will rule on the petition, the following procedures shall apply:
1. Any ruling of the Board will apply only to the extent of the facts presented in the petition and in any clarifying information submitted in writing to the Board.
 2. The Board may order the petitioner to file a written clarification of factual matters, a written brief, memorandum or statement of position.
 3. The Board may set the petition, upon due notice to petitioner, for a non-evidentiary hearing.
 4. The Board may dispose of the petition on the sole basis of the matters set forth in the petition.
 5. The Board may take administrative notice of commonly known facts within its expertise or contained in its records and consider such facts in its disposition of the petition.
 6. If the Board rules upon the petition without a hearing, it shall promptly notify the petitioner of its decision.
- F. The Board may, in its discretion, set the petition for an evidentiary hearing, conducted in conformance with section 24-4-105, C.R.S., upon due notice to petitioner, for the purpose of obtaining additional facts or information or to determine the truth of any facts set forth in the petition. The notice to the petitioner setting such hearing shall set forth, the extent known, the factual or other matters into which the Board intends to inquire. For the purpose of such a hearing, the petitioner shall have the burden of proving all of the facts stated in the petition, all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule or order in question applies or potentially applies to the petitioner and any other facts the petitioner desires to consider.

- G. The parties to any proceeding pursuant to this rule shall be the Board and the petitioner. Any other person may seek leave of the Board to intervene. Such requests will be granted at the sole discretion of the Board. A petition to intervene shall set forth the same matters as required by paragraph (C) of this Rule. Any reference to a "petitioner" in this Rule also refers to any person who has been granted leave to intervene by the Board.

Effective 11/30/83; Revised 09/30/99; Revised 8/19/10; Effective 10/15/10

1.22 SUSPENSIONS

- A. Basis: The authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in Sections 24-4-103, 12-20-204(1), 12-240-106(1)(a), and 12-240-125, C.R.S.
- B. Purpose: The purpose of these rules and regulations is to provide a procedural safeguard for licensees whose licenses are suspended by the Board pursuant to sections 24-4-104(4), 24-60-3602(10), 12-240-125(5)(c)(IV), 12-240-125(7), or 12-240-125(8)(a), C.R.S. These Rules are not intended to apply to the case of suspensions pursuant to section 12-240-125(5)(c)(III), C.R.S. The procedures set forth in this Rule are in addition to those provided by the Medical Practice Act and the Administrative Procedure Act.
- C. SUSPENSIONS PURSUANT TO SECTION 24-4-104(4), C.R.S.

When an Inquiry Panel determines that the suspension of a license is appropriate pursuant to section 24-4-104(4), C.R.S., it shall offer the licensee an opportunity to appear before the Inquiry Panel to offer evidence supporting why the licensee should not be suspended. This hearing does not substitute for the hearing afforded by section 24-4-104(4), C.R.S., but is in addition to such hearing. The Inquiry Panel shall determine whether the opportunity for a hearing may occur before the Inquiry Panel's consideration of whether to suspend, or whether the opportunity for hearing shall occur after the entry of an order suspending a license. The determination of whether to offer a licensee notice of the right to a pre-suspension hearing or to offer a post-suspension hearing shall be in the sole discretion of the Inquiry Panel and shall not be subject to review.

1. Pre-Suspension Notice

In the event that the Inquiry Panel believes that suspension may be indicated, the Inquiry Panel shall:

- a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
- b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and,
- c. Include the following information:
 - (1) A statement of the general nature of the issues that may warrant suspension. Such statement of the general nature of the issues that may warrant suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act;
 - (2) A statement instructing that the Inquiry Panel may suspend the licensee's license at its next meeting;

- (3) A statement that the licensee may request a hearing before the Inquiry Panel at its next meeting, but must do so prior to the Inquiry Panel's next agenda deadline;
- (4) A statement informing the licensee of the next regularly scheduled agenda deadline and the date and time of the next regularly scheduled meeting;
- (5) A statement informing the licensee that written material, up to a limit of thirty pages, may be submitted by the same deadline; and,
- (6) A statement that written material submitted by this deadline will be provided to the Inquiry Panel members prior to the meeting;
- (7) A statement that written material not submitted by the agenda deadline may be presented during the hearing at the Inquiry Panel Chair's discretion.

2. Suspension After Pre-Suspension Notice

In the event that the licensee chooses not to request a pre-suspension hearing and is subsequently suspended, the Inquiry Panel shall:

- a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
- b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and,
- c. Include within the notice a statement of the general nature of the issues that led to suspension. Such statement of the general nature of the issues that led to suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act.

3. Post-Suspension Notice

In the event that the Inquiry Panel determines that suspension without pre-suspension notice and hearing is warranted, the Inquiry Panel shall:

- a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
- b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and,
- c. Include the following information:
 - (1) A statement of the general nature of the issues that led to suspension. Such statement of the general nature of the issues that led to suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act;

- (2) A statement instructing that the licensee may request a hearing before the Inquiry Panel at its next meeting for the purpose of requesting that the suspension be set aside, but the licensee must make such a request prior to the Panel's next agenda deadline;
- (3) A statement informing the licensee of the next regularly scheduled agenda deadline and the date and time of the next regularly scheduled meeting;
- (4) A statement informing the licensee that written material, up to a limit of thirty pages, may be submitted by the same deadline;
- (5) A statement that written material submitted by this deadline will be provided to the Inquiry Panel members prior to the meeting; and,
- (6) A statement that written material not submitted by the agenda deadline may be presented during the hearing at the Inquiry Panel Chair's discretion.

D. SUSPENSIONS PURSUANT TO SECTION 12-240-125(5)(c)(IV), C.R.S.

1. In the event that the board determines that the suspension of a license is appropriate pursuant to section 12-240-125(5)(c)(IV), C.R.S., the Board may order suspension of the licensee's license until such time as the licensee complies with all conditions of the Final Agency Order.
 2. In making the determination to suspend a license, the Board may take into consideration the licensee's prior disciplinary record. If the Board does take into consideration any prior discipline of the licensee, its findings and recommendations shall so indicate.
- C. In the event that the Board orders suspension of a license pursuant to section 12-240-125(5)(c)(IV), C.R.S., the Board shall:
- a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
 - b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and
 - c. Include the following information:
 - (1) A statement of the general nature of the issues that led to suspension. Such statement of the general nature of the issues that led to suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act;
 - (2) A statement instructing that the licensee may request a hearing before the Board for the limited purpose of showing that his or her failure to comply with the Stipulation and Final Agency Order was due to circumstances beyond his or her control, and that therefore his or her license should not be suspended. The licensee must make the request for hearing prior to the Panel's next agenda deadline;

- (3) A statement informing the licensee of the next regularly scheduled agenda deadline and the date and time of the next regularly scheduled meeting;
- (4) A statement informing the licensee that written material, up to a limit of thirty pages, may be submitted by the same deadline;
- (5) A statement that written material submitted by this deadline will be provided to the Board prior to the meeting; and,
- (6) A statement that written material not submitted by the agenda deadline may be presented during the hearing at the Inquiry Panel Chair's discretion.

E. SUSPENSIONS PURSUANT TO SECTION 12-240-125(7), C.R.S.

In the event that any licensee is determined to be mentally incompetent or insane by a court of competent jurisdiction and a court enters an Order making findings of such a degree that a licensee is incapable of continuing to practice, the Board shall automatically suspend the licensee's license pursuant to section 12-240-125(7), C.R.S.

Any suspension shall continue until the licensee is found by such court to be competent to practice.

1. When the Board orders suspension of a license pursuant to section 12-240-125(7), C.R.S., the Board shall:
 - a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
 - b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and,
 - c. Include the following information:
 - (1) A statement of the general nature of the issues that led to suspension. Such statement of the general nature of the issues that led to suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act;
 - (2) A statement instructing that the licensee may request a post-suspension hearing before the Inquiry Panel at its next meeting for the limited purpose of providing evidence that the licensee either has not been determined or is no longer determined to be incompetent or insane by a court and to request that the Suspension Order be set aside;
 - (3) A statement informing the licensee of the next regularly scheduled agenda deadline and the date and time of the next regularly scheduled meeting;
 - (4) A statement informing the licensee that written material, up to a limit of 30 pages, may be submitted by the same deadline;

- (5) A statement that written material submitted by this deadline will be provided to the Inquiry Panel members prior to the meeting;
- (6) A statement that written material not submitted by the agenda deadline may be presented during the hearing at the Inquiry Panel Chair's discretion; and,
- (7) A statement that the licensee may make a request for a hearing at any time after the court makes a determination that the licensee is no longer determined by the court to be incompetent or insane. Such request, with any accompanying documents, shall be placed onto the agenda for the next regularly scheduled agenda deadline.

F. SUSPENSIONS PURSUANT TO SECTION 12-240-125(8)(a), C.R.S.

In the event that an Inquiry Panel issues an Order to a licensee for the reasons articulated in section 12-240-125(8)(a), C.R.S., the licensee must submit to mental or physical examinations as determined by the Board.

When a licensee fails to comply with the Order for examination pursuant to section 12-240-125(8)(a), C.R.S., the Inquiry Panel may suspend the licensee's license until such time as the licensee complies with such conditions.

1. When the Inquiry Panel orders suspension of a license pursuant to section 12-240-125(8)(a), C.R.S., the Inquiry Panel shall:
 - a. Provide notice to the licensee of the suspension. Board staff shall give notice to the licensee by first class mail and shall send notice to the licensee's address of record pursuant to Board Rule 1.11;
 - b. Issue the notice within seventy-two hours of the suspension, excluding interim weekends and state holidays from the calculation; and,
 - c. Include the following information:
 - (1) A statement of the general nature of the issues that led to suspension. Such statement of the general nature of the issues that led to suspension need not be as comprehensive or detailed as a formal charging document in a hearing conducted pursuant to the Administrative Procedure Act;
 - (2) A statement instructing that the licensee may request a post-suspension hearing before the Inquiry Panel at its next meeting for the purpose of requesting that the suspension be set aside, but the licensee must make such a request prior to the Panel's next agenda deadline;
 - (3) A statement informing the licensee of the next regularly scheduled agenda deadline and the date and time of the next regularly scheduled meeting;
 - (4) A statement informing the licensee that written material, up to a limit of thirty pages, may be submitted by the same deadline;
 - (5) A statement that written material submitted by this deadline will be provided to the Inquiry Panel members prior to the meeting; and,

- (6) A statement that written material not submitted by the agenda deadline may be presented during the hearing at the Inquiry Panel Chair's discretion.

G. SUSPENSIONS PURSUANT TO SECTION 24-60-3602, C.R.S.

1. Section 24-60-3601 *et seq.*, C.R.S., applies to licensees who have obtained expedited licensure through the Interstate Medical Licensure Compact.
2. Where Colorado is the licensee's state of principal license, as that term is identified in section 24-60-3602, C.R.S., any suspension proceeding shall follow the procedures identified within Rule 1.22 for the statutory basis on which the suspension action issued.
3. In the event that another state is the licensee's state of principal license, and that principal state suspends the license of a Colorado licensee, then the licensee's Colorado license shall be automatically placed on suspended status, without further action necessary by an Inquiry Panel, pursuant to section 24-60-3602(10)(b), C.R.S.
 - a. In the event that the state of principal license terminates the suspension of the license or otherwise reinstates the license issued by the principal state, an Inquiry Panel will review the matter at its next regularly-scheduled panel meeting to determine whether to terminate the suspension of the license or to reinstate the license.
 - b. In the event that the Inquiry Panel does not terminate the suspension of the Colorado license following its review, the Inquiry Panel shall follow the procedures identified within this Rule 280 for the statutory basis on which the ongoing suspension action is based.
4. Where another member state, as that term is identified in section 24-60-3602, C.R.S., acts to suspend the license of a licensee, the licensee's Colorado license shall be automatically placed on suspended status, without further action necessary by an Inquiry Panel, pursuant to section 24-60-3602(10)(d), C.R.S.
 - a. The Inquiry Panel may maintain its suspension of the licensee's Colorado license for ninety days in order to investigate the basis for the action.
 - b. The Inquiry Panel shall follow the procedures identified within this Rule 1.22 for the statutory basis on which the suspension action issued.
 - c. The Inquiry Panel may terminate the suspension of the licensee's Colorado license prior to the conclusion of the ninety day period.

H. GENERAL RULES APPLICABLE TO ALL HEARINGS

1. Licensee's Right To Hearing

Except as otherwise limited by Section (G) of this Rule, a licensee may request a hearing after any Suspension Order enters. The licensee shall make his or her request for a hearing in conformance with the scope and process described within this Rule, based on the statutory basis for the suspension which has entered against the licensee.

2. Notice Of Time And Place Of Hearing

Upon timely receipt of a request for a hearing, whether before or after a suspension, Board staff shall notify the licensee of the time and place for the hearing. No licensee shall be permitted a hearing at any Board meeting absent written notice to do so from Board staff.

3. The Nature Of The Hearing

The hearing, whether before or after a suspension, shall be conducted by the Chair of the Inquiry Panel and shall be entirely informal. The hearing need not conform to the requirements of section 24-4-105, C.R.S. The hearing shall not be transcribed or recorded either by the Inquiry Panel or the licensee. The licensee may appear with counsel. Both the licensee and counsel may present argument and may comment on the previously submitted written material. The licensee may offer evidence through witnesses. Such testimony may be written or in person (including testimony by telephone) and need not be sworn. If the licensee intends to present testimony by telephone, it shall be coordinated with Board staff prior to the date of the hearing. Cross examination of the witnesses by the Panel members or counsel for the Panel may be permitted in the discretion of the Inquiry Panel's Chair. No hearing shall exceed thirty minutes, unless, in the discretion of the Inquiry Panel's Chair, additional time is necessary in the interests of a fair hearing. Following the presentation of evidence and argument, the licensee, counsel to the licensee, and any witnesses or persons associated with the licensee shall depart the meeting room. The Inquiry Panel shall then deliberate. Following its deliberations, the Inquiry Panel shall instruct its counsel to communicate the Inquiry Panel's decision to the licensee in writing within seventy-two hours of the decision (excluding interim weekends and state holidays from the calculation).

The hearing conducted pursuant to these Rules shall be a "hearing" as set forth in section 12-240-125(9), C.R.S. Nothing in these Rules shall waive or limit the Inquiry Panel's ability to communicate with its counsel, orally or in writing, at any time, in confidence. Nothing in these Rules or in the hearing called for by these Rules shall waive any privilege on the part of the Board, Hearings Panel or Inquiry Panel. Specifically, but not by way of limitation, the Board, Hearings Panel or Inquiry Panel shall not be deemed to have waived its attorney-client or deliberative process privileges. The decision of the Inquiry Panel is not subject to appeal and shall not constitute "final agency action" as set out in section 24- 4-102(1), C.R.S.

Effective: 04/01/99; Revised: 9/30/00; Revised: 8/15/02; Effective: 10/30/02; Revised 8/19/10; Effective 10/15/10; Revised 11/19/15, Effective 1/14/16; Revised 5/18/17, Effective 7/15/17; Revised 11/16/17, Effective

1.23 REGARDING A COLORADO MEDICAL LICENSE IN GOOD STANDING

- A. Basis: The authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1) and 12-240-106(1)(a), C.R.S.
- B. Purpose: To establish and clarify the meaning of "good standing" as applied to a license issued by the Colorado Medical Board.
- C. All licenses issued by the Colorado Medical Board shall be considered to be held in good standing, unless a license is subject to probationary terms as a result of action taken by the Board as defined in section 12-240-125, C.R.S., including any active or inactive license with conditions and/or restrictions which resulted from a disciplinary action.

1. This Rule shall apply to any license issued to a physician, physician assistant, or anesthesiologist assistant by the Colorado Medical Board.
2. This Rule shall apply only in those instances where the phrase "in good standing" is explicitly used in the Colorado Constitution or statutes in reference to licenses issued by the Colorado Medical Board or in the Rules or Policies of the Colorado Medical Board.

Reviewed and tabled 05/19/2011; Reviewed and approved 11/17/2011, Effective 01/14/2012; Revised 5/22/14, Effective 7/15/14

1.24 MISLEADING, DECEPTIVE OR FALSE ADVERTISING: CLARIFICATION OF 12-240-121(1)(z), C.R.S.

- A. Basis: The general authority for promulgation of these Rules by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), and 24-4-103, C.R.S.
- B. Purpose: To provide guidance to physicians, physician assistants, and anesthesiologist assistants ("licensees") regarding the Board's position with respect to misleading, deceptive or false advertising, which is unprofessional conduct pursuant to section 12-240-121(1)(z), C.R.S. This Rule applies to advertising in all types of media including, but not limited to, print, radio, television and the Internet.
- C. Licensees should take special care to advertise truthfully and avoid exploitation of their position of trust. Because of the potential consequences of misinformation regarding health care and the importance of the interests affected by the consumer's choice of a healthcare provider, licensees must avoid misleading the public. Licensees are responsible for the contents of their own advertisements and should review such advertisements to ensure adherence to ethical standards.
- D. Therefore, licensees shall avoid the following types of advertising:
 1. Claims that the services performed, personnel employed, and/or materials or office equipment used are professionally superior to that which is ordinarily performed, employed, and/or used, or that convey the message that one licensee is better than another unless superiority of services, personnel, materials or equipment can be substantiated;
 2. The misleading use of a claim regarding board certification or of an unearned or non-health degree in any advertisement that is likely to cause confusion or misunderstanding as to the credentials, education, or licensure of a health care professional;
 3. Advertising that has the effect of intimidating or exerting undue pressure;
 4. Advertising that uses unsubstantiated testimonials;
 5. Advertising that creates an unjustified expectation or guarantees satisfaction or a cure;
 6. Advertising that offers gratuitous services or discounts, the purpose of which is to deceive the public; or,
 7. Advertising that is otherwise misleading, deceptive or false.

- E. At the time any type of advertisement is placed, the licensee must possess and rely upon information that, when produced, would substantiate the truthfulness of any assertion, omission or claim set forth in the advertisement. When using a subjective testimonial whose truthfulness cannot be substantiated, the advertisement should also include disclaimers or warnings as to the credentials of the person making the testimonial.

Adopted: 5/13/04, Effective 8/1/04; Revised 08/19/10, Effective 10/15/10; Revised 5/22/14, Effective 7/15/14

1.25 CONFIDENTIAL AGREEMENTS

- A. Basis: The authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), 12-240-126, and 12-30-108, C.R.S.
- B. Purpose: To establish and clarify the notification requirements for a physical or mental illness or condition that impacts a physician's, physician assistant's, or anesthesiologist assistant's ability to perform a medical service with reasonable skill and safety to patients. Consistent with sections 12-240-126 and 12-30-108, C.R.S., a physician, physician assistant, or anesthesiologist assistant ("licensee") who appropriately addresses their qualifying physical or mental illness or condition will not be subject to discipline for unprofessional conduct due to such illness or condition.

Prior to the 2009 Sunset Review, the Medical Practice Act defined unprofessional conduct to include having a physical or mental disability that rendered the licensee unable to perform medical services with reasonable skill and with safety to the patient. Licensees who suffered a physical or mental disability, were subject to disciplinary action by virtue of suffering such disability

Through the 2009 Sunset Review, the General Assembly amended the Medical Practice Act to redefine unprofessional conduct as it relates to licensees suffering a physical or mental illness or condition. Pursuant to sections 12-240-126 and 12-30-108, C.R.S., licensees may now be able to address a physical or mental illness or condition without the stigma of a disciplinary action while enabling the Board to ensure public protection through confidential monitoring of the illness or condition as necessary.

- C. No later than thirty days from the date a physical or mental illness or condition impacts a licensee's ability to perform a medical service with reasonable skill and safety, the licensee shall provide the Board, in writing, the following information
1. The diagnosis and a description of the illness or condition;
 2. The date that the illness or condition was first diagnosed;
 3. The name of the current treatment provider and documentation from the current treatment provider confirming the diagnosis, date of onset, and treatment plan;
 4. A description of the licensee's practice and any modifications, limitations or restrictions that have been made to such practice as a result of the illness or condition;
 5. Whether the licensee has been evaluated by, or is currently receiving services from, the Board's authorized Peer Health Assistance Program related to the illness or condition and, if so, the date of initial contact and whether services are ongoing.

- D. The licensee shall further notify the Board of any significant change in the illness or condition (“change of condition”) that impacts the licensee’s ability to perform a medical service with reasonable skill and safety. The licensee must notify the Board of any significant change in condition, whether positive or negative. Such notification shall occur within thirty days of the change of condition. The licensee shall provide the Board, in writing, the following information:
1. The date of the change of condition;
 2. the name of the current treatment provider and documentation from the current treatment provider confirming the change of condition, the date that the condition changed, the nature of the change of condition, and the current treatment plan;
 3. a description of the licensee’s practice and any modifications, limitations or restrictions to that practice that have been made as a result of the change of condition;
 4. whether the licensee has been evaluated by, or is currently receiving services from, the Board’s authorized Peer Health Assistance Program related to the change of condition and, if so, the date of initial contact and whether services are ongoing.
- E. Compliance with this Rule is a **prerequisite** for eligibility to enter into a Confidential Agreement with the Board pursuant to sections 12-240-126 and 12-30-108, C.R.S., and does not guarantee a right to a Confidential Agreement or require the Board to enter into a Confidential Agreement with the licensee. Upon notification by the licensee, the Board will evaluate all facts and circumstances to determine if a Confidential Agreement is appropriate.
- F. If the Board discovers that a licensee has a mental or physical illness or condition that impacts the licensee’s ability to perform a medical service with reasonable skill and safety and the licensee has not timely notified the Board of such illness or condition, the licensee shall not be eligible for a Confidential Agreement and may be subject to disciplinary action pursuant to section 12-240-121(1)(i), C.R.S.

Adopted 08/19/10; Effective 10/15/10; Revised 5/22/14, Effective 7/15/14

1.26 REQUIRED DISCLOSURE TO PATIENTS – CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT

- A. On or after March 1, 2021, a provider, shall disclose to a patient, as defined in section 12-30-115(1)(a), C.R.S., instances of sexual misconduct, including a conviction or guilty plea as set forth in section 12-30-115 (2)(a) C.R.S., or final agency action resulting in probation or limitation of the provider’s ability to practice as set forth in section 12-30-115(2)(b), C.R.S.
- B. Form of Disclosure: The written disclosure shall include all information specified in section 12-30-115(3), C.R.S., and consistent with the sample model disclosure form as set forth in Appendix B of this rule. The patient must, through his or her signature on the disclosure form, acknowledge the receipt of the disclosure and agree to treatment with the provider.
- C. Timing of Disclosure: This disclosure shall be provided to a patient the same day the patient schedules a professional services appointment with the provider. If an appointment is scheduled the same day that services will be provided or if an appointment is not necessary, the disclosure must be provided in advance of the treatment.
1. The written disclosure and agreement to treatment must be completed prior to each treatment appointment with a patient unless the treatment will occur in a series over multiple appointments or a patient schedules follow-up treatment appointments.

2. For treatment series or follow-up treatment appointments, one disclosure prior to the first appointment is sufficient, unless the information the provider is required to disclose pursuant to section 12-30-115, C.R.S., has changed since the most recent disclosure, in which case an updated disclosure must be provided to a patient and signed before treatment may continue.
- D. As set forth in section 12-30-115(3)(e), C.R.S., the requirement to disclose the conviction, guilty plea, or agency action ends when the provider has satisfied the requirements of the probation or other limitation and is no longer on probation or otherwise subject to a limitation on the ability to practice the provider's profession.
- E. A provider need not make the disclosure required by this Rule before providing professional services to the patient if any of the following applies as set forth in section 12-30-115(4), C.R.S.:
1. The patient is unconscious or otherwise unable to comprehend the disclosure and sign an acknowledgment of receipt of the disclosure pursuant to section 12-30-115(3)(d), C.R.S., and a guardian of the patient is unavailable to comprehend the disclosure and sign the acknowledgement;
 2. The visit occurs in an emergency room or freestanding emergency department or the visit is unscheduled, including consultations in inpatient facilities; or
 3. The provider who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.
- F. A provider who does not have a direct treatment relationship or have direct contact with the patient is not required to make the disclosure required by this Rule.

1.27 UNPROFESSIONAL CONDUCT RELATING TO THE PRESCRIBING OF STIMULANT DRUGS

- A. Basis: The general authority for promulgation of rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), C.R.S., whereby, the Board may adopt such rules and regulations as the Board may deem necessary or proper to carry out the provisions and purposes of this Article.
- B. Purpose: The following rules and regulations have been adopted by the Board to further define unprofessional conduct, specifically the generally accepted standards of medical practice regarding prescribing of stimulant drugs, more generally set forth in section 12-240-121(1)(j), C.R.S.
- C. Prescribing of stimulant drugs (amphetamine or sympathomimetic amine drugs designated as Schedule II controlled substances) shall be in accordance with generally accepted standards of medical practice including, but not limited to, the treatment of severe or treatment-resistant depression. Prescribing of stimulant drugs is not acceptable for purposes of diet control for weight loss, increasing work capacity to combat the normal fatigue associated with any endeavor, or to chemically induce euphoria.

Effective: 3/01/84; Revised: 11/30/91; Revised: 9/30/00; Revised 8/19/10; Effective 10/15/10; Revised: 5/19/2016; Effective 7/16/2016

1.28 USE OF BENZODIAZEPINES

- A. Basis: The basis for the Board's promulgation of these rules and regulations is sections 12-20-204(1), 12-240-106(1)(a), and 12-240-123, C.R.S. The specific statutory authority for the promulgation of this Rule is section 12-30-109(6), C.R.S.

- B. Scope: The purpose of these rules and regulations is to implement rules required by section 12-30-109(6), C.R.S., related to requirements for prescribing benzodiazepines to patients who have not previously prescribed benzodiazepines within the last twelve months.
- A. Licensees must limit any prescription for a continuous benzodiazepine to a 30-day supply, for any patient who has not been prescribed a benzodiazepine in the last 12 months.
- Prior to prescribing the second fill of a benzodiazepine for a condition that is not exempt under section 12-280-404(4)(a.5), C.R.S., a licensee must comply with the requirements of section 12-280-404(4), C.R.S.
- C. The limitation stated in section (A) of this Rule does not apply to patients for whom licensees prescribe benzodiazepines for the following conditions:
1. Epilepsy;
 2. A seizure, a seizure disorder, or a suspected seizure disorder;
 3. Spasticity;
 4. Alcohol withdrawal; or
 5. A neurological condition, including a post-traumatic brain injury or catatonia.
- D. These rules do not require or encourage abrupt discontinuation, limitation, or withdrawal of benzodiazepines. Licensees are expected to follow generally accepted standards of medical practice, based on an individual patient's needs, in tapering benzodiazepine prescriptions.

1.29 REGARDING SUBSTANCE USE PREVENTION TRAINING FOR LICENSE RENEWAL, REACTIVATION, OR REINSTATEMENT

- A. Basis: The general authority for promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), and 12-30-114(1), C.R.S.
- B. These Rules are adopted by the Board pursuant to section 12-30-114, C.R.S., in order to require physicians and physician assistants to complete training to demonstrate competency in preventing substance abuse and/or to demonstrate competency in treating patients with substance use disorders.
- C. Every physician and physician assistant is required to complete at least two cumulative hours of training per renewal period in order to demonstrate competency regarding the topics/areas specified in section 12-30-114(1)(a), C.R.S.
- D. Training, for the purposes of this section includes, but is not limited to, relevant continuing education courses; self-study of relevant scholarly articles or relevant policies/guidelines; peer review proceedings that involve opioid prescribing; relevant volunteer service; attendance at a relevant conference (or portion of a conference); teaching a relevant class/course; or participation in a relevant presentation, such as with your practice. All such training must cover or be related to the topics specified in section 12-30-114(1)(a), C.R.S.
- E. The Board shall exempt a physician or physician assistant from the requirements of this section who qualifies for either exemption set forth in section 12-30-114(1)(b), C.R.S.

- F. This section shall apply to any application for reinstatement of an expired license pursuant to Rule 1.8 or reactivation of an inactive license.
- G. Applicants for license renewal, reactivation, or reinstatement shall attest during the application process to either their compliance with this substance abuse training requirement or their exemption from the requirement for training, as specified in section (C) of this Rule.
- H. The Board may audit compliance with this section. Physicians and physician assistants must submit documentation of their compliance with this substance abuse training requirement or basis for their exemption, upon request by the Board.

1.30 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

- A. Basis: The general authority for the promulgation of these rules and regulations by the Colorado Medical Board ("Board") as set forth in sections 12-20-204(1), 12-240-106(1)(a), and 12-30-111(2), C.R.S.
- B. These Rules will be effective on July 1, 2021, and are adopted by the Board pursuant to section 12-30-111(2), C.R.S., in order to define a temporary technological failure, a temporary electrical failure, and an economic hardship for purposes of sections 12-30-111(1)(a)(1) and 12-30-111(1)(a)(XI), C.R.S., as well as to explain the process for a prescriber to demonstrate an economic hardship exception to the requirement to prescribe controlled substances electronically as required by section 12-30-111(1)(a), C.R.S.
- C. Pursuant to section 12-30-111(1)(a), C.R.S., a prescriber, which includes physicians and physician assistants, shall prescribe a controlled substance as set forth in section 12-30-111(1)(a), C.R.S., only by electronic prescription transmitted to a pharmacy unless an exception in section 12-30-111(1)(a), C.R.S., applies.
- D. A "temporary technological failure," for purposes of section 12-30-111(1)(a)(I), C.R.S., is when:
 - 1. A necessary prescribing software program is inaccessible or otherwise not operational;
 - 2. Required technology fails to start; or
 - 3. During a period when a virus or cyber security breach is actively putting patient data and transmission at risk.
- E. A "temporary electrical failure," for purposes of section 12-30-111(1)(a)(I), C.R.S., is a short-term loss of electrical power at the place of business that lasts no more than forty-eight hours or two consecutive business days unless there is a showing of undue hardship.
- F. An "economic hardship," for purposes of section 12-30-111(1)(a)(XI), C.R.S., is a measurement of relative need taking into consideration the individual gross receipts and net profits, cost of compliance, and type of software upgrade required. In order for a prescriber to demonstrate economic hardship, the prescriber must submit to the Board for a final determination:
 - 1. A written statement explaining the economic hardship, including supporting documentation to demonstrate economic hardship. Supporting documentation may, but need not, include the most recent tax return or other business records that show gross receipts and net profits. The Board reserves the right to request additional documentation to support the request, if necessary. The request must also include the requested duration of the economic hardship.

2. If the Board determines there should be an economic hardship exception for the prescriber, then the Board will determine the duration of the economic hardship exception, which shall not exceed one year from the date the exception was granted.
3. In order to renew a request for an economic hardship exception, the prescriber must submit a request to renew the exception in writing to the Board no less than two months prior to the expiration of the economic hardship exception. The prescriber must provide a written statement explaining the need to renew the economic hardship, including supporting documentation.

1.31 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

- A. Basis: The basis for the Board's promulgation of these rules and regulations is sections 12-20-204, 12-30-112, and 12-240-106(1)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.
- B. Purpose: The purpose of these rules and regulations is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.
- C. Definitions, for purposes of this Rule, are as follows:
 1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.
- D. Disclosure requirements.
 1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix C in compliance with section 12-30-112(3.5), C.R.S.
 2. The health care provider shall provide the disclosure contained in Appendix C as set forth in section 12-30-112(3.5), C.R.S.:
- E. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-240-125, C.R.S.

**APPENDIX A - PROTOCOL TO BE DEVELOPED AND USED FOR DRUG THERAPY MANAGEMENT
BY A PHYSICIAN AND PHARMACIST OR GROUPS OF PHYSICIANS AND PHARMACISTS**

DEFINITION

Protocol means a specific written plan for a course of medical treatment for a certain disease state containing a written set of specific directions created by a physician, groups of physicians, hospital medical committee, or pharmacy and therapeutics committee.

ELEMENTS

For the purposes of drug therapy management (DTM), the protocol must contain all of the information required by Board of Pharmacy Rule 6, 3 CCR 719-1, and Section (C) of these Rules.

In addition, a protocol created for drug therapy management by physicians working with pharmacists should adopt the following format:

1. Disease state being addressed.
2. Target audience (a department and/or all physicians participating or an individual physician if applicable).
3. Setting for application (a department, clinic, office, pharmacy).
4. Goal of the use of the protocol for the disease state (limit the degradation, maintain the status, and/or improve the condition of patients with the disease state).
5. Summary of who will do what (what the physician will do, what the pharmacist will do). For example, in a cardiac risk service protocol, the clinical pharmacy specialist, working with the primary care physician or cardiologist may adjust medication doses as needed to achieve defined therapeutic goals within the constraints agreed upon for treatment. He/she may also be asked to contact the prescriber with medication change recommendations, or order necessary tests.
6. Indicate how patients may get referred into this disease state program (for example, from an internist, family physician or cardiologist).
7. Indicate the enrollment criteria for this disease state (for example, a history of myocardial infarction, percutaneous transluminal angioplasty or stent placement, etc.).
8. Indicate any other disease states that may be present and the appropriate attention to those states during treatment for this disease state. If there are any implications for this treatment, specify how those implications will be handled.
9. Specify the nature and scope of the therapy to be undertaken, the specific directions for each drug to be used, the specified dosage regimen, forms or route of administration, directions for implementing and monitoring the therapy, identification of appropriate tests that may be requested and for what purposes, directions for interpreting such tests, and specific parameters for dosage modification. If a laboratory monitoring protocol is not individually developed, indicate the clinical parameters of laboratory monitoring for the disease state for each protocol. The specificity required above may be portrayed via an algorithm or similar matrix if the disease state lends itself to such definition.

10. Specify other interventions necessary for therapy (for example, lipid lowering therapy, aspirin therapy or non-pharmacologic treatment necessary such as diet, physical activity, alcohol use, tobacco cessation, etc.) Indicate whether or not those interventions are within the DTM agreement, and if so, repeat the information in paragraph 9 of this Exhibit A for those states. Specify any mitigating factors that may apply to the therapy.
11. Specify clinical exclusions or aggravating factors. That is, if there are known situations where a patient should not participate in DTM or whose participation should be limited in some way. Specify how this will be addressed.
12. Indicate specific directions for responding to acute allergic or other adverse reactions to therapy and the method whereby patient safety will be preserved and safeguarded in such a situation.
13. Indicate tracking mechanisms to be used to ensure timeliness of therapy and patient visits, and the method of follow-up if the patient does not make visits; specify method of quality assurance checks on this.
14. Indicate the reporting required by the pharmacist and the physician.
15. Indicate the references to the evidence based article(s) that support the protocol being used.

SIGNATURES.

Persons responsible for drug therapy management must sign the protocol, to indicate that they have read them and understand the scope of their responsibilities. For example, in a large hospital setting, chiefs of service will most likely be the signing party. In a small hospital, the chief medical officer might be the signer. In a retail setting, the physician involved, or the physician who represents the group, if the agreement is with a group, should be the signer. In a pharmacy, the pharmacy manager and the pharmacist conducting the therapy should sign. In any event, the individual signing the agreement will be held responsible for the therapy. DTM may not be delegated by physicians to office staff, unless it is staff with prescriptive authority, and only after the physician has made a diagnosis and referred the patient to therapy.

APPENDIX B

MODEL SEXUAL MISCONDUCT DISCLOSURE STATEMENT

DISCLAIMER: This Model Sexual Misconduct Disclosure Statement is to be used as a guide only and is aimed only to assist the practitioner in complying with section 12-30-115, C.R.S., and the rules promulgated pursuant to this statute by the Director. As a licensed, registered, and/or certified health care licensee in the State of Colorado, you are responsible for ensuring that you are in compliance with state statutes and rules. While the information below must be included in your Sexual Misconduct Disclosure Statement pursuant to section 12-30-115, C.R.S., you are welcome to include additional information that specifically applies to your situation and practice.

- A. Provider information, including, at a minimum: name, business address, and business telephone number.
- B. A listing of any final convictions of or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S.
- C. For each such conviction or guilty plea, the provider shall provide, at a minimum:
 - 1. The date that the final judgment of conviction or guilty plea was entered;
 - 2. The nature of the offense or conduct that led to the final conviction or guilty plea;
 - 3. The type, scope, and duration of the sentence or other penalty imposed, including whether:
 - a. The provider entered a guilty plea or was convicted pursuant to a criminal adjudication;
 - b. The provider was placed on probation and, if so, the duration and terms of the probation and the date the probation ends; and
 - c. The jurisdiction that imposed the final conviction or issued an order approving the guilty plea.
- D. A listing of any final agency action by a professional regulatory board or agency that results in probationary status or other limitation on the provider's ability to practice if the final agency action is based in whole or in part on:
 - 1. a conviction for or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S., or a finding by the professional regulatory board or Director that the provider committed a sex offense, as defined in as defined in section 16-11.7-102(3), C.R.S.; OR
 - 2. a finding by a professional regulatory board or agency that the provider engaged in unprofessional conduct or other conduct that is grounds for discipline under the part or article of Title 12 of the Colorado Revised Statutes that regulates the provider's profession, where the failure or conduct is related to, includes, or involves sexual misconduct that results in harm to a patient or presents a significant risk of public harm to patients.
- E. For each such final agency action by a professional regulatory board or agency the provider shall provide, at a minimum:

1. The type, scope, and duration of the agency action imposed, including whether:
 - a. the regulator and provider entered into a stipulation;
 - b. the agency action resulted from an adjudicated decision;
 - c. the provider was placed on probation and, if so, the duration and terms of probation; and
 - d. the professional regulatory board or agency imposed any limitations on the provider's practice and, if so, a description of the specific limitations and the duration of the limitations.
2. The nature of the offense or conduct, including the grounds for probation or practice limitations specified in the final agency action;
3. The date the final agency action was issued;
4. The date the probation status or practice limitation ends; and
5. The contact information for the professional regulatory board or agency that imposed the final agency action on the provider, including information on how to file a complaint.

Sample Signature Block

I have received and read the sexual misconduct disclosure by [Provider Name] and I agree to treatment by [Provider Name].

Print Patient Name

Patient or Responsible Party's Signature

Date

If signed by Responsible Party (parent, legal guardian, or custodian), print Responsible Party's name and relationship to patient:

Print Responsible Party Name

Print Relationship to Patient

Provider Signature

Date

APPENDIX C

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado Medical Board at dora_medicalboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (<https://www.cms.gov/nosurprises/consumers>) for more information about your rights under federal law.

Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - o Cover emergency services by out-of-network providers.
 - o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado Medical Board at dora_medicalboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (<https://www.cms.gov/nosurprises/consumers>) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit the CMS No Surprises Act website (<https://www.cms.gov/nosurprises/consumers>) for more information about your rights under federal law.

Visit the Colorado Medical Board (<https://dpo.colorado.gov/Medical>) website for more information about your rights under section 12-30-112, C.R.S.

Editor's Notes

History

Entire rule eff. 10/15/2010.

Entire rule repealed eff. 07/15/2013.

Entire rule recodified from rules 3 CCR 713-2, 3 CCR 713-7, 3 CCR 713-8, 3 CCR 713-11, 3 CCR 713-12, 3 CCR 713-17, 3 CCR 713-18, 3 CCR 713-20, 3 CCR 713-22, 3 CCR 713-26, 3 CCR 713-28, 3 CCR 713-29, 3 CCR 713-30, 3 CCR 713-31, 3 CCR 713-32, 3 CCR 713-33, 3 CCR 713-36, 3 CCR 713-38, 3 CCR 713-39, 3 CCR 713-40, 3 CCR 713-41, 3 CCR 713-42, 3 CCR 713-43, 3 CCR 713-44, 3 CCR 713-47, 3 CCR 713-48, 3 CCR 713-49, 3 CCR 713-50 eff. 07/15/2023.