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July 1, 2008

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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SECRETARY OF STATE

ROBIN CARNAHAN

Administrative Rules Division
James C. Kirkpatrick State Information Center
600 W. Main
Jefferson City, MO 65101
(573) 751-4015

DIRECTOR

WAYLENE W. HILES

•

EDITORS

CURTIS W. TREAT SALLY L. REID

ASSOCIATE EDITOR

SARAH JORGENSON

•

PUBLICATION TECHNICIAN

JACQUELINE D. WHITE

•

ADMINISTRATIVE ASSISTANT

LUKE RIEKE

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February 17, 2009	**March 16, 2009**	March 31, 2009	April 30, 2009
March 2, 2009	**April 1, 2009**	April 30, 2009	May 30, 2009
March 16, 2009	**April 15, 2009**	April 30, 2009	May 30, 2009

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 1—Organization and Description

PROPOSED AMENDMENT

2 CSR 30-1.020 Laboratory Services and Fees. The director is amending sections (2) and (3).

PURPOSE: This amendment adjusts fees charged for laboratory services performed by Animal Health Laboratories.

(2) No fees will be charged for tests for diseases which are included in a state and federal cooperative program. Fees for nonprogram services performed at the Animal Health Laboratories are as follows:

(A) Pathology—
1. Necropsy—
A. Gross Necropsy Exam Fee $*[20.00]* **32.00**
B. Necropsy Bacterial Culture $*[35.00]* **55.00**
C. Necropsy Exam Fee including Histopathology, Virology, Serology, Bacteriology (excluding Toxicology) $*[65.00]* **92.00**
D. Fresh Tissue Exam Fee including Histopathology, Virology, Serology, Bacteriology (excluding Toxicology) $*[65.00]* **95.00**
2. Histopathology—
A. Biopsy or Mailed-in Tissue Fee (per case) $*[15.00]* **44.50**
B. Immunoperoxidase Stains Fee (per slide) $10.00
C. Special Procedures Fee Inquire

(B) Bacteriology—
1. Microscopic Examination of Specimen Fee (acid fast stain, dark field, phase, and the like) $*[5.00]* **7.00**
2. Abortion Screen Fee $*[20.00]* **32.50**
3. Bacterial Culture (except blood) Isolation and Identification Fee (per sample) $*[12.00]* **17.00**
4. Anaerobic Bacterial Culture Fee (per sample) $*[12.00]* **19.00**
5. Blood Culture Fee (per sample) $*[20.00]* **27.00**
6. Joint Aspirate Cultures Fee (per sample) $*[20.00]* **27.00**
7. Antimicrobial Susceptibility Test Fee $*[12.00]* **20.50**
8. Johne's Culture Fee $*[15.00]* **16.00**
9. Canine, Bovine or Porcine Enteric Screen Fee (per sample) $*[20.00]* **35.50**
10. Mammalian Mycoplasma Isolation Fee $15.00
11. Fungal Culture Fee $*[12.00]* **19.00**
12. FA Screen for Clostridium spp Fee $*[20.00]* **29.00**
13. Custom Testing Procedures Fee Inquire
14. Aerobic Culture plus Salmonella Screen Fee $*[15.00]* **21.00**
15. Characterization of Enterotoxic *E. coli* (call lab for additional information)
16. *Fimbriae (pili)* Typing and Toxin Testing Fee—seven (7) days for DNA probe assay $20.00
17. *In vitro* Cell Adherence and Invasive Assay Fee—seven to ten (7–10) days $20.00
18. Milk Culture and Sensitivity $*[7.50]* **24.00**
19. *Brucella canis* Culture $*[12.00]* **8.00**
20. Johne's PCR, DNA Probe $*[15.00]* **25.00**
21. Johne's Pooling (per sample) $30.00

(C) Virology—
1. Virus Isolation in Cell Culture Fee (intravenous test for bluetongue excluded) $*[10.00]* **21.50**
2. Fluorescent Antibody Examination Fee $*[5.00]* **12.75**
3. Electron Microscopy Fee—negative stain $*[10.00]* **16.00**
4. Chlamydia Isolation or ELISA Fee $10.00
5. Canine Parvovirus (ELISA) Fee $10.00

(D) Serology—
1. Anaplasmosis (CF) Fee
[(1–25 samples) $ 3.00
(26–99 samples) $ 2.00
(100 or more samples) $ 1.50]
(per sample) $5.00
2. Anaplasmosis Card Test Fee (per sample) $*[2.00]* **5.00**
3. *[Blastomycosis (AGID) Fee (per sample) $ 5.00]*
Anaplasmosis (ELISA) Test (per sample) $5.00
4. *[Bluetongue (ELISA) Fee (per sample) $ 3.00]*
Blastomycosis (AGID) Fee (per sample) $ 5.00

5. *[Bluetongue (AGID) Fee (per sample) $ 3.00]*
   Bluetongue (ELISA) Fee (per sample) $ 5.00
6. *[Bovine Leukosis (AGID) Fee (per sample) $ 3.00]*
   Bluetongue (AGID) Fee (per sample) $ 5.00
7. *[Bovine Leukosis (ELISA) Fee (per sample) $ 3.00]*
   Bovine Leukosis (AGID) Fee (per sample) $ 4.00
8. *[BRSV SN Fee (per sample) $ 3.00]*
   Bovine Leukosis (ELISA) Fee (per sample) $ 4.00
9. *[Brucella canis (Card) Fee (1–25 samples) $ 8.00 (26 or more samples) $ 6.00]*
   BRSV (SN) Fee (per sample) $ 6.25
10. *[BVD (SN) Fee (per sample) $ 3.00]*
    ***Brucella canis* (Card) Fee (per sample) $ 5.00**
11. *[CAE (AGID) Fee (per sample) $ 3.00]*
    BVD (SN) Fee per sample $ 6.25
12. *[Canine Distemper IFA Fee (per sample) $15.00]*
    CAE (AGID) Fee (per sample) $ 4.25
13. *[Canine Heartworm (ELISA) Fee (per sample) $ 5.00]*
    Canine Distemper (IFA) Fee (per sample) $18.50
14. *[Coccidioidomycosis (LA and AGID) Fee (per sample) $ 5.00]*
    Canine Heartworm (ELISA) Fee (per sample) $ 6.25
15. *[Cryptoccosis LA Fee (per sample) $ 5.00]*
    Coccidioidomycosis (LA and AGID) Fee (per sample) $ 6.25
16. *[EIA (AGID) Fee (per sample) $ 2.00]*
    Cryptoccosis LA Fee (per sample) $ 6.25
17. *[EIA (ELISA) Fee (per sample) $ 3.00]*
    EIA (AGID) Fee (per sample) $ 3.00
18. *[Ehrlichia canis (IFA) Fee (per sample) $15.00]*
    EIA (ELISA) Fee (per sample) $ 5.00
19. *[Ehrlichia equi (IFA) Fee (per sample) $15.00]*
    ***Ehrlichia canis* (IFA) Fee (per sample) $18.50**
20. *[Ehrlichia risticii (IFA) Fee (per sample) $15.00]*
    ***Ehrlichia equi* (IFA) Fee (per sample) $15.00**
21. *[EHVD (AGID) Fee (per sample) $ 3.00]*
    ***Ehrlichia risticii* (IFA) Fee (per sample) $18.50**
22. *[Encephalomyocarditis (SN) Fee (per sample) $ 3.00]*
    EHVD (AGID) Fee (per sample) $ 4.25
23. *[Equine Rhinopneumonitis (SN) Fee (per sample) $ 3.00]*
    Encephalomyocarditis (SN) Fee (per sample) $ 3.00
24. *[Equine Viral Arteritis (SN) Fee (per sample) $ 3.00]*
    Equine Rhinopneumonitis (SN) Fee (per sample) $ 6.25
25. *[Feline Infectious Peritonitis (ELISA) Fee (per sample) $ 5.00]*
    Equine Viral Arteritis (SN) Fee (per sample) $ 6.25
26. *[Feline Immunodefusion Virus (ELISA) Fee (per sample) $ 5.00]*
    Feline Infectious Peritonitis (ELISA) Fee (per sample) $ 5.00
27. *[Feline Leukemia (ELISA) Fee (per sample) $ 5.00]*
    Feline Immunodefusion Virus (ELISA) Fee (per sample) $ 18.50
28. *[Haemophilus somnus MAT Fee (per sample) $ 3.00]*
    Feline Leukemia (ELISA) Fee (per sample) $ 18.50
29. *[Histoplasmosis (LA and AGID) Fee (per sample) $ 5.00]*
    Haemophilus somnus MAT Fee (per sample) $ 5.00
30. *[IBR (SN) Fee (per sample) $ 3.00]*
    Histoplasmosis (LA and AGID) Fee (per sample) $ 6.25
31. *[Johne's (CF) Fee $ 3.00]*
    IBR (SN) Fee (per sample) $ 6.25
32. *[Johne's (ELISA) Fee (per sample) $ 3.00]*
    Johne's (CF) Fee $ 4.00
33. *[Leptospirosis Dark Field Fee (per sample) $ 5.00]*
    Johne's (ELISA) Fee (per sample) $ 4.00
34. *[Leptospirosis—6 Serovars (MA) Fee (per sample) $ 4.00]*
    Leptospirosis Dark Field Fee (per sample) $ 6.25
35. *[Lyme Disease (ELISA) Fee (per sample) $ 5.00]*
    Leptospirosis—6 Serovars (MA) Fee (per sample) $ 6.25
36. *[Ovine Progressive Pneumonia (OPP) (AGID) Fee (per sample) $ 3.00]*
    Lyme Disease (ELISA) Fee (per sample) $ 5.00
37. *[PI 3 (HAI) Fee (per sample) $ 3.00]*
    Ovine Progressive Pneumonia (OPP) (AGID) Fee (per sample) $ 4.25
38. *[Porcine parvovirus (HAI) Fee (per sample) $ 3.00]*
    PI 3 (SN) Fee (per sample) $ 6.25
39. *[Porcine Resp. Reprod. Syn. (PRRS) IFA Fee (per sample) $ 3.00]*
    Porcine parvovirus (HAI) Fee (per sample) $ 4.25
40. *[Swine Influenza (HAI) Fee (per sample) $ 3.00]*
    Porcine Resp. Reprod. Syn. (PRRS) (IFA) Fee (per sample) $ 3.50
41. *[TGE (SN) Fee (per sample) $ 3.00]*
    Swine Influenza (HAI) Fee (per sample) $ 4.25
42. *[Toxoplasmosis (Latex) Fee (per sample) $ 5.00]*
    TGE (SN) Fee (per sample) $ 6.25
43. *[Vesicular Stomatitis-Indiana (SN) Fee (per sample) $ 3.00]*
    Toxoplasmosis (Latex) Fee (per sample) $ 5.00
44. *[Vesicular Stomatitis-New Jersey (SN) Fee (per sample) $ 3.00]*
    Vesicular Stomatitis-Indiana (SN) Fee (per sample) $ 6.25
45. *[Other Procedures Fee Inquire]*
    Vesicular Stomatitis-New Jersey (SN) Fee (per sample) $ 6.25
46. *[PRRS (ELISA) $ 3.00]*
    Other Procedures Fee Inquire
47. *[Anaplasmosis (26–99 samples) $ 2.00]*
    PRRS (ELISA) $ 3.50
48. *[Anaplasmosis (100 or more samples) $ 1.50]*
    PRV (ELISA/Latex/SN) (per sample) $ 2.00
49. *[PRV (ELISA/Latex/SN) (1–3 samples) $ 2.00]*
    IBR (ELISA) $ 3.00
50. *[PRV (ELISA/Latex/SN) (4 or more samples) $ 1.25]*
    Canine Brucellosis Tube Agg. (TAT) (1–10 samples) $ 5.00
51. *[IBR (ELISA) $ 3.00]*
    Canine Brucellosis Tube Agg. (TAT) (11 or more samples) $ 3.00
52. *[Canine Brucellosis Tube Agg. (TAT) (1–10 samples) $ 5.00]*
    West Nile (ELISA) $10.00

[53. Canine Brucellosis Tube Agg. (TAT) (11 or more samples) $ 3.00]

(E) Toxicology—

1. Aflatoxin Fee (feed) $*[10.00]* **30.00**
2. Alkaloid Screen Fee (strychnine, nicotine, and caffeine) $*[15.00]* **22.00**

3. Ammonia Fee (rumen contents, serum) $*[10.00]* **22.00**
4. Anticoagulant Screen Fee (warfarin, brodifacoum, etc. in bait) $15.00
5. Arsenic-Arsine Fee (tissues, gut contents, bait) $*[15.00]* **27.00**
6. Arsenic-Reinsch Fee (tissue, gut contents, bait) $ 5.00
7. Calcium Fee (serum) $*[6.00]* **16.00**
8. Carbamates Fee (gut contents) $*[20.00]* **43.00**
9. Chlorinated Hydrocarbon Pesticides Fee (brain, gut contents) $*[20.00]* **33.00**
10. Cholinesterase Activity Fee (heparinized blood, brain) $*[12.00]* **22.00**
11. Citrinin Fee (feed) $*[10.00]* **22.00**
12. Copper Fee (blood, tissues) $*[15.00]* **16.00**
13. Cyanide Fee (rumen contents, blood, plant material) $*[10.00]* **16.00**
14. DAS Fee (feed) $10.00
15. Drug Screen Fee (urine, serum) $*[25.00]* **42.00**
16. Ergot Alkaloids Fee (feed) $*[15.00]* **55.00**
17. Ergovaline Fee (fescue) $*[25.00]* **50.00**
18. Ethylene Glycol Fee (urine, serum) $15.00
19. Fumonisin Fee (feed) $*[10.00]* **30.00**
20. Herbicides Fee (gut contents) $25.00
21. Ionophore Screen Fee (feed) $*[20.00]* **16.00**
22. Iron Fee (serum/liver) $*[15.00]* **16.00**
23. Lasalocid Fee (feed) $15.00
24. Lead Fee (heparinized blood) $*[10.00]* **16.00**
25. Lead Fee (tissue) $15.00
26. Magnesium Fee (serum, urine, aqueous humor) $*[6.00]* **16.00**
27. Molybdenum Fee (liver) $15.00
28. Monensin Fee (feed, gut contents) $15.00
29. Mycotoxin Screen Fee—aflatoxin, T-2 toxin, DAS, ochratoxin A, zearalenone, vomitoxin, citrinin, sterigmatocystin (feed) $*[20.00]* **33.00**
30. Narasin Fee (feed) $15.00
31. Nicotine Fee (gut contents, urine) $15.00
32. Nitrates and Nitrites Fee (body fluid) $*[15.00]* **25.00**
33. Nitrates and Nitrites Fee (feed) $*[10.00]* **22.00**
34. Nitrates and Nitrites Fee (spot test) $*[5.00]* **$7.00**
35. Nitrates and Nitrites Fee (water) $10.00
36. Ochratoxin A Fee (feed) $*[10.00]* **22.00**
37. Oosporein Fee (feed) $*[10.00]* **30.00**
38. Organophosphate Pesticides Fee (gut contents, feed) $*[20.00]* **33.00**
39. Pesticide Screen Fee (gut contents, feed, tissue) $40.00
40. pH Fee (rumen contents) $*[5.00]* **16.00**
41. Poisonous Plant Identification Fee $*[5.00]* **16.00**
42. Potassium Fee (serum) $*[6.00]* **4.00**
43. Salinomycin Fee (feed) $15.00
44. Salt Fee (feed) $10.00
45. Selenium Fee (blood, liver) $*[15.00]* **27.00**
46. Sterigmatocystin Fee (feed) $*[10.00]* **22.00**
47. Sulfa-Drugs Fee (urine) $15.00
48. Sulfates Fee (water) $10.00
49. T-2 Toxin Fee (feed) $10.00
50. Urea Fee (feed, rumen contents) $15.00
51. Vitamin A Fee (serum) $15.00
52. Vitamin E Fee (serum) $*[15.00]* **16.00**
53. Vomitoxin Fee (feed) $*[10.00]* **30.00**
54. Warfarin Fee (liver) $15.00
55. Zearalenone Fee (feed) $*[10.00]* **30.00**
56. Zinc Fee (serum, liver) $*[15.00]* **16.00**
57. Prussic Acid (Qualitative) $ 5.00
58. Nitrates (Qualitative) $ 5.00

(F) Avian—

1. Avian Gross Necropsy Only Fee $20.00
2. Necropsy Bacterial Culture $35.00
3. Avian Necropsy Fee including Histopathology, Serology, Virology, Bacteriology (excluding Toxicology) $65.00
4. AGID Avian Influenza Fee $*[.35]* **1.00**
5. AGID Hemorrhagic Enteritis Fee $*[.35]* **1.00**
6. Virus Isolation in Cell Culture Fee $*[10.00]* **21.50**
7. Virus Isolation in Fertile Eggs Fee $*[10.00]* **21.50**
8. Avian Mycoplasma Culture Fee $15.00
9. Avian Fungal Culture Fee (litter) $*[10.00]* **14.00**
10. Hatchery Fluff Bacterial Counts Fee $10.00
11. MG HI Serology Fee $*[.35]* **.75**
12. MS HI Serology Fee $*[.35]* **.75**
13. MM HI Serology Fee $*[.35]* **.75**
14. MG Rapid Plate Test or ELISA Fee $*[.35]* **.40**
15. MS Rapid Plate Test or ELISA Fee $*[.35]* **.40**
16. MM Rapid Plate Test or ELISA Fee $*[.35]* **.40**
17. Newcastle Disease Virus HI Serology Fee $*[.35]* **1.50**
18. IBV HI Serology Fee $ .35
19. Fowl Cholera Microagglutination Test Fee $ 2.00
20. *Salmonella Pullorum* Rapid Plate Test Fee $ .10
21. *Salmonella Pullorum* Tube Agglutination Test Fee $*[.10]* **.25**
22. *Salmonella Typhimurium* Tube Agglutination Test Fee $*[.10]* **.25**
23. NPIP Salmonella Screen *[Inquire]* **$10.00**
24. API Inquire
25. Newcastle (ELISA) $*[1.00]* **1.50**
26. Bordetella (ELISA) $ 1.00
27. Mycoplasma PCR, DNA Probe $*[25.00]* **26.75**
28. Hemorrhagic Enteritis ELISA $ 1.00
29. **ELISA Avian Influenza Fee (per sample) $ 3.00**
30. ***Salmonella Pullorum*** **Microtiter Fee (per sample) $ .10**
31. **Avian Influenza Antigen Detection Fee (per test) $12.00**

(G) Clinical Pathology—

1. Chemistry Profiles (serum)—
   - A. Avian Profile Fee $*[22.50]* **27.00**
   - B. Equine Maxi Profile Fee $*[27.50]* **27.00**
   - C. Equine Mini Profile Fee $*[17.50]* **18.50**
   - D. Food Animal Maxi Profile Fee $27.00
   - E. Food Animal Mini Profile Fee $*[17.50]* **18.50**
   - F. Large Animal Liver Profile Fee $*[14.00]* **13.50**
   - G. Small Animal Liver Profile Fee $*[11.50]* **16.00**
   - H. Small Animal Maxi Panel Fee $*[23.50]* **21.50**
   - I. Small Animal Mini Panel Fee $*[15.00]* **18.50**
   - J. Surgery Panel Serum Biochemistry Fee $ 5.50
2. Chemistries (serum)—
   - A. Albumin Fee $*[3.00]* **4.00**
   - B. ALP/SAP Fee $ 4.00
   - C. ALT/GPT Fee $ 4.00
   - D. Amylase Test Fee $ 4.00
   - E. AST/GOT Fee $ 4.00
   - F. Bile Acid—Single Sample Fee $*[10.00]* **8.00**
   - G. Bile Acid—Pre- and Post-Sample Fee $*[18.00]* **36.00**
   - H. Bilirubin, Direct Fee $*[3.00]* **4.00**
   - I. Bilirubin, Total Fee $*[3.00]* **4.00**
   - J. BUN Fee $*[3.00]* **4.00**
   - K. Calcium Fee $*[3.00]* **4.00**
   - L. Cholesterol Fee $*[3.00]* **4.00**
   - M. CK/CPK Fee $ 4.00
   - N. Chloride Fee $*[2.00]* **4.00**
   - O. TCO_2 Fee $*[2.00]* **4.00**
   - P. Creatinine Fee $*[3.00]* **4.00**
   - Q. GGT/GGTP Fee $4.00

R. Glucose Fee $*[3.00]* **4.00**
S. Lipase Fee $*[4.00]* **13.00**
T. Osmolality Fee $*[3.00]* **15.00**
U. Phosphorus, Inorganic Fee $*[3.00]* **4.00**
V. Potassium Fee $*[2.00]* **4.00**
W. Protein, Serum Electrophoresis Fee $10.00
X. Protein, Total Fee $*[3.00]* **4.00**
Y. Sodium Fee $*[2.00]* **4.00**
Z. SDH Fee $ 5.00
AA. Triglyceride Fee $*[7.00]* **4.00**
BB. Uric Acid Fee $*[3.00]* **4.00**

3. Hematology—
A. CBC or WBC $*[7.50]* **14.00**
B. CBC, Large Animal Fee $*[11.50]* **18.00**
C. Coulter Profile Fee $ 5.00
D. Pack Cell Volume Fee $*[2.00]* **3.00**
E. Pack Cell Volume and pTP Fee $*[3.00]* **5.00**
F. Blood Smear Exam Fee (slide) $*[5.00]* **7.00**
G. Buffy Coat Fee $*[5.00]* **21.50**
H. Coombs Fee (direct) $*[10.00]* **21.50**
I. Bone Marrow Evaluation Fee $12.00
J. Knotts Test Fee (Microfilaria) $*[4.00]* **11.00**
K. Activated Partial Thromboplastin Time Fee (APTT) $ 5.00
L. Prothrombin Time Fee (PT) $*[5.00]* **13.00**
M. Platelet Count Fee $*[4.00]* **7.00**
N. pTP Fee $ 2.00
O. Reticulocyte Count Fee $*[4.00]* **8.00**

4. Urinalysis—
A. Calculus Analysis Fee $ 8.00
B. Specific Gravity Fee $ 2.00
C. Urinalysis—Complete Fee $*[5.00]* **8.00**
D. Urinalysis—Sediment Only Fee $ 4.00
E. BUN Fee $ 4.00
F. Creatinine Fee $ 4.00
G. Osmolality Fee $*[4.00]* **15.00**
H. Phosphorus, Inorganic Fee $ 4.00
I. Potassium Fee $ 4.00
J. Protein Electrophoresis Fee $15.00
K. Protein Quantitative Fee $*[5.00]* **4.00**
L. Sodium Fee $ 4.00

5. Fecal—
A. Occult Blood Fee $*[2.00]* **5.00**
B. Cryoptosporidia Exam Fee $*[5.00]* **7.00**
C. Direct Fecal Smear Fee $*[3.00]* **5.00**
D. Fecal Flotation Fee $*[5.00]* **7.00**

6. Cytology and Fluid Analysis—
A. CSF Fee $*[12.00]* **37.50**
B. Cytological Examination Fee $*[8.00]* **27.00**
C. Gram's Stain Fee $ 5.00
D. Peritoneal/Pleural Fluid Analysis Fee $*[10.00]* **32.50**
E. Synovial Fluid Analysis Fee $*[12.00]* **32.50**

(H) Other—
1. Transfer Media & Other Supplies/Reagent Inquire
2. Custom Testing Procedures Inquire
3. Postage Due Inquire
4. Equine Progesterone Target Test $*[12.00]* **20.00**
5. Pullorum Testing Equipment and Antigen Inquire
6. Milk Quality Control (per sample) $ 4.00
7. Generic *E-Coli* Surveillance $18.00
8. Copies of Test Charts $ .25
[9. Fax Copies (each page) $ .25
10. Fax Copies (each additional page) $ .25]

(3) Samples will be referred to appropriate laboratories for tests not done at the Animal Health Diagnostic Laboratories. The charge for this service will include charges from the referral laboratory plus a *[five dollar ($5) handling fee]* **charge that covers shipping and handling fees**.

AUTHORITY: section 267.122, RSMo 2000. Original rule filed July 15, 1993, effective Jan. 31, 1994. Amended: Filed Jan. 4, 1999, effective July 30, 1999. Amended: Filed March 5, 2004, effective Oct. 30, 2004. Amended: Filed May 21, 2008.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment may cost private entities an estimated ninety-four thousand seven hundred ten dollars and ninety cents ($94,710.90) annually.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Taylor H. Woods, D.V.M., Acting State Veterinarian, PO Box 630, Jefferson City, MO 65102, by facsimile at (573) 751-6919, or via email at Taylor.Woods@mda.mo.gov. Comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE - PRIVATE COST

I. RULE NUMBER

Rule Number and Name	2 CSR 30-1.020 Laboratory Services and Fees
Type of Rulemaking	Proposed amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Estimated: 1,975 licensed veterinarians 21,500 – poultry/swine companies, livestock and small animal stakeholders.	Licensed Veterinarians Poultry and Swine Companies Livestock and small animal stakeholders	Estimated: Total of the increase of fees $94,710.90 – estimated annual increase of fees.

III. WORKSHEET

Section	Test Type	FY07 Tests	Current Fee	FY07 Total Revenue	Proposed Fee	Projected Additional Revenue
(A) Pathology						
1. Necropsy						
A.	Gross Necropsy Exam Fee	12	$20.00	$ 240.00	$32.00	$ 144.00
B.	Necropsy Bacterial Culture	43	$35.00	$ 1,505.00	$55.00	$ 860.00
C.	Necropsy Exam Fee including Histopathology, Virology, Serology, Bacteriology (excluding Toxicology)	0	$65.00		$92.00	
D.	Fresh Tissue Exam Fee including Histopathology, Virology, Serology, Bacteriology (excluding Toxicology)	0	$65.00		$95.00	
2. Histopathology						
A.	Biopsy or Mailed-in Tissue Fee (per case)		$15.00		$44.50	
(B) Bacteriology						
1.	Micro Examination of Specimen Fee (acid fast stain, dark field, phase and the like)	0	$ 5.00		$ 7.00	
2	Abortion Screen Fee	0	$20.00		$32.50	
3	Bacterial Culture (except blood) Isolation and Identification Fee (per sample)	267	$12.00	$ 3,204.00	$17.00	$ 1,335.00
4.	Anaerobic Bacterial Culture Fee (per sample)	0	$12.00		$19.00	
5.	Blood Culture Fee (per sample)	0	$20.00		$27.00	
6.	Joint Aspirate Cultures Fee (per sample)	0	$20.00		$27.00	
7.	Antimicrobial Susceptibility Test Fee	225	$12.00	$ 2,700.00	$20.50	$ 1,912.50
8.	Johne's Culture Fee	203	$15.00	$ 3,045.00	$16.00	$ 203.00
9.	Canine, Bovine or Porcine Enteric Screen Fee (per sample)	0	$20.00		$35.50	

11.	Fungal Culture Fee	2	$12.00	$ 24.00	$19.00	$ 14.00
12.	FA Screen for Clostridium spp Fee	0	$20.00		$29.00	
14.	Aerobic Culture plus Salmonella Screen Fee	56	$15.00	$ 840.00	$21.00	$ 336.00
18.	Milk Culture and Sensivity	42	$ 7.50	$ 315.00	$24.00	$ 693.00
19.	*Brucella canis* Culture	3,299	$12.00	$ 39,588.00	$ 8.00	-$13,196.00
20.	Johne's PCR, DNA Probe	0	$15.00		$25.00	
21.	Johne's Pooling (per sample)	0	Not on current list		$30.00	
(C) Virology -						
1.	Virus Isolation in Cell Culture Fee (intravenous test for bluetongue excluded)	0	$10.00		$21.50	
2.	Fluorescent Antibody Examination Fee	0	$ 5.00		$12.75	
3	Electron Microscopy Fee Negative stain	0	$10.00		$16.00	
(D) Serology -						
1.	Anaplasmosis (CF) Fee	0	$ 3.00		$ 5.00	
2.	Anaplasmosis Card Test Fee (per sample)	76	$ 2.00	$ 152.00	$ 5.00	$ 228.00
3.	Anaplasmosis (ELISA) Test Fee (per sample)	666	NC		$ 5.00	$ 3,330.00
5.	Bluetongue (Elisa) Fee (per sample)	93	$ 3.00	$ 279.00	$ 5.00	$ 186.00
6.	Bluetongue (AGID) Fee (per sample)	0	$ 3.00		$ 5.00	
7.	Bovine Leukosis (AGID) Fee (per sample)	0	$ 3.00		$ 4.00	
8.	Bovine Leukosis (ELISA) Fee (per sample)	8,173	$ 3.00	$ 24,519.00	$ 4.00	$ 8,173.00
9.	BRSV SN Fee	0	$ 3.00		$ 6.25	
10.	*Brucella canis* (Card) Fee	6,246	$ 8.00	$ 49,968.00	$ 5.00	-$18,738.00
11.	BVD (SN) Fee per sample	0	$ 3.00		$ 6.25	
12.	CAE (AGID) Fee per sample	0	$ 3.00		$ 4.25	
13.	Canine Distemper IFA Fee (per sample)	0	$15.00		$18.50	
14.	Canine Heartworm (ELISA) Fee (per sample)	0	$ 5.00		$ 6.25	
15.	Coccidioidomycosis (LA and AGID) Fee (per sample)	0	$ 5.00		$ 6.25	
16.	Cryptoccosis LA Fee (per sample)	0	$ 5.00		$ 6.25	
17.	EIA (AGID) Fee (per sample)	58,470	$ 2.00	$116,940.00	$ 3.00	$58,470.00
18.	EIA (ELISA) Fee (per sample)	4,425	$ 3.00	$ 13,275.00	$ 5.00	$ 8,850.00
19.	Ehrlichia canis (IFA) Fee (per sample)	0	$15.00		$18.50	
21.	Ehrlichia risticii (IFA) Fee (per sample)	0	$15.00		$18.50	
22.	EHVD (AGID) Fee (per sample)	0	$ 3.00		$ 4.25	
24.	Equine Rhinopneumonitis (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
25.	Equine Viral Arteritits (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
26.	Feline Immunodefusion Virus	0	$ 5.00		$18.50	

	(ELISA) Fee (per sample)					
27.	Feline Leukemia (ELISA) Fee (per sample)	0	$ 5.00		$18.50	
29.	Haemophilus sommnus MAT fee (per sample)	0	$ 3.00		$ 5.00	
30.	Histoplasmosis (LA and AGID) Fee (per sample)	0	$ 5.00		$ 6.25	
31.	IBR (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
32.	Johne's (CF) Fee	0	$ 3.00		$ 4.00	
	PRRS (ELISA)	722	$ 3.00	$ 2,166.00	$ 3.50	$ 361.00
33.	Johne's Elisa Fee	8007	$3.00	$24,021.00	$4.00	$8,007.00
34.	Leptospirosis Dark Field Fee (per sample)	0	$ 5.00		$ 6.25	
35.	Leptospirosis – 6 Serovars (MA) Fee (per sample)	0	$ 5.00		$ 6.25	
37.	Ovine Progressive Pneumonia (OPP) (AGID) Fee (per sample)	0	$ 3.00		$ 4.25	
38.	PI 3 SN Fee (per sample)	0	$ 3.00		$6.25	
39.	Porcine parvovirus (HAI) Fee (per sample)	0	$ 3.00		$ 4.25	
40.	Porcine Resp. Reprod. Syn. (PRRS) IFA Fee (per sample)	0	$ 3.00		$ 3.50	
41.	Swine Influenza (HAI) Fee (per sample)	0	$ 3.00		$ 4.25	
42.	TGE (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
44.	Vesicular Stomatitits-Indiana (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
45.	Vesicular Stomatitis – New Jersey (SN) Fee (per sample)	0	$ 3.00		$ 6.25	
48.	PRV (ELISA/Latex/SN)				$ 2.00	
52.	West Nile (Elisa) per sample	83	Not on Current list		$10.00	$ 830.00
(E) Toxicology						
1.	Aflatoxin Fee (feed)	0	$10.00		$30.00	
2.	Alkaloid Screen Fee (strychnine, nicotine and caffine)	0	$15.00		$22.00	
3.	Ammonia Fee (rumen contents, Serum)	0	$10.00		$22.00	
5.	Arsenic-Arsine Fee (tisues, gut contents, bait)	0	$15.00		$27.00	
7.	Calcium Fee (Serum)	0	$ 6.00		$16.00	
8.	Carbamates Fee (gut contents)	0	$20.00		$43.00	
9.	Chlorinated Hydrocarbon Pesticides Fee (brain, gut contents)	0	$20.00		$33.00	
10.	Cholinesterase Activity Fee (heparinized blood, brain)	0	$12.00		$22.00	
11.	Citrinin Fee (feed)	0	$10.00		$22.00	
12.	Copper Fee (blood, tissues)	0	$15.00		$16.00	
13.	Cyanide Fee (rumen contents, blood, plant material)	0	$10.00		$16.00	
15.	Drug Screen Fee (urine, serum)	0	$25.00		$42.00	
16.	Ergot Alkaloids Fee (feed)	0	$15.00		$55.00	
17.	Ergovaline Fee (fescue)	0	$25.00		$50.00	

19.	Fumonisin Fee (feed)	0	$10.00		$30.00	
20.	Ionophore Scree Fee (feed)	0	$20.00		$16.00	
22.	Iron Fee (serum/liver)	0	$15.00		$16.00	
24.	Lead Fee (heparinized blood)	0	$10.00		$16.00	
26.	Magnesium Fee (serum, urine, aqueous humor)	0	$ 6.00		$16.00	
29.	Mycotoxin Scree Fee- aflatoxin, T-2 toxin, DAS, ochratoxin A, zearalenone, vomitoxin, citrinin, sterigmatocystin (feed)	0	$20.00		$33.00	
32.	Nitrates and Nitrites Fee (body fluid)	0	$15.00		$25.00	
33.	Nitrates and Nitrities Fee (feed)	0	$10.00		$22.00	
34.	Nitrates & Nitrites Fee (spot test)	0	$ 5.00		$ 7.00	
36.	Ochratoxin A Fee (feed)	0	$10.00		$22.00	
37.	Oosporein Fee (feed)	0	$10.00		$30.00	
38.	Organophosphate Pesticides Fee (gut content, feed)	0	$20.00		$33.00	
40.	pH Fee rumen contents		$ 5.00		$16.00	
41.	Poisonous Plant Identification Fee	0	$ 5.00		$16.00	
42.	Potassium Fee (serum)	0	$ 6.00		$ 4.00	
45.	Selenium Fee (blood, liver)	0	$15.00		$27.00	
46.	Sterigmatocystin Fee (feed)	0	$10.00		$22.00	
52.	Vitamin E Fee (serum)	0	$15.00		$16.00	
53.	Vomitoxin Fee (feed)	0	$10.00		$30.00	
55.	Zearalenone Fee (feed)	0	$10.00		$30.00	
56.	Zinc Fee (serum, liver)	0	$15.00		$16.00	
(F) Avian						
4.	AGID Avian Influenza	24,282	$ .35	$ 8,498.70	$ 1.00	$15,783.30
6.	AGID Hemorrhagic Enteritits Fee	0	$ .35		$ 1.00	
7.	Virus Isolation in Cell Culture Fee	0	$10.00		$21.50	
8.	Virus Isolation in Fertile Eggs Fee	0	$10.00		$21.50	
10.	Avian Fungal Culture Fee (litter)	0	$10.00		$14.00	
12.	MG HI	7,908	$ .35	$ 2,767.80	$ .75	$ 3,163.20
13	MS HI	2,346	$ .35	$ 821.10	$ .75	$ 938.40
14.	MM HI	3,991	$ .35	$ 1,396.85	$ .75	$ 1,596.40
15	MG Rapid Plate Test or ELISA Fee	4,387	$ .35	$ 1,535.45	$ .40	$ 219.35
16.	MS Rapid Plate Test or ELISA Fee	581	$ .35	$ 203.35	$ .40	$ 29.05
17.	Mm Rapid Plate Test or ELISA Fee	2,903	$ .35	$ 1,016.05	$ .40	$ 145.15
18.	Newcastle Disease Virus HI Serology Fee	0	$ .35		$ 1.50	
22.	*Salmonella Pullorum* Tube Agglutination Test Fee	2,241	$ .10	$224.10	$ .25	$336.15
23.	*Salmonella Typhimurium* Tube Agglutination Test Fee	800	$ .10	$80.00	$ .25	$120.00
24.	NPIP Salomonella Screen	503	Inquire		$10.00	$ 5,030.00

28.	Mycoplasma PCR, DNA Probe	0	$25.00		$26.75	
	New Castle Elisa	2,505	$ 1.00	$ 2,505.00	$ 1.50	$ 1,252.50
29.	ELISA Avian Influenza Fee (per sample)	1,263	Not on current list		$ 3.00	$3,789.00
30.	Salmonella Pullorum Microtiter Fee	2,899	Not on current list		$ .10	$289.90
31.	Avian Influenza Antigen Detection Fee (per test)		Not on current list		$12.00	
(G) Clinical Pathology						
1. Chemistry Profiles (serum)						
A.	Avian Profile Fee	0	$22.50		$27.00	
B.	Equine Maxi Profile Fee	0	$27.50		$27.00	
C.	Equine Mini Profile Fee	0	$17.50		$18.50	
E.	Food Animal Mini Profile Fee	0	$17.50		$18.50	
F.	Large Animal Liver Profile Fee	0	$14.00		$13.50	
G.	Small Animal Liver Profile Fee	0	$11.50		$16.00	
H	Small Animal Maxi Panel Fee	0	$15.00		$21.50	
I	Small Animal Mini Panel Fee	0	$15.00		$18.50	
2. Chemistries (serum)-						
A.	Albumin Fee	0	$ 3.00		$ 4.00	
F.	File Acid - -Single Sample Fee	0	$10.00		$ 8.00	
G.	Bile Acid-Pre – and Post-Sample Fee	0	$18.00		$36.00	
H.	Bilirubin, Direct Fee	0	$ 3.00		$ 4.00	
I	Bilirubin, Total Fee	0	$ 3.00		$ 4.00	
J.	BUN Fee	0	$ 3.00		$ 4.00	
K.	Calcium Fee	0	$ 3.00		$ 4.00	
L.	Cholesterol Fee	0	$ 3.00		$ 4.00	
N.	Chloride Fee	0	$ 2.00		$ 4.00	
O.	TCO Fee	0	$ 2.00		$ 4.00	
P	Creatinine Fee	0	$ 3.00		$ 4.00	
R.	Glucose Fee	0	$ 3.00		$ 4.00	
S.	Lipase Fee	0	$ 3.00		$ 4.00	
T.	Osmolaity Fee	0	$ 3.00		$15.00	
U.	Phosphorus, Inorganic Fee	0	$ 3.00		$ 4.00	
V.	Potassuim Fee	0	$ 2.00		$ 4.00	
X.	Protein, Total Fee	0	$ 3.00		$ 4.00	
Y.	Sodium Fee	0	$ 2.00		$ 4.00	
AA.	Triglyceride Fee	0	$ 7.00		$ 4.00	
BB.	Uric Acid Fee	0	$ 3.00		$ 4.00	
3. Hematology -						
A.	CBC or WBC	0	$ 7.50		$14.00	
B.	CBC, Large Animal Fee	0	$11.50		$18.00	
D.	Pack Cell Volume Fee	0	$ 2.00		$ 3.00	
E.	Pack Cell Volume and pTP Fee	0	$ 3.00		$ 5.00	
F.	Blood Smear Exam Fee (slide)	0	$ 5.00		$ 7.00	
G.	Buffy Coat Fee	0	$ 5.00		$21.50	
H	Coombs Fee (direct)	0	$10.00		$21.50	
J.	Knotts Test Fee (Microfilaria)	0	$ 4.00		$11.00	
K.	Activated Partial Thromboplastin Time Fee (APTT)	0	$ 5.00		$13.00	
L.	Prothromblin Time Fee (PT)	0	$ 5.00		$13.00	
M.	Platelet Count Fee	0	$ 4.00		$ 7.00	
O.	Reticulocyte Count Fee	0	$ 4.00		$ 8.00	

4. Urinalysis						
C.	Urinalysis-Complete Fee	0	$ 5.00		$ 8.00	
G.	Osmolaity Fee	0	$ 4.00		$15.00	
K.	Protein Quantitaive Fee	0	$ 5.00		$ 4.00	
5. Fecal						
A.	Occult Blood Fee	0	$ 2.00		$ 5.00	
B	Cryoptosporidia Exam Fee	0	$ 5.00		$ 7.00	
C.	Direct Fecal Smear Fee	0	$ 3.00		$ 5.00	
D.	Fecal Flotation Fee	10	$ 5.00	$ 50.00	$ 7.00	$ 20.00
6. Cytology and Fluid Analysis						
A.	CSF Fee	0	$12.00		$37.50	
B.	Cryoptosporidia Exam Fee	0	$ 8.00		$27.00	
D.	Peritoneal/Pleural Fluid	0	$10.00		$32.50	
E.	Synovial Fluid Analysis Fee	0	$12.00		$32.50	
(H) Other						
2.	Custom Testing Procedures		Inquire		$ 1.00	
4.	Equine Progesterone Target Test	0	$12.00		$ 20.00	
	Total			$301,879.40		$94,710.90

IV. ASSUMPTION

§267.122, RSMo, established the Animal Health Diagnostic Laboratories for diagnosing animal diseases and the "Laboratory Fee Fund" to assist in defraying operating laboratory expenses. Fees are charge for diagnostic services not associated with mandatory disease testing programs. The current fee structure was established with the original filing of 2CSR 30-1.020.

Since Fiscal Year 2001, General Revenue funding for the Division of Animal Health has been reduced by 61%. Therefore, revenues from the laboratory fee charges provide additional support to the laboratories to continue offering services to veterinarians, producers and other stakeholders for the purpose of diagnosing animal diseases to protect the livestock, poultry and small animal industry of the state.

This fiscal note assumes that the increased fees will not cause a reduction of tests completed.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

PROPOSED AMENDMENT

10 CSR 10-6.110 Submission of Emission Data, Emission Fees and Process Information. The commission proposes to amend subsection (3)(D). If the commission adopts this rule action, it will be submitted to the U.S. Environmental Protection Agency to replace the current rule in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address and phone number listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, www.dnr.mo.gov/regs/ruleindex.htm.

PURPOSE: This rule deals with submittal of emission information, emission fees and public availability of emission data. It provides procedures for collection, recording and submittal of emission data and process information on state-supplied Emission Inventory Questionnaire and Emission Statement forms, or in a format satisfactory to the director, so that the state can calculate emissions for the purpose of state air resource planning. This amendment will amend the emissions reporting threshold for small sources that increase or decrease emissions during the year and remove reference to an annual fee adjustment. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is section 643.079, RSMo and the August 31, 2006 Air Program Advisory Forum Meeting Notes.

(3) General Provisions.

(D) Emission Fees.

1. Any air contaminant source required to obtain a permit under sections 643.010–643.190, RSMo, except sources that produce charcoal from wood, shall pay an annual emission fee, regardless of their EIQ reporting frequency, of forty dollars and no cents ($40.00) per ton of regulated air pollutant emitted starting with calendar year 2007 in accordance with the conditions specified in paragraph (3)(D)2. of this rule. Sources which are required to file reports once every three (3) or six (6) years may use the information in their most recent EIQ to determine their annual emission fee if they have an EIQ on file. Sources that increase or decrease emissions by *[twenty percent (20%)]* **ten (10) tons or more** will be required to provide a complete (rather than the short form) EIQ for that year and every CERR reporting year thereafter (i.e., 2011, 2014, 2017, etc. as applicable).

2. General requirements.

A. The fee shall apply to the first four thousand (4,000) tons of each regulated air pollutant emitted. However, no air contaminant source shall be required to pay fees on total emissions of regulated air pollutants in excess of twelve thousand (12,000) tons in any calendar year. A permitted air contaminant source which emitted less than one (1) ton of all regulated pollutants shall pay a fee equal to the amount of one (1) ton.

B. The fee shall be based on the information provided in the facility's EIQ.

C. An air contaminant source which pays emissions fees to a holder of a certificate of authority issued pursuant to section 643.140, RSMo, may deduct those fees from the emission fee due under this section.

D. The fee imposed under paragraph (3)(D)1. of this rule shall not apply to ammonia, carbon monoxide, and $PM_{2.5}$ particulate matter emissions.

E. The fees for emissions produced during the previous calendar year shall be due June 1 each year for all United States Department of Labor Standard Industrial Classifications. The fees shall be payable to the Department of Natural Resources.

F. All Emissions Inventory Questionnaire forms or equivalent approved by the director shall be due annually on June 1 according to the required reporting schedules in paragraph (3)(A)6. of this rule for all United States Department of Labor Standard Industrial Classifications.

G. For the purpose of determining the amount of air contaminant emissions on which the fees are assessed, a facility shall be considered one (1) source under the definition of section 643.078.2, RSMo, except that a facility with multiple operating permits shall pay emission fees separately for air contaminants emitted under each individual permit.

3. Fee collection. *[The annual]* **Any emission fee** changes to this rule *[to establish emission fees for a specific year]* do not relieve any source from the payment of emission fees for any previous year.

AUTHORITY: section 643.050, RSMo 2000. Original rule filed June 13, 1984, effective Nov. 12, 1984. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., July 31, 2008. The public hearing will be held at the Inn at Grand Glaize, Grand Ballroom, Highway 54 and Lake Road 40, Osage Beach, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Written request to be heard should be submitted at least seven (7) days prior to the hearing to Director, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176, (573) 751-4817. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., August 7, 2008. Written comments shall be sent to Chief, Operations Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to apcprulespn@dnr.mo.gov.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 4—Conditions of Participant Participation, Rights and Responsibilities

PROPOSED AMENDMENT

13 CSR 70-4.080 State Children's Health Insurance Program. The division is amending sections (4) and (13) and adding a new section (14).

PURPOSE: The division is proposing to bring the rule into compliance with the provisions of Senate Bill 577 enacted by the 94th General Assembly, 2007, for which there is an appropriation beginning in State Fiscal Year 2009.

(4) The six (6)-month period of ineligibility would not apply to children who lose health insurance due to—

(D) Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian; *[or]*

(E) Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted*[.]***; or**

(F) Lapse of a child's (children's) health insurance when the health insurance plan does not cover an eligible child's (children's) preexisting condition.

(13) For the purposes of this rule, children participating in the Missouri Health Insurance Pool *[and child/children whose annual maximum benefits on a particular medical service under their private insurance have been exhausted]* are considered insured. Child/children whose parent(s) or guardian(s) drop Missouri Health Insurance Pool coverage in order to qualify under this rule shall not be eligible for six (6) months from the month coverage was terminated.

(14) For the purposes of this rule, a child/children whose annual maximum benefits of a particular medical service under their private insurance has been exhausted is not considered insured and does not have access to affordable health insurance.

*AUTHORITY: sections 208.633, 208.636, 208.643, 208.646, 208.650, 208.655, and 208.657, RSMo 2000 and sections 208.201, 208.631, 208.640, and 208.647, RSMo Supp. 2007. Original rule filed July 15, 1998, effective Feb. 28, 1999. For intervening history, please consult the **Code of State Regulations**. Amended: Filed June 2, 2008.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions $1,682,749 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 4 - Conditions of Recipient Participation, Rights and Responsibilities

Rule Number and Name:	13 CSR 70-4.080, State Children's Health Insurance Program
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services MO HealthNet Division	$1,682,749

III. WORKSHEET

The public cost of these changes in the Children's Health Insurance Program is $1,682,749. The cost is based on the number of new eligibles expected to enter the program and the current cost per eligible in the program. The number of eligibles and cost by component are:

Exceeded annual coverage limit	1,367 eligibles	$1,682,749

IV. ASSUMPTIONS

Applicants for the Children's Health Insurance Program will not be considered insured if they have been excluded from private insurance if they have exceeded their annual coverage limits for particular medical services.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—*[Division of Medical Services]* *MO HealthNet Division*
Chapter 26—Federally-Qualified Health Center Services

PROPOSED AMENDMENT

13 CSR 70-26.010 *[Medicaid]* *MO HealthNet* Program Benefits for Federally-Qualified Health Center Services. The division is amending sections (1)–(5).

PURPOSE: This amendment updates incorporated by reference material. To comply with state law it also changes the name of the state's medical assistance program to MO HealthNet, revises the name of the program's administering agency to MO HealthNet Division, changes reference from program recipients to participants, and revises reference from MC+ to managed care.

(1) Pursuant to the Omnibus Reconciliation Act of 1989, this regulation provides the payment methodology used to reimburse federally-qualified health centers (FQHCs) the allowable costs which are reasonable for the provision of FQHC-covered services to *[Medicaid recipients]* **MO HealthNet participants**.

(2) General Principles.

(A) The *[Missouri Medicaid Assistance]* **MO HealthNet** program shall reimburse FQHC providers based on the reasonable cost of FQHC-covered services related to the care of *[Medicaid recipients]* **MO HealthNet participants** (within program limitations) less any copayment or deductible amounts which may be due from *[Medicaid recipients]* **MO HealthNet participants** effective for services on and after July 1, 1990.

(B) Reasonable costs shall be determined by the *[Division of Medical Services]* **MO HealthNet Division** based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.

(C) Reasonable costs shall be apportioned to the *[Medicaid]* **MO HealthNet** program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for both *[Medicaid recipients]* **MO HealthNet participants** and other patients. *[Medicaid]* **MO HealthNet** charges shall include *[Medicaid]* **MO HealthNet** managed care *[(MC+)]* charges for covered services.

(E) FQHCs which are not certified for participation as an FFHC must provide an independent audit annually to the *[Division of Medical Services]* **MO HealthNet Division** which is also consistent with the principles and procedures applied by Medicare in satisfying its audit responsibilities.

(3) Nonallowable Costs. Any costs which exceed those determined in accordance with the Medicare cost reimbursement principles set forth in 42 CFR Part 413 are not allowable in the determination of a provider's total reimbursement. 42 CFR Part 413 (Revised as of *[October 1, 2004]* **October 1, 2007**), incorporated by reference in this rule, is published by the U.S. Government Printing Office; for sale by the Superintendent of Documents, U.S. Government Printing Office; Internet: bookstore.gpo.gov; telephone toll free 1-866-512-1800; Washington, DC area 202/512-1800; fax 202/512-2250; mail: Stop SSOP, Washington, DC 20401-0001. The rule does not incorporate any subsequent amendments or additions. In addition, the following items specifically are excluded in the determination of a provider's total reimbursement:

(A) Grants, gifts, and income from endowments will be deducted from total operating costs, with the following exceptions:

1. Grants awarded by federal government agencies, such as the Health Resources and Services Administration and Public Health Service, directly to an FQHC;

2. Grants received from the Missouri Primary Care Association (MPCA) in accordance with contractual agreements between the *[Division of Medical Services]* **MO HealthNet Division** and MPCA; and

3. Payments for uninsured primary care from the St. Louis Regional DSH Funding Authority (RDFA).

(4) Interim Payments.

(A) FQHC services shall be reimbursed on an interim basis up to ninety-seven percent (97%) of charges for covered services billed to the *[Medicaid]* **MO HealthNet** program. Interim billings will be processed in accordance with the claims processing procedures for the applicable programs.

(B) An FQHC in a *[Medicaid]* **MO HealthNet** managed care *[(MC+)]* region shall be eligible for supplemental reimbursement of up to ninety-seven percent (97%) of *[MC+]* **managed care** charges. This reimbursement shall make up the difference between ninety-seven percent (97%) of the FQHC's *[MC+]* **managed care** charges for a reporting period, and payments made by the *[MC+]* **managed care** health plans to the FQHC for covered services rendered to *[MC+]* **managed care** patients during that period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the FQHC, but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested on forms provided by the division. Supplemental reimbursement for *[MC+]* **managed care** charges shall be considered interim reimbursement of the FQHC's *[Medicaid]* **MO HealthNet** costs.

(5) Final Settlement.

(A) An annual desk review will be completed following submission of the Medicare cost report *[(Health Care Financing Administration (HCFA)-242)]* **for Freestanding Federally-Qualified Health Centers (Centers for Medicare and Medicaid Services – CMS-222-92)** and supplemental *[Missouri Medicaid]* **MO HealthNet** schedules. The *[Division of Medical Services]* **MO HealthNet Division** will make an additional payment to the FQHC when the allowable reported *[Medicaid]* **MO HealthNet** costs exceed interim payments made for the cost-reporting period. The FQHC must reimburse the division when its allowable reported *[Medicaid]* **MO HealthNet** costs for the reporting period are less than interim payments.

AUTHORITY: sections 208.153 and 208.201, RSMo [2000] ***Supp. 2007****. Emergency rule filed June 4, 1990, effective July 1, 1990, expired Oct. 28, 1990. Original rule filed June 4, 1990, effective Nov. 30, 1990. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Amended: Filed July 30, 2002, effective Jan. 30, 2003. Amended: Filed Jan. 14, 2005, effective July 30, 2005. Amended: Filed June 2, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered,*

comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—*[Division of Medical Services]* ***MO HealthNet Division***
Chapter 30—Podiatry Program

PROPOSED AMENDMENT

13 CSR 70-30.010 Podiatric Services Program. The division is amending sections (1)–(3).

PURPOSE: The purpose of this amendment is to update the incorporation by reference material for provider manuals to July 1, 2008, and to update program name references.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Persons Eligible for Podiatric Services. Any person who is eligible for Title XIX benefits from the *[Division of Family Services]* **Family Support Division** and who is found to be in need of podiatric services in accordance with the procedures described in this rule.

(2) Payment will be made for services by podiatrists who have an agreement with the *[Division of Family Services]* **MO HealthNet Division** to the extent that those services are covered under the guidelines established by the *[Division of Family Services]* **MO HealthNet Division and shall be included in the MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, July 1, 2008. This rule does not incorporate any subsequent amendments or additions.**

(3) Payments will be on a fee basis**,** and fees will be established by the *[Division of Family Services]* **MO HealthNet Division** which shall not exceed Title XVIII reimbursement levels. Payment will be on a vendor payment basis.

AUTHORITY: section [207.020, RSMo 1986] ***208.201, RSMo Supp. 2007****. This rule was previously filed as 13 CSR 40-81.130. Original rule filed Dec. 1, 1978, effective March 11, 1979. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 2, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 98—Psychiatric/Psychology/Counseling/Clinical Social Work Program

PROPOSED AMENDMENT

13 CSR 70-98.015 Psychiatric/Psychology/Counseling/Clinical Social Work Program Documentation. The division is amending sections (1)–(3).

PURPOSE: The purpose of this amendment is to update the incorporation by reference material for provider manuals to July 1, 2008, update program name references, and update the provider participation requirements of the MO HealthNet psychiatric/psychology/counseling/clinical social work program documentation regulation to include a limitation on the number of hours a provider may bill on a monthly basis.

(1) Administration. The MO HealthNet psychiatric/psychology/counseling/clinical social work program shall be administered by the Department of Social Services, MO HealthNet Division (MHD). The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by MHD and shall be included in the *MO HealthNet Psychology/Counseling Provider Manual* and Section 13.57 of the *Physician's Provider Manual*, which are incorporated by reference in this rule and available through the Department of Social Services, MO HealthNet Division website at www.dss.mo.gov/mhd, *[December 3, 2007]* **July 1, 2008**. This rule does not incorporate any subsequent amendments or additions. Psychiatric/psychology/counseling/clinical social work services shall include only those which are clearly shown to be medically necessary.

(2) Persons Eligible. The MO HealthNet Program pays for approved MO HealthNet services for psychiatric/psychology/counseling/clinical social work services when furnished within the provider's scope of practice. The participant must be eligible on the date the service is furnished. Participants may have specific limitations for psychiatric/psychology/counseling/clinical social work services according to the type of assistance for which they have been determined eligible. It is the provider's responsibility to determine the coverage benefits for a participant based on their type of assistance as outlined in the provider program manual. The provider shall ascertain the patient's MO HealthNet*[/MC+]* and managed care or other lock-in status before any service is performed. The participant's eligibility shall be verified in accordance with methodology outlined in the provider program manual.

(3) Provider Participation. To be eligible for participation in the MO HealthNet psychiatric/psychology/counseling/clinical social work program, a provider must meet the licensing criteria specified for his or her profession and be an enrolled MO HealthNet provider.

(A) The enrolled MO HealthNet provider shall *[agree to]* **comply with the following requirements**:

1. Keep any records necessary to disclose the extent of services the provider furnishes to participants; *[and]*

2. On request furnish to the MO HealthNet agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan*[.]***;**

3. Limit MO HealthNet billable hours to a maximum of one hundred fifty (150) hours in a single calendar month. Services provided to MO HealthNet participants and participants who are both MO HealthNet and Medicare eligible are counted toward the monthly one hundred fifty (150)-hour limit; and

4. Refund payment for MO HealthNet services to the MO HealthNet Division when the provider has billed the MO HealthNet Division for more than one hundred fifty (150) hours in a single calendar month.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2007. Original rule filed Nov. 14, 2003, effective June 30, 2004. Amended: Filed Oct. 30, 2007, effective April 30, 2008. Amended: Filed June 2, 2008.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities one hundred eighty-two thousand dollars ($182,000) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: **Title 13 – Department of Social Services**
Division Title: **Division 70 – MO HealthNet Division**
Chapter Title: **Chapter 98 – Psychiatric/Psychology/Counseling/Clinical Social Work Program**

Rule Number and Title:	13 CSR 70-98.015 Psychiatric/Psychology/Counseling/Clinical Social Work Program Documentation
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
32	MO HealthNet providers billing over 150 hours per month	$182,000

III. WORKSHEET

The fiscal note is based on a review of providers billing more than 150 hours per month during calendar year 2007.

IV. ASSUMPTIONS

With 22 working days per month the 150 hour limit allows providers 6.82 billable working hours per day. This is face-to-face time with the participant and does not include any documentation time, lunch, breaks, continuing education, billing time, consultation, travel, court testimony or chart review.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.308 Application and Licensure Requirements Standards for the Licensure and Relicensure of Air Ambulance Services. The department is amending sections (1)–(9) and (11), adding a new section (10), and renumbering sections (10), (11), and (12).

PURPOSE: This amendment adds educational requirements and requirements for backup communication equipment for air ambulance services.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Application Requirements for Air Ambulance Service Licensure.

(A) Each applicant for *[ownership of]* an air ambulance service license or relicense shall submit an application for licensure to the *[Bureau of]* Emergency Medical Services (EMS) **Bureau** no less than thirty (30) days or no more than one hundred *[and]* twenty (120) days prior to their desired date of licensure or relicensure.

(B) An application shall include the following information: type of license applied for (rotary wing or fixed wing); trade name of air ambulance service; location of aircraft; number of aircraft to be used as an air ambulance(s); name, address, telephone numbers**,** and e*[-]*mail address (if applicable) of operator of air ambulance service; *[name of manager;]* **name, address, telephone numbers, and email address (if applicable) of manager;** name, address, whether a medical doctor or doctor of osteopathy, telephone numbers, e*[-]*mail address (if applicable), and signature of medical director and date signed; certification by the medical director that they are aware of the qualification requirements and the responsibilities of an air ambulance service medical director and agree to serve as medical director; name, address, telephone numbers**,** and e*[-]*mail address (if applicable) of proposed licensee of air ambulance service; name of licensee's chief executive officer; all ambulance service licensure and related administrative licensure actions taken against the ambulance service or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge*[,]* and that the ambulance service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo**.** *[Supp. 1998.]*

(D) Air ambulance services which are currently accredited by the Commission on Accreditation of Medical Transportation Services (CAMTS) and have the required liability insurance coverage shall be considered to be compliant with the rules for air ambulance services. Accredited air ambulance services shall attach to their application evidence of accreditation and proof of their liability insurance coverage. The *[Bureau of]* EMS **Bureau** shall conduct periodic site reviews and inspections of applicable records and medical equipment as necessary to verify compliance.

(E) Fixed wing air ambulances shall meet the requirements stated in this regulation except *[(2)(E), (4)(A)1., (4)(A)2.,]* (8)(D), *[(8)(E),]* **(8)(F),** and *[(11)]***(12)**.

(2) Air ambulance services shall meet the following operation and maintenance standards:

(A) Air ambulance services shall possess or contract for a valid Federal Aviation Administration Title 14 CFR part 135 Certificate and *[if a rotary air ambulance]* **comply with 14 CFR section 119, a regulation from the Federal Aviation Administration and** be authorized to conduct helicopter air ambulance operations in accordance with Federal Aviation Regulation part 135 and this operations specification;

(B) The air ambulance service shall ensure prompt response to all requests to that service for emergency care twenty-four (24) hours per day, each and every day of the year, and shall provide patients with medically necessary care and transportation in accordance with that air ambulance service's protocols*[;]***, scope of care, and capabilities.**

1. If a scene request for emergency services is made to an air ambulance service which is not the recognized emergency provider, then the 911 provider or the recognized emergency provider shall be notified immediately by the air ambulance service receiving the request; and

2. Emergency transports shall not require a guarantee of payment prior to transport;

(E) The aviation crew of an air ambulance shall meet all requirements of the Federal Aviation Administration Title 14 CFR part 135*[.]* **and the medical crew shall be able to demonstrate successful completion and maintenance of the following:**

1. Education—

A. Basic Cardiac Life Support (BCLS) which is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions;

B. Advanced Cardiac Life Support (ACLS) or national equivalent. ACLS is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions;

C. Pediatric Advanced Life Support (PALS) or national equivalent. PALS is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions; and

D. Trauma Nurse Core Course (TNCC) or a trauma course approved by the medical director. TNCC is incorporated by reference in this rule as published by the Emergency Nurses Association in 2007 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Examples of equivalent courses are, but not limited to: Pediatric Education for Pre-Hospital Professionals (PEPP); Emergency Nurse Pediatric Course (ENPC); International Trauma Life Support (ITLS); Pre-Hospital Trauma Life Support (PHTLS); and Transport Nurse Advanced Trauma Course (TNATC). PEPP is incorporated by reference in this rule as published by the American Academy of Pediatrics in 2006 and is available at the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove, IL 60007. This rule does not incorporate any subsequent amendments or additions. ENPC is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. ITLS is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Ave., Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent

amendments or additions. PHTLS is incorporated by reference in this rule as published by the National Association of Emergency Medical Technicians in 2006 and is available at the National Association of Emergency Medical Technicians, PO Box 1400, Clinton, MS 39060. This rule does not incorporate any subsequent amendments or additions. TNATC is incorporated by reference in this rule as published by the Air and Surface Transport Nurse's Association in 2006 and is available at the Air and Surface Transport Nurse's Association, 7995 East Prentice Avenue, Suite 100, Greenwood Village, CO 80111. This rule does not incorporate any subsequent amendments or additions; and

2. Licensure/certification—

A. Each medical crew member must hold a current and valid Missouri license as required for their level of practice.

(3) Each aircraft, when operated as an air ambulance, shall meet the following equipment requirements:

(A) Documentation that each aircraft is equipped with pediatric and/**or** adult medical supplies and equipment as required by the air ambulance service medical director for the various advanced life support procedures or protocols for the patient care activities in the out-of-hospital setting to which it will respond. Each service shall be able to produce these records for inspection during normal business hours;

(B) The aircraft will be equipped with all equipment to allow reliable communication*[,]* **and** flight following *[and emergency locator transmitter]; [and]*

(C) The air ambulance service shall have a policy and provide for the effective maintenance, storage, usage**,** and replacement of its medical equipment, devices**,** and medications*[.]***;**

(D) All medical equipment, except disposable items, shall be so designed, constructed, and of such material that under normal conditions and operations, it is durable and capable of withstanding repeated cleaning and being stored in a secure and protected manner; and

(E) The service shall:

1. Comply with Occupational Safety and Health Administration (OSHA) standard 29 CFR 1910.1030 and section 191.694, RSMo; and

2. Monitor and direct the use, control, and security of drugs.

(4) Each aircraft operated as an ambulance shall *[meet the following staffing requirements:]* **be staffed by personnel selected by each air ambulance program to meet the mission and scope of that program, and at a minimum—**

[(A) Air medical staff mix shall be selected by each air ambulance program in accordance with the medical director's best judgment as to what is best for patients transported by the service, and—]

*[1.]***(A)** On scene flights**,** there shall be at least two (2) air medical crew members. The primary crew member shall be a registered nurse or physician and the secondary crew member shall be an EMT-Paramedic, registered nurse**,** or physician; and

*[2.]***(B)** On all transports other than scenes, there shall be at least two (2) air medical crew members, one (1) of whom will be a registered nurse or physician, and a secondary crew member who is approved by the medical director to provide critical care; *[and]*

(C) A minimum of sixteen (16) hours of continuing education is required annually for each crew member to include safety, crew resource management, survival, and flight physiology; and

*[(B)]***(D)** The medical flight crew members will receive training designed by the medical director and clinical registered nurse supervisor to provide knowledge and skills needed to carry out advanced life support procedures and written protocols. The unique flight and pre-hospital environment will be addressed during training.

(5) **Records and forms, policies and procedures—***[E]*each air ambulance service shall maintain accurate records and forms that include the following:

(A) An air ambulance report **form approved by the EMS Bureau** to record information on each *[air ambulance request]* **patient transport**;

[(B) Air ambulance service license;

(C) Medical director protocol and policy authorization;

(D) Equipment maintenance records; and

(E) Continuing education records.]

(B) Disaster/multiple casualty protocols;

(C) Medical equipment maintenance records;

(D) Air ambulance service license;

(E) Licensed service personnel records;

(F) Medical director qualifications and authorized physician-ordered treatment protocols and policies;

(G) Patient care records;

(H) Quality improvement program;

(I) Records required by other regulatory agencies including the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (BNDD), and the Federal Drug Enforcement Administration (DEA);

(J) Safety program to include a safety committee and infection control policy as required by OSHA standard 29 CFR 1910.1030 and section 191.694, RSMo;

(K) Continuing education records; and

(L) Flight response records.

(6) Each air ambulance service shall have medical control policies, procedures**,** and standing orders that have been approved by their medical director and clinical registered nurse supervisor—

(B) The written protocols will be provided to the *[Bureau of]* EMS **Bureau** upon request; and

(7) Each air ambulance service shall have a designated medical director, working under an agreement, who is trained and meets the requirements for a medical director in accordance with 19 CSR 30-40.303(1).

(D) The medical director of the flight program shall have access to consulting physicians with expertise in specialties to include, but is not limited to:

1. Pediatrics;

2. Neonatology;

3. Burns;

4. Cardiology;

5. Trauma; and

6. Neurology/Neurosurgery.

(E) In the event of a resignation or other occurrence, and there is no medical director for the air ambulance service, the service is only authorized to operate under strict radio communications or direct written and/or verbal orders by a physician for a period not to exceed ten (10) days before appointing a new or replacement medical director.

(F) Each air ambulance service shall notify the EMS Bureau in writing of any change in medical director within five (5) days.

(8) *[Each aircraft operated as an ambulance shall have the capability to communicate by voice with local hospital(s), trauma centers, and the service's own dispatching agency.]* **Communication Centers and Communication Specialists.**

[(A) Communication specialists shall have the training commensurate to the scope of responsibility in the communication center.]

*[(B)]***(A)** Training shall be provided in aircraft capabilities, operational limitations, navigation**,** and map coordination **to the communication specialists**.

*[(C)]***(B)** Information pertinent to each call shall be logged in order to retrieve complete activity review reports.

*[(D)]***(C)** Communication specialists shall be responsible for flight following based on requirements of the program and Federal Aviation Administration Title 14 CFR part 135.

*[(E)]***(D)** A system shall be in place to assure emergency requests are answered, the phone calls and radio traffic are recorded**,** and a back-up power source is available. The system shall include means to provide the crew the ability to communicate by voice with *[local]* hospitals*[, trauma centers, police, sheriff and fire dispatching]* **and emergency** agencies.

*[(F)]***(E)** The hospital emergency ambulance radio system shall not be used for flight following.

(F) Each aircraft operated as an ambulance shall have the capability to communicate by voice with hospitals and the service's own communication center.

(G) The communication center shall:

1. Have a least one (1) dedicated telephone line for the purpose of receiving requests and the coordination of the air ambulance service;

2. Have a system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings shall be kept for a minimum of thirty (30) days;

3. Have the capability to immediately contact the aviation staff, medical crew, and online medical direction (through page, radio, or telephone, etc.);

4. Maintain all equipment in full operating condition and in good repair;

5. Have a back-up emergency power source for communications or a policy delineating methods for maintaining communications during power outages and in disaster situations; and

6. Have a communications policy and procedures manual to include:

A. A pre-arranged emergency plan to cover situations in which the aircraft is overdue, communications cannot be established, or an aircraft location cannot be verified.

(H) All helicopter air ambulance services shall have flights coordinated by designated communication specialists assigned and available twenty-four (24) hours per day to receive and coordinate the request for an air ambulance.

1. The communication specialists must advise the requesting caller of an accurate estimated time of arrival of the responding aircraft for all flight requests.

2. The communication specialists shall have training commensurate with the scope of responsibility of the communications center personnel and it shall include:

A. Federal Communications Commission regulations and appropriate provisions of the certificate holder's operations specifications and operations manual;

B. General safety rules, emergency procedures, and flight following procedures;

C. Map reading, aeronautical chart interpretation, basic navigation, and flight planning;

D. Weather terminology and procedures for flight service weather advisories;

E. Types of radio frequency bands used; and

F. Annual training that includes at least a review of the program's Post-Accident/Incident Plan (PAIP) and competency in the areas included in subsections (8)(A)–(G).

(9) There shall be an ongoing quality improvement program designed to objectively and systematically monitor, review**,** and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care**,** and resolve identified problems. *[A safety committee shall be established and shall meet regularly to assess and evaluate the safety aspects of the operation.]*

(10) A safety committee shall be established and shall meet regularly to assess and evaluate the safety aspects of the operation.

*[(10)]***(11)** Each air ambulance service shall maintain policies and procedures that include the following:

(A) Safety program, including infection control program;
(B) Communications procedures;
(C) Ambulance operations procedures;
(D) Standards of clinical care (medical protocols);
(E) Equipment maintenance;
(F) Disaster/multiple casualty protocols; and
(G) Quality improvement program.

*[(11)]***(12)** Helicopter visual flight rule programs will adhere to the ceiling and visibility standards of the Federal Aviation Administration as authorized when conducting helicopter air ambulance operations in accordance with Federal Aviation Regulation part 135. These operations specifications will be available for inspection by the *[Bureau of]* EMS **Bureau** during normal business hours.

*[(12)]***(13)** Each ambulance service shall display a copy of their ambulance service license in the patient care compartment of each ambulance aircraft operated by the ambulance service.

AUTHORITY: sections 190.103 ***and 190.176, RSMo 2000 and sections*** *190.108, 190.120, 190.160, 190.165, [190.175, 190.176] and 190.185, RSMo Supp. [1998]* ***2007****. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $1,322,500 for the first year and one hundred twenty-two thousand five hundred dollars ($122,500) annually.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 40-Comprehensive Emergency Medical Services System Regulations:

Rule Number and Title:	**19 CSR 30-40.308**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
15 Air Ambulance services	**Private air ambulance services**	**$122,500.00/annually.**
15 Communication centers	**Dispatch agencies for backup communication systems with recording device**	**$1,125,000.00 one time fee.**
15 Communication centers	**Dispatch agencies for backup generators**	**$ 75,000 one time fee.**
	Total cost=	**$1,322,500.00 for the first year and $122,500.00 annually.**

III. WORKSHEET
Basic Cardiac Life Support = $25.00/per year
Pediatric Advanced Life Support= $100/per year
Advanced Cardiac Life Support = $125/per year
Trauma Nurse Core Course cost $56.25/per year
Training costs per year = 306.25/per year per employee annually
$306.25 per crew member x 10 crewmembers x 40 aircraft = $122,500.00
$ 5,000 for backup generator x 15 = $75,000.00 one time fee.
$75,000.00 for backup communication system with recording device = $75,000.00 x 15 agencies for a one time fee = $1,125,000.00.

IV. ASSUMPTIONS
Each flight crewmember must maintain certifications in Basic Cardiac Life Support, Pediatric Advanced Life Support, Advanced Cardiac Life Support and Trauma Nurse Core Course. Each aircraft would require 10 crewmembers. There are 40 aircraft currently in Missouri.

Backup communication systems with recording devices are required; the average cost for systems is $75,000.00 for a one-time fee for first full fiscal year after implementation.

There are 15 air ambulance services. The average cost for a backup generator is an average cost of $5,000.00 per generator x 15 services for first full fiscal year of implementation, and is a one-time cost.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.331 Application and Accreditation or Certification Requirements for Training Entities that Conduct Training for First Responders, Emergency Medical Dispatchers, Emergency Medical Technicians-Basic, *Emergency Medical Technicians-Intermediate* and Emergency Medical Technicians-Paramedic. The department is amending sections (1)–(4), (7) and (8) and adding a new section (9).

PURPOSE: This amendment defines requirements for EMT scope of practice and training.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Requirements for Certification of Emergency Medical Technician-Basic (EMT-B) Training Entities, Emergency Medical Technician-Paramedic (EMT-P) Training Entities, **Emergency Medical Technician-Intermediate (EMT-I) Training Entities,** EMT-B Continuing Education Training Entities, and EMT-P Continuing Education Training Entities.

(A) Each applicant for certification as an emergency medical services (EMS) training entity shall make application to the *[Bureau of]* EMS **Bureau** and undergo a review by *[Bureau of]* **the** EMS **Bureau** staff to determine compliance with these rules. An application shall include**, but not be limited to, the following**: trade name of the training entity; training entity business address; daytime telephone number of the training entity; type of accreditation applied for; name, address, telephone number**,** and signature of the program director; name, address, telephone number**,** and signature of the medical director; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge, and that the training entity has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo *[Supp. 1998]*. **The training entity accreditation application form, included herein, is available at the EMS Bureau office or by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.**

(B) Only certified EMS training entities shall be authorized to conduct EMS training programs. Upon receipt of an application for EMS training entity certification, the *[Bureau of]* EMS **Bureau** shall cause an inspection of the applicant to determine compliance with these rules, and such subsequent inspection as is necessary or desirable to *[assure]* **ensure** compliance with these rules. Such inspections shall occur not less than once every five (5) years.

1. Training entities shall be certified to conduct the following programs:

A. EMT-P training entities shall be certified to conduct initial EMT-P; EMT-P refresher to include remedial training and National Registry bridge programs; EMT-P continuing education; initial EMT-I programs; EMT-I refresher to include remedial training; EMT-I continuing education; initial EMT-B; EMT-B refresher to include remedial training and National Registry bridge programs; EMT-B continuing education; initial first responder; first responder refresher; and emergency medical dispatcher (EMD) courses;

B. EMT-P continuing education training entities shall be certified to conduct EMT-P continuing education courses, EMT-I continuing education courses, and EMT-B continuing education courses;

C. EMT-B training entities shall be certified to conduct initial EMT-B; EMT-B refresher to include remedial training and National Registry bridge programs; EMT-B continuing education; initial first responder; first responder refresher; and emergency medical dispatcher courses;

D. EMT-B continuing education training entities shall be certified to conduct EMT-B continuing education programs;

E. First responder training entities shall be certified to conduct only initial first responder and first responder refresher courses; and

F. EMD training entities shall be certified to conduct only EMD courses.

(C) Each EMS training entity shall demonstrate an organizational structure that *[assures]* **ensures** responsibility for the organization, administration, periodic review, continued development**,** and effectiveness of all educational programs conducted by the EMS training entity. The EMS training entity shall have an organizational chart and job descriptions for relevant positions within the training entity and make this available to *[Bureau of]* **the** EMS **Bureau** personnel on request.

(D) Each EMS training entity shall demonstrate adequate resources for the continued operation of all educational programs conducted. This shall be available to the *[Bureau of]* EMS **Bureau** personnel on request.

(F) Each EMS training entity shall demonstrate a methodology to evaluate the need for training and to *[assure]* **ensure** availability of effective training programs. **The tools used to develop the methodology shall be made available for review by the EMS Bureau.**

(G) Faculty Requirements.

1. Each EMS training entity shall have a qualified faculty. Credentials of faculty shall be available for review by the *[Bureau of]* EMS **Bureau**.

A. Primary faculty (those who teach twenty percent (20%) or more of classroom sessions) shall meet *[Bureau of]* **the** EMS **Bureau** requirements for EMS instructors.

B. The training entity shall describe qualifications and training for laboratory instructors, where lab instructors are used.

C. The training entity shall describe qualifications and training for clinical instructors and field preceptors, where clinical instructors and field preceptors are used.

2. Qualifications for any adjunct instructors such as physicians, registered nurses, paramedics, clinical specialists**,** or expert lecturers shall be documented and available for review by *[Bureau of]* **the** EMS **Bureau**.

(H) Physical Facilities.

1. Classrooms and laboratories shall have sufficient space to accommodate the maximum planned number of students and shall be environmentally conducive to providing a quality learning environment. The *[Bureau of]* EMS **Bureau** may inspect classroom and laboratory facilities to determine compliance.

2. Equipment and supplies used in the provision of instruction shall be available and consistent with the requirements of the curriculum and adequate for the volume of students enrolled.

A. The *[Bureau of]* EMS **Bureau** may periodically inspect such equipment and supplies to determine compliance with this requirement.

B. The EMS training entity shall describe how they will meet this requirement to the *[Bureau of]* EMS **Bureau**.

C. The EMS training entity shall *[assure]* **ensure** that the equipment used in its training programs is in proper working order and appropriately cleaned.

3. Training entities that conduct initial courses of instruction shall make available to all students clearly defined and published policies and procedures. Such policies and procedures shall include the following:

A. Admission criteria;

B. Student withdrawal and refund of tuition and/or fees policies;

C. Attendance policy;

D. Grading and academic criteria;

E. Class cancellation policy;

F. Appeal and grievance procedures;

G. Examination policies;

H. Health and safety procedures; *[and]*

I. Certification requirements of the National *[Standard]* **Registry** of Emergency Medical Technicians*[.]* **and licensing requirements for the state of Missouri; and**

J. Recent statutes and regulations of the state of Missouri that pertain to EMS which can be obtained from the EMS Bureau. This can either be in an electronic or paper format.

(J) Record Keeping and Reporting.

1. Records shall be maintained for each student that demonstrate all attendance, clinical, practical**,** and written examination records.

2. Records shall be maintained for each class session that document name of instructor, title of session, beginning and ending time of each session, and attendance at the session.

3. Records shall be maintained for each initial course of instruction that document location of course, primary instructor, beginning enrollment, drop-out rate, course fail rate**,** and number of students successfully completing the course.

4. Lesson plans shall be maintained for each course offered.

5. All records shall be available for review by *[Bureau of]* **the** EMS **Bureau** and kept on file for at least five (5) years.

6. Each EMS training entity shall submit to the *[Bureau of]* EMS **Bureau** an annual report indicating the number, type**,** and location of courses offered, the pass/fail rate for each course, and the numbers of students completing training. Each annual report shall contain an affidavit that the principal officers and medical director of the training entity remain the same as the original application, or shall indicate any change.

7. Certificates of completion shall be issued by the training entity to students, at the request of the student, after successful completion of the appropriate criteria.

(K) EMS training entities may cooperate and develop satellite programs under their approval. In these cases, the EMS training entity remains responsible for assuring quality EMS education and compliance with *[Bureau of]* **the** EMS **Bureau** rules.

(L) Upon EMS training entity approval by the *[Bureau of]* EMS **Bureau**, the *[Bureau of]* EMS **Bureau** shall assign an accreditation number to each EMS training entity. The EMS training entity shall reference this accreditation number on each course completion letter or certificate issued by the EMS training entity.

(2) Specific Requirements for EMS Training Entities Offering Initial EMT-P Courses **and EMT-I Courses**.

(A) Only EMS training entities certified by the *[Bureau of]* EMS **Bureau** to conduct initial EMT-P courses shall offer initial EMT-P **and EMT-I** courses.

(B) EMT-P **and EMT-I** students are only authorized to perform the skills and practice in accordance with the national standard curriculum for EMT-P and **EMT-I and** approved by the training entity medical director. The skills and practice performed by the student must be under the direct supervision of a clinical preceptor **during scheduled clinicals at an approved site with a current clinical agreement** and cannot be performed while *[being employed as an EMT-B]* **on duty**.

(C) EMS training entities offering initial EMT-P **and EMT-I** courses shall also be certified to conduct **EMT-I,** EMT-B, and/or first responder and/or emergency medical dispatcher, and/or EMS continuing education programs. If the training entity conducts these programs, the training entity shall also be responsible for *[assuring]* **ensuring** compliance with the rules set forth for those programs.

(D) Each EMT-P training entity shall have a formal affiliation with an appropriately accredited university, senior college, community college, vocational school, technical school**,** or an appropriately accredited medical institution with dedication to educational endeavors. This affiliation shall include the following:

1. Ability for the EMT-P training program to require prerequisite post-secondary educational courses;

2. Responsibility by the accredited post-secondary educational institution and/or medical institution over **the instructor(s) and** the educational methodologies used by the EMT-P training program; *[and]*

3. Access by the EMT-P training program into remedial education as may be necessary for the EMT-P training program*[.]***; and**

4. Access by the students to financial assistance such as, but not limited to, grants and Veteran's Benefits.

(E) Each EMT-P training program shall have a designated program director. Each EMT-P course shall have a designated *[lead]* **primary** instructor.

(F) Each EMT-P training program shall demonstrate and document that the EMT-P courses taught under its authority meet or exceed the requirements of the **current** national standard curriculum for EMT-P training.

(H) Clinical Requirements.

1. Each EMS training entity that provides EMT-P programs shall document and demonstrate a supervised clinical experience for all students. **Each training entity shall approve or disapprove clinical preceptors.**

2. Clinical affiliations shall be established and confirmed in current written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision.

3. Students shall be assigned in clinical settings where experiences are clinically and educationally effective in achieving the program's objectives.

4. When participating in clinicals, students *[will]* **shall** be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. *[Field internship]* **Clinical experience** shall occur only in association with an Advanced Life Support ambulance service which demonstrates medical accountability and employs preceptors who meet the training entity requirements. **Each training entity shall approve or disapprove services to be used as clinic experience sites.**

6. The *[Bureau of]* EMS **Bureau** *[will]* **shall** establish minimum standards for clinical experiences in accordance with current clinical recommendations of the national standard curriculum for EMT-P training.

7. All EMT-I students shall be currently licensed as an EMT-B.

8. All EMT-P students shall be currently licensed as an EMT-B or an EMT-I.

(I) Examination Requirements.

1. Each EMT-P training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity.

2. Exam scores for all students shall be maintained and be made available for review by the *[Bureau of]* EMS **Bureau** staff.

3. *[The Bureau of EMS may review the overall pass rates for these examinations to pass rates for examination for licensure (the appropriate National Registry examination).*

Repeated and disparate differences in these rates from state averages may be ground for review, recommendation or action by the Bureau of EMS on the training entity accreditation.] **The EMS Bureau shall review the first attempt computer adaptive test examinations results (pass rates) from each EMT-P training entity. The computer adaptive test licensure examination pass rate for first attempt candidates from each EMT-P training entity shall be no less than the national pass rate, as documented by the National Registry of EMTs for each calendar year. The EMT-P training entity with a pass rate below the national pass rate shall:**

A. First year—provide the EMS Bureau with a report analyzing all aspects of the education program and identifying areas contributing to the unacceptable pass rate and a plan of action to resolve low pass rates;

B. Second consecutive year—the program manager shall be required to appear before and present to the EMS Bureau an analysis of measures taken the first year, problems identified, and plan of correction; and

C. The training entity must appear before the EMS Bureau and provide the information outlined in (2)(I)3.B. until they have two (2) consecutive years of pass rates on the first attempt at the national pass rate.

(J) *[Training entities which are currently accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) shall be considered to be compliant with the rules for training entities that conduct EMT-Paramedic programs. Joint Review Committee accredited programs shall attach to their application evidence of accreditation. The Bureau of EMS may conduct periodic site reviews as necessary to verify compliance.]* **Training entities accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and/or the Committee on Accreditation for EMS Professions (CoAEMSP) shall be considered to be compliant with the rules for training entities that conduct EMT-Paramedic programs. CAAHEP and/or CoAEMSP accredited programs shall attach to their application evidence of accreditation. The EMS Bureau may conduct periodic site reviews as necessary to verify compliance.**

(K) An EMT-P primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as an EMT-P. This primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the curriculum.

(L) Minimum EMT-P course requirements: one thousand (1,000) hours of instruction to include:

1. Two hundred fifty (250) hours of clinical experience in a clinical setting with a Missouri licensed ambulance service;

2. Five hundred (500) hours of classroom/practical lab;

3. Two hundred fifty (250) hours of clinical hours in a health care facility; and

4. Clinical skills as outlined in the most current EMT-P National Standard Curriculum and the National Scope of Practice for EMT-P shall be the established minimums. The EMT-P National Standard Curriculum is incorporated by reference in this rule as published in 1998 and the refresher course in 2001 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The National Scope of Practice is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

(M) Minimum EMT-I course requirements: three hundred (300) hours of instruction to include:

1. Seventy-five (75) hours of clinical experience in a clinical setting with a Missouri licensed ambulance service;

2. One hundred seventy-five (175) hours of classroom/practical lab;

3. Fifty (50) hours of clinical hours in a health care facility; and

4. Clinical skills as outlined in the most current EMT-I National Standard Curriculum and the National Scope of Practice for EMT-I shall be the established minimums. The EMT-I National Standard Curriculum is incorporated by reference in this rule as published in 1999 and the refresher course in 2001 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The National Scope of Practice is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

(3) Specific Requirements for EMS Training Entities Offering Initial EMT-B Courses.

(A) Only EMS training entities certified by the *[Bureau of]* EMS **Bureau** to conduct initial EMT-B courses shall offer EMT-B courses.

(C) Each EMT-B training program shall have a designated program director. Each EMT-B course shall have a designated *[lead]* **primary** instructor.

(E) Clinical Requirements.

1. Each EMS training entity that provides EMT-B programs shall document and demonstrate a supervised clinical experience for all students.

2. Clinical affiliations shall be established and confirmed in current written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision. **Clinical supervision shall be conducted by a preceptor.**

3. Students shall be assigned in clinical settings where experiences are clinically and educationally effective in achieving the program's objectives.

4. When participating in clinicals, students *[will]* **shall** be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. The *[Bureau of]* EMS **Bureau** *[will]* **shall** establish minimum standards for clinical experiences in accordance with current clinical recommendations of the **current** national standard curriculum for EMT-B training.

(F) Examination Requirements.

1. Each EMT-B training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity. **The practical examination shall include all skills designated in the National Standard Curriculum, except endotracheal intubation.**

2. Exam scores **and practical examination forms** for all students shall be maintained and be made available for review by the *[Bureau of]* EMS **Bureau** staff.

3. *[The Bureau of EMS may review the overall pass rate for these examinations to pass rates for examination for licensure (the appropriate National Registry examination). Repeated and disparate differences in these rates from state averages may be grounds for review, recommendation or action by the Bureau of EMS on the training entity accreditation.]* **The EMS Bureau shall review the first attempt computer**

adaptive test examinations results (pass rates) from each EMT-B training entity. The computer adaptive test licensure examination pass rate for first attempt candidates from each EMT-B training entity shall be no less than the national pass rate, as documented by the National Registry of EMTs for each calendar year. The EMT-B training entity with a pass rate below the national pass rate shall:

A. First year—provide the EMS Bureau with a report analyzing all aspects of the education program and identifying areas contributing to the unacceptable pass rate and a plan of action to resolve low pass rates;

B. Second consecutive year—the program manager shall be required to appear before and present to the EMS Bureau an analysis of measures taken the first year, problems identified, and plan of correction; and

C. The training entity must appear before the EMS Bureau to provide the information outlined in (3)(F)3.B. until they have two (2) consecutive years of pass rates on the first attempt at the national pass rate.

(G) An EMT-B primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as an EMT-B. The primary instructor is responsible for the teaching of a specific lesson of the EMT-B course. The primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the new curriculum. The course shall use the following minimums:

1. Minimum of one hundred ten (110) hours of instruction; and

2. Minimum of five (5) patient contacts in a clinical setting.

(4) Specific Requirements for EMS Training Entities Offering EMS Continuing Education for EMT-B and EMT-P.

(A) *[EMS training entities offering EMS continuing education shall be certified to conduct EMT continuing education and/or first responder and/or emergency medical dispatcher training. If the training entity conducts these programs, the training entity shall also be responsible for assuring compliance to the rules set forth for those programs.]* **EMT-P continuing education training entities shall be certified to conduct EMT-P, EMT-I, and EMT-B continuing education. Continuing education training entities shall not conduct refresher courses, National Registry bridge programs, or remedial education. EMT-B continuing education training entities shall be certified to conduct only EMT-B continuing education courses.**

(G) Accreditation of continuing education by appropriate recognized national accrediting bodies **and other state EMS agencies** shall constitute approval under *[Bureau of]* **the** EMS **Bureau** rules.

(5) Specific Requirements for EMS Training Entities Offering Emergency Medical Dispatcher Training.

(A) Each training entity offering emergency medical dispatcher training shall demonstrate and document that the emergency medical dispatcher courses taught under its authority meet or exceed the *[requirements of a national standard curriculum for emergency medical dispatcher training.]* **standards set forth by the National Academy of Emergency Medical Dispatch.**

(6) Specific Requirements for EMS Training Entities Offering First Responder Training.

(C) Each training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity. **The first responder in Missouri shall be taught and permitted to perform all skills including spinal motion restriction in the current First Responder National Standard Curriculum and the National Scope of Practice for First Responder shall be the established minimums. First Responder National Standard Curriculum is incorporated by reference in this rule as published in 1995 and the refresher course in 1996 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The National Scope of Practice is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.**

(7) *[EMT-B and EMT-P Core Continuing Education Requirements.*

(A) EMS training entities may offer EMT-B and/or EMT-P core continuing education programs by offering a stand-alone program, by attending appropriate sessions of an initial training program or through a continuing education format.

(B) EMT-B and/or EMT-P core continuing education programs shall include a final or modular evaluation.

(C) The Bureau of EMS will promulgate standards for offering EMT-B core continuing education programs through a continuing education format.

(D) The Bureau of EMS will promulgate standards for offering EMT-P core continuing education programs through a continuing education format.] **EMT-B, EMT-I, and EMT-P Core Continuing Education Requirements.**

(A) EMS training entities may offer EMT-B and/or EMT-P core continuing education programs by offering a stand-alone program, by attending appropriate sessions of an initial training program, or through a continuing education format.

(B) EMT-B and/or EMT-P core continuing education programs shall include a final or modular written evaluation and, if applicable, a practical evaluation.

(C) Continuing education training entities must have a current copy of the most recent statutes and regulations of the state of Missouri that pertain to EMS which can be obtained from the EMS Bureau. These copies shall be available at all times for reference by the student and/or the training entity.

(8) Primary Instructor Qualifications.

[(A) The Bureau of EMS may authorize as primary instructors for EMS training programs those who can document the following:

1. Clinical expertise, which meets the following:

A. Current licensure and at least two (2) years clinical experience in the level of certification instructed or higher; or

B. Credentials as a subject matter expert as approved by the training entity's medical director;

2. Instructor training which meets the following:

A. Successful completion of an instructor training program that meets or exceeds the United States Department of Transportation EMS instructor curriculum; or

B. Current certification as a Missouri Fire Service Instructor I; or

C. Successful completion of a course from an appropriately accredited post-secondary educational institution that is at least three (3) credit hours on educational methodology;

3. EMS instructional experience, which meets the following:

A. Experience as an Advanced Cardiac Life Support, Basic Cardiac Life Support, Basic Trauma Life Support,

Pre-Hospital Trauma Life Support, or Pediatric Advanced Life Support instructor; or

B. Experience as a laboratory or guest instructor with an EMS training entity;

4. Continuing education in instructional topics of at least twenty (20) hours over the past five (5) years; and

5. Competent in adult education theory and clinical competency consistent with the level of curricula that they intend to teach.]

(A) The EMS Bureau may authorize as primary instructors for EMS training programs those who can document the following:

1. EMT-B Instructor:

A. Current Missouri licensure, National Registry, or other state license or certification as a paramedic and at least two (2) years clinical experience as an EMT-P, EMT-B, or licensure as a registered nurse or physician with at least two (2) years clinical experience;

B. Successful completion of an instructor-training program that meets or exceeds the United States Department of Transportation EMS Instructor Curriculum which is incorporated by reference in this rule as published in 2002 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

C. EMS instructional experience, which meets the following:

(I) Documentation of instructor status as an Advanced Cardiac Life Support, Basic Cardiac Life Support, International Trauma Life Support, or Pre-Hospital Trauma Life Support. Advanced Cardiac Life Support is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. International Trauma Life Support is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Ave., Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent amendments or additions. Pre-Hospital Trauma Life Support is incorporated by reference in this rule as published by the National Association of EMTs in 2006 and is available at the National Association of EMTs, PO Box 1400, Clinton, MS 39060-1400. This rule does not incorporate any subsequent amendments or additions; or

(II) Experience as a laboratory or guest instructor with an EMS training entity;

D. Continuing education in instructional topics of at least twenty (20) hours in total over the past five (5) years; and

E. Competent in adult education theory and clinical skills consistent with the current EMT-B National Standard Curriculum which is incorporated by reference in this rule as published in 1994 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

2. EMT-P and EMT-I Instructor:

A. Current Missouri licensure, National Registry, or other state license or certification as a paramedic and at least two (2) years clinical experience as an EMT-P, or licensure as a registered nurse or physician with at least two (2) years clinical experience;

B. Successful completion of an instructor training program that meets or exceeds the United States Department of Transportation EMS Instructor Curriculum. The United States Department of Transportation EMS Instructor Curriculum is incorporated by reference in this rule as published in 2002 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions;

C. EMS instructional experience, which meets the following:

(I) Documentation of instructor experience in Advanced Cardiac Life Support, International Trauma Life Support, Pre-Hospital Trauma Life Support, Pediatric Advanced Life Support, or Pediatric Education for Pre-Hospital Professionals (PEPP). Advanced Cardiac Life Support (ACLS) is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. International Trauma Life Support (ITLS) is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Avenue, Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent amendments or additions. Pre-Hospital Trauma Life Support (PHTLS) is incorporated by reference in this rule as published by the National Association of Emergency Medical Technicians in 2006 and is available at the National Association of Emergency Medical Technicians, PO Box 1400, Clinton, MS 39060-1400. This rule does not incorporate any subsequent amendments or additions. Pediatric Advanced Life Support (PALS) is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. PEPP is incorporated by reference in this rule as published by the American Academy of Pediatrics in 2006 and is available at the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007. This rule does not incorporate any subsequent amendments or additions; and

(II) Experience as a laboratory or guest lecturer;

D. Continuing education in instructional topics of at least twenty (20) hours over the past five (5) years;

E. Competent in adult education theory and clinical skills consistent with the most current EMT-P National Standard Curriculum and the National Scope of Practice for EMT-P shall be the established minimums. The EMT-P National Standard Curriculum is incorporated by reference in this rule as published in 1998 and the refresher course in 2001 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The National Scope of Practice is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions; and

F. As of July 1, 2012, all newly employed primary instructors of initial EMT-P training entities shall possess a minimum of sixty (60) credit hours from an accredited post secondary educational institution.

3. First Responder Instructor:

A. The primary instructor must be a first responder, licensed EMT-B, EMT-I, EMT-P, registered nurse, or physician.

B. The primary instructor must be knowledgeable in all aspects of out-of-hospital emergency medical care, in the techniques and methods of adult education, and in managing resources and personnel;

C. The primary instructor shall have attended and successfully completed a program in EMS instruction methodology;

D. The primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as a first responder. The primary instructor is responsible for the teaching of a specific lesson of the first responder course. The primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the new curriculum.

(9) Initial licensure examination for EMT-B, EMT-Intermediate, and EMT-Paramedic.

(A) The EMS Bureau shall use the National Registry of EMTs examination process as the basis for initial licensure examinations for all level of EMTs. The EMT-Basic exam conducted in Missouri is considered "the state approved practical examination" by the National Registry of Emergency Medical Technicians. It shall serve as the state of Missouri examination used for National Registry Certification as an EMT-Basic.

1. Any student of an accredited Missouri EMT-Basic program must complete the EMT-B practical examination in Missouri.

2. If a student from a Missouri accredited EMT-B program attempts a state approved exam outside the state of Missouri, that student must complete all practical testing in that state and is ineligible from completing the Missouri EMT-B practical examination.

3. EMT-I and EMT-P candidates must complete the National Registry practical exam in Missouri or at an approved National Registry Advanced Level exam site in another state.

(B) The EMS Bureau shall select providers of the practical licensure examination in the state of Missouri. The providers shall, with the EMS Bureau approval, operate all test sites and dates in accordance with the policies and procedures of the National Registry of EMTs and the EMS Bureau.

1. The EMS Bureau shall have oversight and review authority of all EMT-B, EMT-I, and EMT-P practical and written examinations administered in the state of Missouri used to obtain licensure.

2. Out-of-state applicants for EMT-B practical testing shall have their practical skills reviewed by a Missouri accredited EMT-B or EMT-P training entity. The training entity shall provide documentation to the EMS Bureau that verifies that the student is competent in all the skills listed in the National Standard Curriculum for EMT-B, except endotracheal intubation. The EMT-B National Standard Curriculum is incorporated by reference in this rule as published in 1994 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
UNIT OF EMERGENCY MEDICAL SERVICES
TRAINING ENTITY ACCREDITATION APPLICATION

FOR DHSS OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ **INITIAL ACCREDITATION**	**TRAINING ENTITY ACCRED NO.** ☐☐☐☐☐☐	**DATE PASSED REVIEW** ☐☐ ☐☐ ☐☐
☐ **REACCREDITATION**	**DATE APPLICATION REC'D** ☐☐ ☐☐ ☐☐	**ISSUE DATE** ☐☐ ☐☐ ☐☐
	DATE INSPECTOR ASSIGNED ☐☐ ☐☐ ☐☐	**EXPIRATION DATE** ☐☐ ☐☐ ☐☐
INSPECTOR ASSIGNED ___________________	**DATE OF FIRST INSPECTION** ☐☐ ☐☐ ☐☐	

APPLICANT MUST COMPLETE INFORMATION BELOW ***TYPE OR PRINT***

1. TRADE NAME OF TRAINING ENTITY	**DAYTIME TELEPHONE NO.**
	( )

TRAINING ENTITY BUSINESS ADDRESS *(STREET, ROUTE, CITY, STATE, ZIP)*

2. TYPE OF ACCREDITATION APPLIED FOR (check all that apply)

☐EMT-P ☐EMT-B ☐CEUS ☐FIRST RESPONDER ☐EMERGENCY MEDICAL DISPATCH

3. PROGRAM DIRECTOR

NAME *(LAST, FIRST, MI)*			TELEPHONE NUMBER ( )
MAILING BUSINESS ADDRESS *(STREET, ROUTE, ETC.)*			FAX NUMBER ( )
CITY	STATE	ZIP CODE	E-MAIL

4. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)* ☐ M.D. ☐ D.O.

MAILING ADDRESS *(STREET, ROUTE, ETC.)*				OFFICE TELEPHONE NUMBER ( )
CITY	STATE	ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an accredited training entity medical director and I agree to serve as medical director.

SIGNATURE OF MEDICAL DIRECTOR	DATE

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Training Entity has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo.
I have attached all training entity licensure and related administrative licensure actions taken against this training entity or owner by any state agency in any state.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF TRAINING ENTITY LICENSEE	DATE

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. §575.060. RSMo

Mail Application to: Unit of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102

MO-580-2317 (R 08/07) EMS-52

*AUTHORITY: section[s] 190.103, **RSMo 2000 and sections** 190.131 and 190.185, RSMo Supp. [1998] **2007**. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.342 Application and Licensure Requirements for the Initial Licensure and Relicensure of Emergency Medical Technician-Basics, *Emergency Medical Technician-Intermediate,* and Emergency Medical Technician-Paramedics. The department is amending sections (1)–(4).

PURPOSE: This amendment makes the addition of Emergency Medical Technician-Intermediate and the requirements for licensure. It also defines requirements for obtaining criminal background checks for all Emergency Medical Technician levels.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Application Requirements for Emergency Medical Technician (EMT) Licensure.

(A) Each applicant for licensure or relicensure as an EMT-Basic**, EMT-Intermediate,** or EMT-Paramedic shall submit an application for licensure to the *[Bureau of]* Emergency Medical Services (EMS) **Bureau**. An applicant for relicensure must submit their application no less than thirty (30) days or no more than one hundred twenty (120) days prior to the expiration date of their current license.

(B) An application shall include**, but is not limited to,** the following information: whether an initial licensure or relicensure application; if previously licensed, their license number and expiration date; type of licensure applied for (EMT-Basic **(EMT-B), EMT-Intermediate (EMT-I),** or EMT-Paramedic **(EMT-P)**); type of certification or education used for licensure or relicensure; applicant's name, signature, address, date of birth, sex, daytime telephone number, e*[-]*mail address (if applicable), and Social Security number; if applicable, type of present primary EMS affiliation; prior administrative licensure actions taken against *[their EMT license]* **any license or certification** in Missouri or any other state; whether they have been*[, during the past five (5) years,]* finally adjudicated and found guilty, or entered a plea of guilty or *nolo contendere*, in a criminal prosecution under the laws of any state or of the United States, whether or not they received a suspended imposition of sentence for any criminal offense; if the answer is yes to the preceding statement**,** they must attach to their application a certified copy of all charging documents (such as complaints, informations, or indictments), *[judgements]* **judgments** and sentencing information**, plea agreements and probation terms,** and any other information they wish considered; certification by the applicant that they have the ability to speak, read**,** and write the English language; certification by the applicant that they do not have a physical or mental impairment which would substantially limit their ability to perform the essential functions of an emergency medical technician position with or without a reasonable accommodation; certification by the applicant that if relicensing using continuing education that they have successfully completed the required continuing education in accordance with state regulations, have attached a list of these continuing education units, and are in possession of documents of the required continuing education, and will make all records available to the *[Bureau of]* EMS **Bureau** upon request under penalty of license action up to and including revocation; certification by the applicant that the application contains no misrepresentation or falsifications and that the information given by them is true and complete to the best of their knowledge; certification by the applicant that they have the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Services Systems Act, Chapter 190, RSMo *[Supp. 1998]*; and certification by the applicant that they have been a resident of Missouri for five (5) consecutive years prior to the date on their application or have attached to the application *[at least two (2) completed fingerprint cards supplied by the Bureau of EMS]* **an approved criminal background check as determined by the EMS Bureau and performed within the last sixty (60) days from each state the applicant has lived in during that time. The EMS personnel license application form, included herein, is available at the EMS Bureau office or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.**

(C) *[All applicants shall provide their Social Security number on their application so the Bureau of EMS can perform criminal history checks to determine the recency and relatedness of any criminal convictions prior to the licensure or relicensure of the applicant.]* **All applicants shall provide approved criminal background checks as determined by the EMS Bureau and performed within the last sixty (60) days to demonstrate the recency and relatedness of any criminal convictions prior to the licensure or relicensure of the applicant.** Criminal *[history]* **background** checks that the *[Bureau of]* EMS **Bureau** finds not to be relevant to the licensure or relicensure of an EMT will not be maintained in the applicant's file.

(D) All applicants shall attach to the application a list of the qualifying continuing education used for relicensure, as applicable. This list shall include verification by the applicant's training officer or medical director that all core requirements have been met. Receipt of this list does not constitute approval of continuing education by the *[Bureau of]* EMS **Bureau**.

(E) An applicant shall provide all information and certification required on the *[Bureau of]* EMS **Bureau** application for EMT licensure. Incomplete or inaccurate information on an application shall be cause to deny or take action upon a license.

(F) An applicant shall disclose if they have ever been subject to limitation, suspension, or termination of their right to practice in a health care occupation and/or voluntarily surrendered a health care license or certification in any state.

(2) EMT-Basic (EMT-B) Licensure and Relicensure Requirements.

(A) EMT-Basic (Initial Licensure). Initial licensure requirements apply to any person who was not licensed in Missouri prior to August 28, 1998, as an attendant or attendant-driver by the *[Bureau of]* EMS **Bureau** or whose Missouri license has expired for more than two (2) years. The applicant for initial licensure shall submit with their license application to the *[Bureau of]* EMS **Bureau** evidence of current certification with the National Registry of EMTs as an EMT-B, *[EMT-Intermediate]* **EMT-I** or *[EMT-Paramedic]* *[(]*EMT-P*[)]*.

(B) The EMT-B in Missouri may be permitted to perform all skills including blood glucose analysis and dual lumen airway in the National Scope of Practice for Emergency Medical Technicians which is incorporated by reference in this rule as published in 2007 by the U.S. Department of Transportation and is available at U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

*[(B)]***(C)** EMT-Basic (Relicensure or Step Down from EMT-P **or EMT-I**).

1. The applicant for relicensure shall submit with their license application to the *[Bureau of]* EMS **Bureau** evidence of current certification with the National Registry of EMTs as an EMT-Basic, EMT-Intermediate or EMT-Paramedic; or

2. An applicant shall certify to the *[Bureau of]* EMS **Bureau**:

A. That they have successfully completed one hundred (100) hours of continuing education which meet *[Bureau of]* **the** EMS **Bureau's** approval criteria under 19 CSR 30-40.331, forty-eight (48) hours of which cover all elements of the EMT-B core continuing education curriculum and fifty-two (52) hours of which may be elective topics from the EMT-B**, EMT-I,** or EMT-P curriculum;

B. That they are able to produce documentation of the required continuing education, and will make all records available to the *[Bureau of]* EMS **Bureau** upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure. Failure to obtain and retain complete and accurate documentation shall be cause for taking action upon a license; and

C. That they have current basic cardiac life support training (does not count towards core continuing education curriculum).

(3) EMT-Paramedic Licensure and Relicensure Requirements.

(A) EMT-Paramedic (Initial Licensure). Initial licensure requirements apply to any person who was not licensed in Missouri prior to August 28, 1998 as a mobile emergency medical technician by the *[Bureau of]* EMS **Bureau** or whose Missouri license has expired for more than two (2) years. The applicant for initial licensure shall submit with their license application to the *[Bureau of]* EMS **Bureau** evidence of current certification with the National Registry of EMTs as an EMT-P. **The EMT-P in Missouri may perform all the skills in the National Scope of Practice for Paramedic which is incorporated by reference in this rule as published in 2007 by the U.S. Department of Transportation and is available at U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.**

(B) EMT-Paramedic (Relicensure).

1. The applicant for relicensure shall submit with their license application to the *[Bureau of]* EMS **Bureau** evidence of current certification with the National Registry of EMTs as an EMT-P; or

2. An applicant shall certify to the *[Bureau of]* EMS **Bureau**:

A. That they have successfully completed one hundred *[and]* forty-four (144) hours of continuing education which meet *[Bureau of]* **the** EMS **Bureau's** approval criteria under 19 CSR 30-40.331, forty-eight (48) hours of which may be elective topics and the remaining ninety-six (96) hours covering all elements of the EMT-P core continuing education curriculum;

B. That they are able to produce documentation of the required continuing education, and will make all records available to the *[Bureau of]* EMS **Bureau** upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure. Failure to obtain and retain complete and accurate documentation shall be cause for taking action upon a license; and

C. That they have current advanced cardiac life support training (can be counted towards the refresher requirement).

(4) *[The Bureau of EMS may select one (1) or more qualified providers to administer the practical licensure examination for EMT-Bs and EMT-Ps. The provider shall—*

(A) Meet all the requirements of the National Registry of EMTs;

(B) Make application to the Bureau of EMS that—

1. Demonstrates necessary expertise, experience and resources needed in administering EMT practical examinations; and

2. Demonstrates evidence of practical examiner training and credentialling;

(C) Operate all tests in accordance with the policies and procedures of the National Registry of EMTs and the Bureau of EMS.] **EMT-Intermediate (EMT-I) Licensure and Relicensure Requirements.**

(A) EMT-I (Initial Licensure). Initial licensure requirements apply to any person applying for licensure in Missouri. The applicant for initial licensure shall submit with their license application to the EMS Bureau evidence of current certification with the National Registry of Emergency Medical Technicians as an EMT-I. The EMT-I in Missouri may perform all the skills except intraosseous infusions in the National Scope of Practice for Advanced EMT which is incorporated by reference in this rule as published in 2007 by the U.S. Department of Transportation and is available at U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

(B) EMT-Intermediate (EMT-I) Relicensure.

1. The applicant for relicensure shall submit with their license application to the EMS Bureau evidence of current certification with the National Registry of EMTs as an EMT-I; or

2. An applicant shall certify to the EMS Bureau:

A. That they have successfully completed one hundred forty-four (144) hours of continuing education which meet the EMS Bureau's approval criteria under 19 CSR 30-40.331, seventy-two (72) hours of which cover all elements of the EMT-I core continuing education curriculum, and seventy-two (72) hours of which may be elective topics from the EMT-B, EMT-I, or EMT-P curriculum;

B. That they are able to produce documentation of the required continuing education and shall make all records available to the EMS Bureau upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure.

(C) EMT-B Step-Down from EMT-P or EMT-I.

1. The applicant for relicensure shall submit with their license application to the EMS Bureau evidence of current certification with the National Registry of EMTs as an EMT-B, EMT-I, or EMT-P; or

2. An applicant shall certify to the EMS Bureau:

A. That they have successfully completed one hundred (100) hours of continuing education which meet the EMS Bureau's approval criteria under 19 CSR 30-40.331, forty-eight (48) hours of which cover all elements of the EMT-B core continuing education curriculum, and fifty-two (52) hours of which may be elective topics from the EMT-B, EMT-I, or EMT-P curriculum;

B. That they are able to produce documentation of the required continuing education and shall make all records available to the EMS Bureau upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure.

C. Applicants shall also have current basic cardiac life support training. This does not count towards core continuing education curriculum.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
EMS PERSONNEL LICENSE APPLICATION

UEMS USE ONLY

FOR DOH OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

EMT LICENSE NO. ☐☐☐☐☐☐	APPROVED BY/DATE	DATE LICENSED ☐☐ ☐☐ ☐☐
DATE APP. REC'D. ☐☐ ☐☐ ☐☐	________________	EXPIRATION DATE ☐☐ ☐☐ ☐☐

APPLICANT MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

1. ☐ INITIAL LICENSE APP.
2. ☐ RELICENSURE APP.

IF APPLICABLE CURRENT MO EMS LIC NO. ☐☐☐☐☐☐ AND EXPIRATION DATE ☐☐ ☐☐ ☐☐

3. TYPE OF LICENSE APPLIED FOR (Check One) **EMT-Basic** ☐ **EMT-Intermediate** ☐ **EMT-Paramedic** ☐

4. CERTIFICATION/EDUCATION USED FOR INITIAL LICENSURE OR RELICENSURE: (*PLEASE CHECK ONLY ONE)*

☐ EMT-B NATIONAL REGISTRY *(Attach copy of card)*	☐ EMT-I NATIONAL REGISTRY *(Attach copy of card)*	☐ EMT-P NATIONAL REGISTRY *(Attach copy of card)*	☐ EMT-B CONTINUING EDUCATION	☐ EMT-I CONTINUING EDUCATION	☐ EMT-P CONTINUING EDUCATION

5. NAME *(LAST, FIRST, MIDDLE INITIAL)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH MO___DAY___YR___	SEX ☐ M ☐ F	DAYTIME PHONE NUMBER E-MAIL ADDRESS (if applicable)

MAILING ADDRESS *(STREET)*

CITY	STATE	ZIP CODE	COUNTY

6. NAME OF THE EMS AGENCY YOU ARE CURRENTLY WORKING FOR.(If applicable)

7. TYPE OF PRESENT PRIMARY EMS AFFILIATION *(IF APPLICABLE)*

☐ AMBULANCE SERVICE ☐ UNLICENSED FIRST RESPONDER AGENCY ☐ POLICE DEPARTMENT
☐ LICENSED EMRA ☐ FIRE SERVICE ☐ OTHER

8. Have you ever had administrative licensure action taken against your EMT license in Missouri or any other state?
Yes ☐ No ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

9. Has your right to practice in a health care occupation ever been subject to limitations, suspension or termination?
Yes ☐ No ☐ Not Applicable ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

10. Have you ever voluntarily surrendered a health care license or certification in any state?
Yes ☐ No ☐ Not Applicable ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

11. HAVE YOU EVER BEEN FINALLY ADJUDICATED AND FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDERE IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES, WHETHER OR NOT YOU RECEIVED A SUSPENDED IMPOSITION OF SENTENCE FOR ANY CRIMINAL OFFENSE? Yes ☐ No ☐
IF YOU HAVE ANSWERED YES TO THE ABOVE QUESTION YOU MUST ATTACH TO YOUR APPLICATION A CERTIFIED COPY OF ALL CHARGING DOCUMENTS (SUCH AS COMPLAINTS, INFORMATIONS OR INDICTMENTS), JUDGMENTS AND SENTENCING INFORMATION, PLEA AGREEMENTS AND PROBATION TERMS AND ANY OTHER INFORMATION YOU WISH CONSIDERED.

12. I HEREBY CERTIFY THAT:

A. I am able to speak, read and write the English language.

B. I do not have a physical or mental impairment which would substantially limit my ability to perform the essential functions of an emergency medical technician with or without a reasonable accommodation.

C. This application contains no misrepresentations or falsifications and the information given by me is true and complete to the best of my knowledge. I further certify that I have both the intention and the ability to comply with the regulations promulgated under Chapter 190 RSMo.

D. I have enclosed an approved criminal background check determined by the Bureau of EMS and performed within the last 60 days. If I have not lived in Missouri for the last five consecutive years, then I have attached an approved criminal background check determined by the Bureau of EMS and performed within the last 60 days from each state I have lived in during that time. If you need fingerprint cards, please contact the Bureau of EMS by calling 573-751-6356.

IF RELICENSING USING CONTINUING EDUCATION, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

APPLICANT'S SIGNATURE	DATE

WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor pursuant to section 575.06 RSMo.

Mail application to: Bureau of EMS, P.O. Box 570, Jefferson City, MO 65102

MO 580-0988 (R 11/07) EMS-3

DECLARATION OF CEUS

NAME OR TYPE OF COURSE	DIV OR MODULE	# OF HRS CORE	# OF HRS ELECTIVE	TRAINING ENTITY ACCREDITATION #, CECBEMS APPROVAL #, OR OTHER ACCREDITING AGENCY (ACLS, PALS, BTLS, MONA, ACEP, ETC.)
TOTAL HOURS				

COPY THIS SHEET IF NECESSARY

IF RELICENSING USING CONTINUING EDUCATION, I HEREBY CERTIFY THAT:

1. I have successfully completed the required continuing education in accordance with state regulations.
2. I have attached a list of these continuing education units.
3. I am in possession of documentation of the required continuing education and will make all records available to the Missouri Department of Health and Senior Services upon request under penalty of license action, up to and including revocation.
4. EMT-B and EMT-I applicants must attach a copy of current CPR card.
5. EMT-P applicants must attach copy of current ACLS card.

APPLICANT'S SIGNATURE	DATE

MO 580-0988 (R 11/07) EMS-3

*AUTHORITY: sections 190.142, 190.160, 190.165, and 190.185, RSMo Supp. [1998] **2007**. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities forty thousand three hundred fifty dollars ($40,350) annually.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 40-Comprehensive Emergency Medical Services System Regulations:

Rule Number and Title:	19 CSR 30-40.342
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
3,400	EMT (Missouri residents)	$30,600 annually.
250	EMT (non-Missouri residents)	$9,750.00 annually.
	Total cost=	$40,350.00 annually.

III. WORKSHEET

There are currently 16,800 Emergency Medical Technicians (EMTs) licensed in Missouri. The license is issued for 5 years. Once every 5 years, the applicant must obtain a background check to attach to the license application.
If the applicant has resided in Missouri for the past 5 consecutive years, a simple name and social security check is done. The current cost is $9.00 per background check.
There are 250 applicants that did not live in Missouri for the past 5 consecutive years. Background checks in surrounding states differ but are expected to be less than the $39.00 charged for a fingerprint check.

IV. ASSUMPTIONS

16,800 EMTs in Missouri. 20% relicense every five years totaling approximately 3,400 per year.
3400 x $9.00 = $30,600.00 per year with expected 12% increase per year.
Missouri has seen a 12% increase in initial licensees per year.
There are currently approximately 1,200 EMTs living outside of Missouri.
The applicant would obtain a background check from each state lived in during the past five years.
The cost for a background check out of state is not expected to be greater than the Federal Bureau of Investigation fingerprint check which costs $39.00.
There are approximately 250 out of state applicants each year.
250 x $39.00 = $9,750.00
Total = $40,350.00

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.410 Definitions and Abbreviations Relating to Trauma Centers. The department is amending section (1).

PURPOSE: This amendment defines severely injured child and adds educational programs in the definitions.

(1) The following definitions and abbreviations shall be used in the interpretation of the rules in 19 CSR 30-40.400 to 19 CSR 30-40.450:

[(D) Bureau of EMS means the Missouri Department of Health and Senior Services' Bureau of Emergency Medical Services;]

*[(E)]***(D)** Board-admissible means that a physician has applied to a specialty board and has received a ruling that s/he has fulfilled the requirements to take the examinations. Board certification must be obtained within five (5) years of the first appointment;

*[(F)]***(E)** Board-certified means that a physician has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in a specialty field;

*[(G)]***(F)** Certified registered nurse anesthetist (CRNA) means a registered nurse who has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor and who has been certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists;

*[(H)]***(G)** CME means continuing medical education and refers to the highest level of continuing education approved by the Missouri State Medical Association, the Missouri Association of Osteopathic Physicians and Surgeons, The American Osteopathic Association, or the Accreditation Council for Continuing Medical Education;

*[(I)]***(H)** Continuing nursing education means education approved or recognized by a national *[nurses']* **and/or state professional** organization and/or trauma medical director;

(J) Core surgeon is a member of the trauma team listed on the trauma call schedule ten percent (10%) of the time or greater;

*[(J)]***(K)** Credentialed or credentialing is a hospital-specific system of documenting and recognizing the qualifications of medical staff and nurses and authorizing the performance of certain procedures **and establishing clinical privileges** in the hospital setting;

(L) EMS Bureau means the Missouri Department of Health and Senior Services Emergency Medical Services Bureau;

*[(K)]***(M)** Glasgow coma scale is a scoring system for assessing a patient's level of consciousness utilizing a point system which measures eye opening, verbal response, and motor response. The higher the total score, the better the patient's neurological status;

*[(L)]***(N)** Immediately available (IA) means being present **at bedside** at the time of the patient's arrival at the hospital when prior notification is possible and no more than twenty (20) minutes from the hospital under normal driving and weather conditions;

*[(M)]***(O)** In-house (IH) means being on the hospital premises twenty-four (24) hours a day;

[(N) Major pediatric trauma case means a patient fifteen (15) years of age or under with a revised trauma score of 11 or less;]

[(O) Major trauma case is a patient with an injury severity score of more than fifteen (15), using the scoring method described in the article "The Injury Severity Score," pages 187-196 of The Journal of Trauma, Vol. 14, No. 3, 1974;]

[(P) Major trauma patient means a trauma patient with cardiopulmonary arrest, unstable blunt or penetrating chest or abdominal injury, airway compromise, systolic blood pressure less than ninety (90) millimeters of mercury, pulse less than sixty (60) or greater than one hundred (100) per minute with clinical signs of shock, severe neurological injuries or signs of deteriorating neurological status, or prolonged loss of consciousness;]

(P) Liaison means one (1) physician representative from each of the following areas: Emergency Medicine, Neurosurgery, Orthopedics, and Anesthesia who is selected to attend the Performance Improvement and Patient Safety Committee and to disseminate information to the other physicians within his/her specialty taking trauma call;

(Q) Missouri trauma registry is a statewide data collection system to compile and maintain statistics on mortality and morbidity of trauma victims, using a reporting *[form]* **method** provided by the Missouri Department of Health and Senior Services;

(S) Non-core surgeon is a member of the trauma call team listed on the trauma call schedule less than ten percent (10%) of the time;

*[(S)]***(T)** PALS means *[p]***P**ediatric *[a]***A**dvanced *[l]***L**ife *[s]***S**upport, *[a course of training available through the American Heart Association]* **ENPC means Emergency Nurses Pediatric Course, and APLS means Advanced Pediatrics Life Support;** when required, certification shall be maintained;

*[(T)]***(U)** Physician advisory group is two (2) or more physicians who collectively assume the role of a medical advisor;

*[(U)]***(V)** Promptly available (PA) means arrival at the hospital **at the patient's bedside** within thirty (30) minutes after notification of a patient's arrival at the hospital;

*[(V)]***(W)** R is a symbol to indicate that a standard is a requirement for trauma center designation at a particular level;

*[(W)]***(Y)** Revised trauma score (RTS) is a numerical methodology for categorizing the physiological status of trauma patients;

*[(Y)]***(Z)** Senior **trauma surgery** resident is a physician in at least the third post-graduate year of study;

*[(Z)]***(AA)** Severely injured **adult** patient is an injured patient with a glasgow coma score **(GCS)** less than *[thirteen (13)]* **fourteen (14)** or a systolic blood pressure less than ninety (90) millimeters of mercury or respirations less than ten (10) per minute or more than twenty-nine (29) per minute;

(BB) Severely injured child is defined as a patient fourteen (14) years of age or less having a GCS less than fourteen (14), shock following injury, pediatric trauma score less than eight (8), or with any of the following conditions: unable to establish or maintain an airway; ineffective respiratory effort; penetrating injury to head, neck, chest, abdomen, or extremity proximal to elbow or knee; burns greater than ten percent (10%) of the body surface area or involving inhalation injury; two (2) or more proximal long bone fractures or pelvic fracture; open or depressed skull fracture; suspected spinal cord injury and/or paralysis; amputation proximal to wrist or ankle; facial or tracheal injury with airway compromise; pre-existing medical conditions; or respiratory or cardiopulmonary arrest after injury;

*[(AA)]***(CC)** Surgical trauma call roster is a hospital-specific list of surgeons assigned to trauma care, including date(s) of coverage and back-up surgeons **when indicated**;

*[(BB)]***(DD)** Trauma center is a hospital that has been designated in accordance with the rules in this chapter to provide systematized medical and nursing care to trauma patients. Level I is the highest level of designation*[, usually representing a large urban hospital with a university affiliation.]* **and functions as the resource center for the hospitals within that region.** Level II is the next highest level of designation *[and is usually a large community hospital]* dealing with large volumes of serious trauma *[in a geographic area lacking a hospital with resources of level 1]*. Level III is the next level *[and usually represents a small rural hospital with a commitment to trauma care that is commensurate]* with limited resources;

*[(CC)]***(EE)** Trauma medical director is a surgeon designated by the hospital who is responsible for the trauma service and *[quality assurance]* **performance improvement and patient safety** programs related to trauma care;

*[(DD)]***(FF)** Trauma nurse coordinator/**trauma program manager** is a registered nurse designated by the hospital with responsibility for monitoring and evaluating the *[nursing]* care of trauma patients and the coordination of *[quality assurance]* **performance improvement and patient safety programs** for the trauma center **in conjunction with the trauma medical director**;

*[(EE)]***(GG)** Trauma nursing course is an education program in nursing care of trauma patients;

*[(FF)]***(HH)** Trauma service is an organizational component of the hospital specializing in the care of injured patients;

*[(GG)]***(II)** Trauma team is a team consisting of the emergency physician, physicians on the surgical trauma call roster, appropriate anesthesiology staff, nursing and other support staff as needed;

*[(HH)]***(JJ)** Trauma team activation protocol is a hospital document outlining the criteria used to identify *[major trauma]* **severely injured** patients and the procedures for notification of trauma team members and indicating surgical and non-surgical specialty response times acceptable for treating major trauma patients; and

*[(II)]***(KK)** Trauma triage is an estimation of injury severity at the scene of an accident.

AUTHORITY: section[s] 190.185, ***RSMo Supp.*** *[2006]* ***2007*** *and* ***section*** *190.241, RSMo 2000. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed June 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.420 Trauma Center Designation Requirements. The department is amending sections (1)–(4).

PURPOSE: This amendment defines trauma center review team requirements and the trauma center designation as being site specific.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Participation in Missouri's trauma center program is voluntary and no hospital shall be required to participate. No hospital shall in any way indicate to the public that it is a trauma center unless that hospital has been designated as such by the *[Bureau of]* Emergency Medical Services (EMS) **Bureau**. Hospitals desiring trauma center designation shall apply to the *[Bureau of]* EMS **Bureau**. Only those hospitals found by review to be in compliance with the requirements of the rules in this chapter shall be designated by *[Bureau of]* **the** EMS **Bureau** as trauma centers.

(2) The application required for trauma center designation shall be made upon forms prepared or prescribed by the *[Bureau of]* EMS **Bureau** and shall contain information the *[Bureau of]* EMS **Bureau** deems necessary to make a fair determination of eligibility for review and designation in accordance with the rules of this chapter.

(A) An application shall include**, but is not limited to,** the following information: designation level requested; name, address**,** and telephone number of hospital; name of chief executive officer, chairman/president of board of trustees, surgeon in charge of trauma care, trauma nurse coordinator/**program manager**, director of emergency medicine, and director of trauma intensive care; number of emergency department trauma caseload, trauma team activations, computerized tomography scan capability, magnetic resonance imaging capability, operating rooms, intensive care unit/critical care unit beds, burn beds, rehabilitation beds, trauma surgeons, neurosurgeons, orthopedists, emergency department physicians, anesthesiologists, certified registered nurse anesthetists, pediatricians, and pediatric surgeons; date of application; and signatures of the chairman/president of board of trustees, hospital chief executive officer, surgeon in charge of trauma, and director of emergency medicine. **The trauma center review and designation application form, included herein, is available at the EMS Bureau office or may be obtained by mailing a written request to Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.**

(B) The *[Bureau of]* EMS **Bureau** shall notify the hospital of any apparent omissions or errors in the completion of the application and shall contact the hospital to arrange a date for the review.

(3) The review of hospitals for trauma center designation shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. The cost of any and all site reviews shall be paid by each applicant hospital or renewing trauma center unless adequate funding is available to *[Bureau of]* **the** EMS **Bureau** to pay for reviews.

(A) For the purpose of reviewing trauma centers and hospitals applying for trauma center designation, the *[Bureau of]* EMS **Bureau** shall use review teams consisting of two (2) surgeons*[,]* **and** one (1) emergency physician*[,]* **who are experts in trauma care** and one (1) *[registered nurse]* **trauma nurse coordinator/trauma program manager** *[who are experts in trauma care,]* experienced in trauma center review *[and disinterested politically and financially in the hospitals to be reviewed]*. **The team shall be disinterested politically and financially in the hospitals to be reviewed.** Out-of-state review teams shall conduct levels I and II reviews. In-state reviewers may conduct level III reviews. **In the event that out-of-state reviewers are unavailable, level II reviews may be conducted by in-state reviewers from EMS regions other than the region being reviewed with approval of the director of the Department of Health and Senior Services or his/her designee. When utilizing in-state review teams, the level II trauma center shall have the right to refuse one (1) review team.**

(B) Any substantial deficiencies cited in the initial review or the validation review regarding patient care issues, especially those related to delivery of timely surgical intervention, shall require a focused review to be conducted. When deficiencies involve documentation or policy or equipment, the hospital's plan of correction shall be submitted to *[Bureau of]* **the** EMS **Bureau** and verified by *[Bureau of]* EMS **Bureau** personnel.

(D) Validation reviews shall occur every five (5) years. Level I and II trauma centers undergoing American College of Surgeons reverification review at shorter intervals may incorporate *[Bureau of]* EMS **Bureau** personnel in these reviews and, if they successfully pass reverification and meet all requirements herein, submit that review for *[Bureau]* EMS **Bureau** reverification.

(E) Upon completion of a review, the reviewers shall submit a report of their findings to the *[Bureau of]* EMS **Bureau**. If this is also an American College of Surgeons (ACS) verification or reverification, the hospital shall request a copy of the report be sent directly to the *[Bureau of]* EMS **Bureau** from the ACS verification committee. The report shall state whether the specific standards for trauma center designation have or have not been met; if not met, in what way they were not met. The report shall include the patient chart audits and a narrative summary to include pre-hospital, hospital, trauma service, emergency department, operating room, recovery room, clinical lab, intensive care unit, blood bank, rehabilitation, *[quality]* **performance** improvement **and patient safety programs**, education, outreach, research, chart review, and interviews. The *[Bureau of]* EMS **Bureau** has final authority to determine compliance with the rules of this chapter.

(F) Within thirty (30) days after receiving a review report, the *[Bureau of]* EMS **Bureau** shall return a copy of the report in whole to the chief executive officer of the hospital reviewed. Included with the report shall be notification indicating that the hospital has met the criteria for trauma center designation or has failed to meet the criteria for the designation level for which it applied and options the hospital may pursue.

(G) If a verification review is required, the hospital shall be allowed a period of *[up to eight (8)]* **six (6)** months to correct deficiencies. A plan of correction form shall be provided *[by]* **to** the *[Bureau of]* EMS **Bureau** and shall be completed by the hospital and returned to the *[Bureau of]* EMS **Bureau** within *[sixty (60)]* **thirty (30)** days after notification of review findings.

(H) Once a review is completed, a final report shall be prepared by the *[Bureau of]* EMS **Bureau**. The final report shall be public record and shall disclose the standards by which the reviews were conducted and whether the standards were met. The reports filed by the reviewers shall be held confidential and shall be disclosed only to the hospital's chief executive officer or an authorized representative.

(4) The *[Bureau of]* EMS **Bureau** shall have the authority to put on probation, suspend, revoke**,** or deny trauma center designation if there is reasonable cause to believe that there has been a substantial failure to comply with the requirements of the rules in this chapter. Once designated as a trauma center, a hospital may voluntarily surrender the designation at any time without giving cause, by contacting the *[Bureau of]* EMS **Bureau**. In these cases, the application and review process shall be completed again before the designation may be reinstated.

(A) Trauma center designation shall be valid for a period of five (5) years from the date the trauma center is designated. Expiration of the designation shall occur unless the trauma center applies for validation review within this five (5)-year period. **Trauma center designation shall be site specific and not transferable when a trauma center changes location.**

(B) The *[Bureau of]* EMS **Bureau** shall investigate complaints against trauma centers. Failure of the hospital to cooperate in providing documentation and interviews with appropriate staff may result in revocation of trauma center designation. Any hospital, which takes adverse action toward an employee for cooperating with the *[Bureau of]* EMS **Bureau** regarding a complaint, is subject to revocation of trauma center designation.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
APPLICATION FOR TRAUMA CENTER REVIEW AND DESIGNATION

In accordance with the requirements of Chapter 190, RSMo and the applicable regulations, this application is hereby submitted for trauma center review and designation.	Designation Level Requested ☐ I ☐ II ☐ III

HOSPITAL INFORMATION

Name Of Hospital (Name To Appear On Designation Certificate)		Telephone Number
Address (Street And Number)	(City)	(Zip)

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President Of Board Of Trustees
Surgeon In Charge Of Trauma Care	Trauma Nurse Coordinator/Program Manager
Director Of Emergency Medicine	Director Of Trauma Intensive Care

RESOURCE INFORMATION

E.D. Trauma Caseload	Trauma Team Activations	C.T. Scan Capability	M.R.I. Capability
Operating Rooms	ICU/CCU Beds	Burn Beds	Rehab. Beds
Trauma Surgeons	Neurosurgeons	Orthopaedists	E.D. Physicians
Anesthesiologists	C.R.N.A.s	Pediatricians	Pediatric Surgeons

CERTIFICATION

WE, the undersigned, hereby certify that the information provided in this application for trauma center review and designation is true and accurate and give assurance of the intent and ability of the hospital to comply with the regulations promulgated under Chapter 190, RSMo. We further certify that the hospital will comply with all recommendations for improvement contained in the trauma center site review reports prepared by the Missouri Department of Health and Senior Services. We further certify that we have attached additional documention for trauma center review and designation as listed in Section B of the attached instruction document.

Date of application__________________

Signed______________________________
Chairman/President of Board of Trustees, Owner, or one Partner of Partnership

Signed______________________________
Hospital Chief Executive Officer

Signed______________________________
Surgeon In Charge Of Trauma Care

Signed______________________________
Director of Emergency Medicine

MO 580-1628 (R 08/07) EMS-18

*AUTHORITY: section[s] 190.185, **RSMo Supp. 2007** and **section** 190.241, RSMo [Supp. 1998] **2000**. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED AMENDMENT

19 CSR 30-40.430 Standards for Trauma Center Designation. The department is amending sections (1)–(5).

PURPOSE: This amendment revises education requirements for trauma center staff, updates equipment utilized by trauma centers, and further defines performance improvement requirements.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Standards for Trauma Center Designation.

(C) The hospital shall demonstrate evidence of a trauma program that provides the trauma team with appropriate experience to maintain skill and proficiency in the care of trauma patients. Such evidence shall include*[,]* meeting of continuing education unit requirements by all professional staff, documented regular attendance *[at trauma quality improvement]* **by all core trauma surgeons and liaison representation from neurosurgeons, orthopedic surgeons, emergency medicine physicians, and anesthesiologists at trauma program performance improvement and patient safety program** meetings, documentation of continued experience **as defined by the trauma medical director** in management of sufficient numbers of *[severe trauma]* **severely injured** patients to maintain skill levels, and outcome data on quality of patient care*[.]* **as defined by regional emergency medical service committees. Regular attendance shall be defined by each trauma service, but shall be not less than fifty percent (50%) of all meetings. The trauma medical director must ensure and document dissemination of information and findings from the peer review meetings to the non-core surgeons on the trauma call roster.**

(E) The hospital shall appoint a board-certified surgeon to serve as the trauma medical director. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma medical director and other services. (I-R, II-R, III-R)

2. The trauma medical director shall be a member of the surgical trauma call roster. (I-R, II-R, III-R)

3. The trauma medical director shall be responsible for **the oversight of** the education and training of the medical and nursing staff in trauma care. (I-R, II-R, III-R)

4. The trauma medical director shall document a minimum average of sixteen (16) hours of continuing medical education (CME) in trauma care every year. (I-R, II-R, III-R)

5. The trauma medical director shall participate in the trauma center's research and publication projects. (I-R)

(F) There shall be a trauma nurse coordinator/**trauma program manager**. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma nurse coordinator/**trauma program manager** and other services. (I-R, II-R, III-R)

2. The trauma nurse coordinator/**trauma program manager** shall document a minimum average of *[twenty-four (24) hours]* **sixteen (16) hours** of continuing nursing education in trauma care every year. (I-R, II-R, III-R)

(G) By the time of the initial review, all **general surgeon** members of the surgical trauma call roster shall have successfully completed or be registered for a provider Advanced Trauma Life Support (ATLS) course. **Current certification must then be maintained by each general surgeon on the trauma call roster.** (I-R, II-R, III-R)

(H) All members of the surgical trauma call roster and **emergency medicine physicians including liaisons for** anesthesiology, neurosurgery**,** and orthopedic surgery shall document a minimum average of eight (8) hours of CME in trauma care every year. In hospitals designated as adult/pediatric trauma centers, *[an additional six (6) hours per year of pediatric trauma education must be maintained by trauma surgeons caring for pediatric patients.]* **providing care to injured children fourteen (14) years of age and younger, four (4) of the eight (8) hours of education per year must be applicable to pediatric trauma.** (I-R, II-R, III-R)

(I) The hospital shall demonstrate that there is **a plan for** adequate post-discharge follow-up on trauma patients, including rehabilitation *[results where applicable. This shall include identification of members of the rehabilitation team, discharge summary of trauma care to the patient's private physician and documentation in the patient's medical record of the post-discharge plan]*. (I-R, II-R, III-R)

(J) A Missouri trauma registry shall be completed on each *[of the following trauma patients: any patient who is admitted and has a length of stay of twenty-four (24) hours or more; any patient who is transferred to or admitted from another acute care hospital; any patient who dies in the hospital; and any patient who is admitted to the intensive care unit (ICU) at any time during the hospital stay. The registry form shall include the following items: hospital identification number and hospital medical record number; patient name and address, Social Security number, date of birth, sex and race; if minor (under eighteen (18) years) name of parent or guardian; date of injury; time of injury; external cause of injury (E code); scene of injury; place of injury; protective equipment used; mode of arrival; ambulance service number; ambulance report number; ambulance times; if transfer in, name of sending hospital, city located, date and time patient arrived at sending hospital; date and time of arrival in emergency department; glasgow coma score, systolic blood pressure and respiratory rate at arrival in the emergency department; time sent to computerized tomography (ct); time of call and arrival in emergency department of the trauma surgeon and neurosurgeon; time of discharge from emergency department; blood alcohol concentration (mg/dl);*

drugs detected as result of toxicology test; admitting service; emergency department disposition; if transferred out, name and location of receiving hospital; date and time of arrival in operating room; operating room procedures ranked by apparent severity; final diagnoses ranked by apparent severity; date and time admitted; date and time discharged; total ICU days; disposition at discharge; degree of disability and disability related to; billed hospital charges; and expected main source of payment. The registry forms for patients discharged during any one (1) month shall be completed and sent to the Department of Health by the last day of the following month.] **patient who sustains a traumatic injury and meets the following criteria: Includes at least one (1) code within the range of the following injury diagnostic codes as defined in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9)-(CM) 800-959.9 which is incorporated by reference in this rule as published by the Centers for Disease Control and Prevention in 2006 and is available at National Center for Health Statistics, 1600 Clifton Road, Atlanta, GA 30333. This rule does not incorporate any subsequent amendments or additions. Excludes all diagnostic codes within the following code ranges: 905-909.9 (late effects of injury), 910-924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites), 930-939.9 (foreign bodies), and must include one of the following criteria: hospital admission, patient transfer out of facility, or death resulting from the traumatic injury (independent of hospital admission or hospital transfer status).** The registry *[may]* **shall** be submitted electronically in a format defined by the Department of Health **and Senior Services**. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. A patient log with admission date, patient name, and injuries must be available for use during the site review process. Information provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. **The trauma care data elements shall be those identified and defined by the National Trauma Data Standard which is incorporated by reference in this rule as published by the American College of Surgeons in 2008 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions.** (I-R, II-R, III-R)

(K) The hospital shall have a trauma team activation protocol that establishes the criteria used to rank trauma patients according to the severity and type of injury and identifies the persons authorized to notify trauma team members when a *[major trauma]* **severely injured** patient is en route or has arrived at the trauma center. (I-R, II-R, III-R)

1. The trauma team activation protocol shall provide for immediate notification and *[rapid]* response requirements for trauma team members when a *[major trauma]* **severely injured** patient is en route to the trauma center. (I-R, II-R, III-R)

(2) Hospital Organization Standards for Trauma Center Designation.

(B) All members of the surgical trauma call roster shall comply with the availability and response requirements in subsection (2)(D) of this rule. If not on the hospital premises, trauma team members who are immediately available shall carry electronic *[paging]* **communication** devices at all times to permit contact by the hospital and shall respond immediately to a contact by the hospital. (I-R, II-R, III-R)

(C) Physicians who are board-certified or board-admissible **or complete an alternate pathway as documented and defined by the trauma medical director using the criteria established by the American College of Surgeons (ACS) in the current Resource for Optimal Care Document** in the following specialties and who are credentialed by the hospital for trauma care shall be on the trauma center staff*[;]* **and be available as indicated. The Resource for Optimal Care Document is incorporated by reference in this rule as published by the American College of Surgeons in 2006 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions.**

[1. Cardiac surgery—I-R;
2. General surgery—I-R, II-R, III-R;
3. Neurologic surgery—I-R, II-R;
4. Obstetric-gynecologic surgery—I-R, II-R;
5. Ophthalmic surgery—I-R, II-R;
6. Dental surgery—I-R;
7. Orthopedic surgery—I-R, II-R;
8. Otorhinolaryngologic surgery—I-R, II-R;
9. Pediatric surgery—I-R;
10. Plastic, oral and maxillofacial surgery—I-R, II-R;
11. Thoracic surgery—I-R, II-R; and
12. Urologic surgery—I-R, II-R]

[(D) The following specialists who are credentialed by the hospital for trauma care shall be available to the patient as indicated:]

1. General surgery—I-IH, II-IA, III-PA.

A. The general surgery staffing requirement may be fulfilled by senior residents credentialed in general surgery, including trauma care, **and Advanced Trauma Life Support (ATLS) certification,** and capable of assessing emergent situations in general surgery.

B. The trauma surgeon shall be immediately available and be in attendance with the patient when a *[senior surgical resident]* **trauma surgery resident** is fulfilling availability requirements;

C. In a level I or II trauma center, call rosters providing back-up coverage will be maintained for general trauma surgeons. In a level III center, call rosters providing for back-up coverage for general trauma surgeons will be maintained or a written transfer agreement to a regional level I or II center provided.

2. Neurologic surgery—I-IH, II-IA.

A. The neurologic surgery staffing requirement may be fulfilled by a surgeon who has been approved by the chief of neurosurgery for care of patients with neural trauma.

B. The surgeon shall be capable of initiating measures toward stabilizing the patient and performing diagnostic procedures.

3. Cardiac/**Thoracic** surgery—I-PA**, II-PA**;
4. Obstetric-gynecologic surgery—I-PA, II-PA;
5. Ophthalmic surgery—I-PA, II-PA;
6. Orthopedic surgery—I-PA, II-PA;
7. Maxillofacial trauma surgery—I-PA, II-PA;
*[7.]***8.** Otorhinolaryngolic surgery—I-PA, II-PA;
*[8.]***9.** Pediatric surgery **and/or trauma surgeon credentialed and privileged in pediatric trauma care**—I-IA**, II-PA; this requirement will be waived in centers that provide evaluation and care to adults only;**
*[9.]***10.** Plastic *[and maxillofacial]* surgery—I-PA, II-PA;
[10. Thoracic surgery-I-PA, II-PA;]
11. Urologic surgery—I-PA, II-PA;
12. Emergency medicine—I-IH, II-IH, III-IH; **and**
13. Anesthesiology—I-IH, II-IA, III-PA.

A. In a level I or II trauma center, anesthesiology staffing requirements may be fulfilled by anesthesiology residents **or certified registered nurse anesthetists (CRNA) or anesthesiologist assistants** capable of assessing emergent situations in trauma patients and of providing any indicated treatment **including induction of anesthesia**. When anesthesiology residents**, anesthesiologist assistants, or CRNAs** are used to fulfill availability requirements, the staff anesthesiologist on call will be advised and promptly available **for all operative interventions and emergency airway conditions**.

[B. In a level II trauma center, anesthesiology staffing requirements may be fulfilled when the staff anesthesiologist is promptly available and an in-house certified registered nurse anesthetist (CRNA) capable of assessing emergent

situations in trauma patients and of initiating and providing any indicated treatment is available.]

*[C.]***B.** In a level III trauma center, anesthesiology requirements may be fulfilled by either a CRNA with physician supervision or an anesthesiologist assistant with anesthesiologist supervision in accordance with sections 334.400 to 334.430, RSMo;

14. Cardiology—I-PA, II-PA;
15. Chest **pulmonary** medicine—I-PA**, II-PA**;
16. Gastroenterology—I-PA, **II-PA**;
17. Hematology—I-PA, II-PA;
18. Infectious diseases—I-PA**, II-PA**;
19. Internal medicine—I-PA, II-PA, III-PA;
20. Nephrology—I-PA, II-PA;
21. Pathology—I-PA, II-PA;
22. Pediatrics—I-PA, II-PA;
23. Psychiatry—I-PA, II-PA; and
24. Radiology—I-PA, II-PA.

(3) Standards for Special Facilities/Resources/Capabilities for Trauma Center Designation.

(A) The hospital shall meet emergency department standards for trauma center designation.

1. The emergency department staffing shall ensure immediate and appropriate care of the trauma patient. (I-R, II-R, III-R)

A. The physician director of the emergency department shall be board-certified or board-admissible in emergency medicine. (I-R, II-R)

B. There shall be a physician *[competent]* **trained** in the care of the critically injured **as evidenced by credentialing in ATLS and current in trauma CME** in the emergency department twenty-four (24) hours a day. **ATLS is incorporated by reference in this rule as published by the American College of Surgeons in 2003 and is available at American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions.** (I-R, II-R, III-R)

*[(I)]***C.** All emergency department physicians shall be *[currently]* certified in ATLS *[and advanced cardiac life support (ACLS).]* **at least once. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status.** (I-R, II-R, III-R)

[(II) The emergency department physician shall be a designated member of the trauma team, and shall document a minimum average of sixteen (16) hours of trauma education per year. (I-R, II-R, III-R)]

*[C.]***D.** There shall be written protocols defining the relationship of the emergency department physicians to other physician members of the trauma team. (I-R, II-R, III-R)

[D. The emergency department shall employ a trauma utilization assessment system which predicts the number of registered nurses needed to provide adequate care and resuscitation of trauma patients. There shall be no fewer than one (1) registered nurse per shift credentialed in trauma nursing on duty in the emergency department. (I-R, II-R, III-R)]

E. All registered nurses *[regularly]* assigned to the emergency department shall be credentialed in trauma nursing by the hospital within one (1) year of assignment. (I-R, II-R, III-R)

(I) Registered nurses credentialed in trauma nursing shall document a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)

[(II) By the time of the initial review, all registered nurses assigned to the emergency department shall have successfully completed or be registered for a provider ACLS course. (I-R, II-R, III-R)]

(II) Registered nurses credentialed in trauma care shall maintain current provider status in the Trauma Nursing Core Curriculum or Advanced Trauma Care for Nurses and either Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), or Emergency Nursing Pediatric Course (ENPC) within one (1) year of employment in the emergency department. The requirement for Trauma Nurse Core Curriculum, Advanced Pediatric Life Support, or Emergency Nursing Pediatric Course may be waived in centers where policy exists diverting injured children to a pediatric trauma center and where a pediatric trauma center is immediately available and a performance improvement filter reviewing any children seen is maintained. The Trauma Nursing Core Curriculum is incorporated by reference in this rule as published in 2007 by the Emergency Nurses Association and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Advanced Trauma Care for Nurses is incorporated by reference in this rule as published in 2003 by the Society of Trauma Nurses and is available at the Society of Trauma Nurses, 1926 Waukegan Road, Suite 100, Glenview, IL 60025. This rule does not incorporate any subsequent amendments or additions. Pediatric Advanced Life Support is incorporated by reference in this rule as published in 2005 by the American Heart Association and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. The Emergency Nursing Pediatric Course is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

2. Equipment for resuscitation and life support **with age appropriate sizes** for the critically or seriously injured shall include the following:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, sources of oxygen**,** and mechanical ventilator*[, including pediatric sizes]*—I-R, II-R, III-R;

B. Suction devices*[, including pediatric sizes]*—I-R, II-R, III-R;

C. Electrocardiograph, *[oscilloscope]* **cardiac monitor,** and defibrillator*[, including pediatric capability]*—I-R, II-R, III-R;

D. Central line insertion equipment—I-R, II-R, III-R;

E. All standard intravenous fluids and administration devices including intravenous catheters*[, including pediatric sizes]*—I-R, II-R, III-R;

F. Sterile surgical sets for procedures standard for the emergency department*[, including pediatric sizes]***—**I-R, II-R, III-R;

G. Gastric lavage equipment*[, including pediatric sizes]*—I-R, II-R, III-R;

H. Drugs and supplies necessary for emergency care*[, including pediatric dosages]*—I-R, II-R, III-R;

I. Two-way radio linked with emergency medical service (EMS) vehicles—I-R, II-R, III-R;

J. End-tidal carbon dioxide monitor—I-R, II-R, III-R and mechanical ventilators*[, including pediatric capability]*—I-R, II-R;

[K. Skeletal tongs—I-R, II-R, III-R.]

*[L.]***K.** Temperature control devices for patient, parenteral fluids**,** and blood—I-R, II-R, III-R; and

*[M.]***L.** Rapid infusion system for parenteral infusion—I-R, II-R, III-R.

3. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

4. There shall be a designated trauma resuscitation area in the emergency department. (I-R, II-R)

5. There shall be X-ray capability with twenty-four (24)-hour coverage by technicians. (I-IH, II-IH, III-IA)

6. Nursing documentation for the trauma patient shall be on a trauma flow sheet **approved by the trauma medical director and trauma nurse coordinator/trauma program manager**. (I-R, II-R, III-R)

(B) The hospital shall meet intensive care unit (ICU) standards for trauma center designation.

1. There shall be a designated surgeon medical director for the ICU. (I-R, II-R, III-R)

2. A physician who is not the emergency department physician shall be on duty in the ICU or available in-house twenty-four (24) hours a day in a level I trauma center and shall be on call and available within twenty (20) minutes in a level II trauma center.

3. *[The ICU shall utilize a patient classification system which defines the severity of injury and indicates the number of registered nurses needed to staff the unit.]* The minimum registered nurse/trauma patient ratio used shall be one to two (1:2). (I-R, II-R, III-R)

4. Registered nurses shall be credentialed in trauma care within one (1) year of assignment documenting a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)

5. Nursing care documentation shall be on a *[twenty-four (24)-hour]* patient flow sheet. (I-R, II-R, III-R)

6. At the time of the initial review, nurses assigned to ICU shall have successfully completed or be registered for a provider ACLS course. **The requirement for ACLS may be waived in pediatric centers where policy exists diverting injured adults to an adult trauma center and where an adult trauma center is immediately available and a performance improvement filter reviewing any adult trauma patients seen is maintained.** (I-R, II-R, III-R)

7. There shall be separate pediatric and adult ICUs or a combined ICU with nurses trained in pediatric intensive care. In ICUs providing care to children, registered nurses shall maintain credentialing in PALS, APLS, or ENPC (I-R, II-R)

*[7.]***8.** There shall be beds for trauma patients or comparable **level of** care provided until space is available in ICU. (I-R, II-R, III-R)

*[8.]***9.** Equipment for resuscitation and to provide life support for the critically or seriously injured shall *[include, but not be limited to:]* **be available for the intensive care unit. In ICUs providing care for the pediatric patient, equipment with age appropriate sizes shall also be available. This equipment shall include, but not be limited to:**

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, and a mechanical ventilator*[, including pediatric sizes]*—I-R, II-R, III-R;

B. Oxygen source with concentration controls—I-R, II-R, III-R;

C. Cardiac emergency cart, including *[pediatric cardiac equipment and]* medications—I-R, II-R, III-R;

D. Temporary transvenous pacemakers*[, including pediatric sizes]*—I-R, II-R, III-R;

E. Electrocardiograph, *[oscilloscope]* **cardiac monitor,** and defibrillator*[,including pediatric sizes]*—I-R, II-R, III-R;

F. Cardiac output monitoring—I-R, II-R;

G. Electronic pressure monitoring and pulse oximetry—I-R, II-R;

H. End-tidal carbon dioxide monitor and mechanical ventilators*[,including pediatric capability]*—I-R, II-R, III-R;

I. Patient weighing devices*[, including pediatric scales]*—I-R, II-R, III-R;

[J. Pulmonary function measuring devices, including pediatric capability—I-R, II-R, III-R;]

*[K.]***J.** Temperature control devices *[for adult and pediatric patients]*—I-R, II-R, III-R;

*[L.]***K.** Drugs, intravenous fluids, and supplies *[for adult and pediatric patients]*—I-R, II-R, III-R; and

*[M.]***L.** Intracranial pressure monitoring devices—I-R, II-R.

*[9.]***10.** There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

[10. There shall be separate pediatric and adult ICU's or a combined ICU with nurses trained in pediatric intensive care. (I-R)]

(C) The hospital shall meet post-anesthesia recovery room (PAR) standards for trauma center designation.

1. Registered nurses and other essential personnel who are not on duty shall be on call and available within *[twenty (20)]* **sixty (60)** minutes. (I-R, II-R, III-R)

2. Equipment for resuscitation and to provide life support for the critically or seriously injured shall include, but not be limited to:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, sources of oxygen, and mechanical ventilator—I-R, II-R, III-R;

B. Suction devices—I-R, II-R, and III-R;

C. Electrocardiograph, *[oscilloscope]* **cardiac monitor,** and defibrillator—I-R, II-R, III-R;

D. Apparatus to establish central venous pressure monitoring—I-R, II-R;

E. All standard intravenous fluids and administration devices, including intravenous catheters—I-R, II-R, III-R;

F. Sterile surgical set for emergency procedures—I-R, II-R, and III-R;

G. Drugs and supplies necessary for emergency care—I-R, II-R, III-R;

H. Temperature control devices for the patient, for parenteral fluids, and for blood—I-R, II-R, III-R;

[I. Intracranial pressure monitoring devices—I-R, II-R;]

*[J.]***I.** Temporary pacemaker—I-R, II-R, III-R;

*[K.]***J.** Electronic pressure monitoring—I-R, II-R; and

*[L.]***K.** Pulmonary function measuring devices—I-R, II-R, III-R.

(G) The hospital shall *[have]* **possess** pediatric trauma management capability or *[a]* **maintain** written transfer agreements. (I-R, II-R, III-R)

(H) Radiological capabilities for trauma center designation **including a mechanism for timely interpretation to aid in patient management** shall include:

1. Angiography *[of all types]* **with interventional capability available twenty-four (24) hours a day with a one (1)-hour maximum response time**—I-R, II-R;

2. Sonography available twenty-four (24) hours a day with a thirty (30)-minute maximum response time—I-R;

[3. Nuclear scanning available twenty-four (24) hours a day with a thirty (30)-minute maximum response time—I-R;]

*[4.]***3.** Resuscitation equipment available to the radiology department—I-R, II-R, III-R;

*[5.]***4.** Adequate physician and nursing personnel present with monitoring equipment to fully support the trauma patient and provide documentation of care during the time the patient is physically present in the radiology department and during transportation to and from the radiology department. **Nurses providing care for the trauma patients that are not accompanied by a trauma nurse while in the radiology department during initial evaluation and resuscitation shall maintain the same credentialing required of emergency department nursing personnel**—I-R, II-R, III-R;

*[6.]***5.** In-house computerized tomography *[(Mobile computerized tomography services, contracts for those services with other institutions or computerized tomography in remote areas of a hospital requiring transportation from the main hospital building shall not be considered in-house.)]*—I-R, II-R; and

*[7.]***6.** Computerized tomography technician—I-IH, II-IA.

(J) Medical surgical floors of a designated trauma center shall have the following personnel and equipment:

1. Registered nurses and other essential personnel on duty twenty-four (24) hours a day—I-R, II-R, III-R;

2. Equipment for resuscitation and to provide support for the injured patient including, but not limited to:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, and sources of oxygen—I-R, II-R, III-R;

B. Suction devices—I-R, II-R, III-R;

C. Electrocardiograph, *[oscilloscope]* **cardiac monitor,** and defibrillator—I-R, II-R, III-R;

D. All standard intravenous fluids and administration devices and intravenous catheters—I-R, II-R, III-R; and

E. Drugs and supplies necessary for emergency care—I-R, II-R, III-R; and

3. Documentation that all equipment is checked according to the hospital preventive maintenance schedule—I-R, II-R, III-R.

(K) The operating room personnel, equipment, and procedures of a trauma center shall include, but not be limited to:

1. An operating room adequately staffed in-house twenty-four (24) hours a day—I-R, II-R;

2. Equipment *[for resuscitation and to provide life support for the critically or seriously injured]* including, but not limited to:

[A. Cardiopulmonary bypass capability—I-R;]

*[B.]***A.** Operating microscope—I-R;

*[C.]***B.** Thermal control equipment for patient, parenteral fluids, and blood—I-R,II-R,III-R;

*[D.]***C.** X-ray capability—I-R, II-R, III-R;

*[E]***D.** *[Endoscopes]* **Endoscopic capabilities**, all varieties—I-R, II-R, III-R;

*[F.]***E.** Instruments necessary to perform an open craniotomy—I-R, II-R; and

*[G.]***F.** Monitoring equipment—I-R, II-R, III-R; **and**

3. Documentation that all equipment is checked according to the hospital preventive maintenance schedule—I-R, II-R, III-R; *[and]*

[4. Documentation that any certified registered nurse anesthetist (CRNA) participating in care of trauma patients completes a minimum average of eight (8) hours of trauma-related continuing nursing education every year—I-R, II-R, III-R;]

(4) Standards for Programs in *[Quality Assurance,]* **Performance Improvement and Improvement Patient Safety Program,** Outreach, Public Education, and Training for Trauma Center Designation.

(A) There shall be an ongoing *[quality assurance program]* **performance improvement and patient safety program** designed to objectively and systematically monitor, review, and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. (I-R, II-R, III-R)

(B) The following additional *[quality assurance]* **performance improvement and patient safety** measures shall be required:

1. Regular reviews of all trauma-related deaths *[that are within seven (7) days of admission to the trauma center]*—I-R, II-R, III-R;

2. A regular morbidity and mortality review**, at least quarterly**—I-R, II-R, III-R;

3. A regular multidisciplinary trauma conference that includes **representation of** all members of the trauma team, with minutes of the conferences to include attendance*[, individual cases reviewed]* and findings—I-R, II-R, III-R;

[4. Regular medical nursing audits, utilization reviews and tissue reviews—I-R,II-R, III-R;]

*[5.]***4.** Regular reviews of the reports generated by the Department of Health **and Senior Services** from the Missouri trauma registry and the head and spinal cord injury registry—I-R, II-R, and III-R;

*[6.]***5.** Regular reviews of pre-hospital *[and regional systems of]* trauma care **including inter-facility transfers and all adult patients seen in pediatric centers**—I-R, II-R, III-R;

6. Participation in reviews of regional systems of trauma care as established by the Department of Health and Senior Services—I-R, II-R, III-R; and

[7. In trauma centers using CRNAs to fulfill any part of the anesthesiology staffing requirements, a separate quality assurance program to assure ongoing review by the physician(s) responsible for the anesthesiology service.]

7. Trauma patients remaining greater than six (6) hours prior to transfer will be reviewed as a part of the performance improvement and patient safety program—I-R, II-R, III-R.

(D) A public education program shall be established to promote injury prevention *[and standard first aid]* **and trauma care** and to resolve problems confronting the public, medical profession, and hospitals regarding optimal care for the injured. **These must address major trauma issues as identified in that program's performance improvement and patient safety process.** (I-R, II-R)

[(E) The hospital shall document existing or planned programs to increase public awareness of trauma prevention. These programs may be collectively presented with other hospitals and organizations. (I-R, II-R)]

*[(F)]***(E)** The hospital shall be actively involved in local and regional emergency medical services systems by providing training and clinical resources. (I-R, II-R, III-R)

*[(G)]***(F)** There shall be a hospital-approved procedure for credentialing nurses in trauma care. (I-R, II-R, III-R)

1. All nurses *[regularly]* **providing care to severely injured patients and** assigned to the emergency department or ICU shall complete a minimum of sixteen (16) hours of trauma nursing courses to become credentialed in trauma care. (I-R, II-R, III-R)

2. The content and format of any trauma nursing courses developed and offered by a hospital shall be developed in cooperation with the trauma medical director. A copy of the course curriculum used shall be filed with the *[Bureau of]* EMS **Bureau**. (I-R, II-R, III-R)

3. Trauma nursing courses offered by institutions of higher education in Missouri **such as the Advanced Trauma Care for Nurses, Emergency Nursing Pediatric Course,** or the Trauma Nurse Core *[c]***C**urriculum *[offered by the Emergency Nurses' Association]* may be used to fulfill this requirement. To receive credit for this course, a nurse shall obtain advance approval for the course from the trauma medical director and trauma nurse coordinator/**trauma program manager** and shall present evidence of satisfactory completion of the course. (I-R, II-R, III-R)

*[(H)]***(G)** *[Hospital diversion information must be maintained to include date, length of time and reason for diversion. This must be monitored as a part of the quality improvement process and available when the hospital is site reviewed.]* **A hospital trauma diversion protocol must be maintained in accordance with state regulations. This protocol is designed to allow best resource management within a given area. This protocol must contain a defined performance improvement and patient safety process to review and validate established criteria within that institution. Hospital diversion information must be maintained to include date, length of time, and reason for diversion.**

(H) Each trauma center shall have a disaster plan. A copy of this disaster plan must be maintained within the trauma center policies and procedures and should document the trauma services role in planning and response.

(5) Standards for the Programs in Trauma Research for Trauma Center Designation.

(A) The hospital and its staff shall *[document a research program in trauma]* **support a research program in trauma as evidenced by any of the following:**

1. Publications in peer reviewed journals—I-R;

2. Reports of findings presented at regional or national meetings—I-R;

3. Receipt of grants for study of trauma care—I-R; and

4. Production of evidence-based reviews—I-R.

(B) The hospital shall agree to cooperate and participate with the *[Bureau of]* EMS **Bureau** in conducting epidemiological studies and individual case studies for the purpose of developing injury control and prevention programs. (I-R, II-R, III-R)

AUTHORITY: section[s] 190.185, ***RSMo Supp.*** *[2006]* ***2007*** *and* ***section*** *190.241, RSMo 2000. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions thirty thousand six hundred twenty-five dollars ($30,625) annually.

PRIVATE COST: This proposed amendment will cost private entities four hundred eleven thousand nine hundred seventy-five dollars ($411,975) annually.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Missouri Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 40-Comprehensive Emergency Medical Services System Regulations:

Rule Number and Title:	**19 CSR 30-40.430**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
1 Trauma Center	**Level I Trauma Center**	**$30,625.00 annually.**

III. WORKSHEET
There is one (1) state-owned trauma center.

Advanced Trauma Life Support costs $600.00/full course and $200.00 to recertify. This is required for Certified Registered Nurse Anesthetists, resident staff and general trauma surgeons.

Pediatric Advanced Life Support costs $100.00/year. This is required for Emergency Department nurses, Intensive Care Unit nurses caring for pediatric patients and radiology nurses if they take care of trauma patients without the Emergency Department nurse present.

Emergency Nurse Pediatric Course and Trauma Nurse Core Course cost $56.25/ yr. is required for Emergency Department nurses, Intensive Care Unit nurses caring for Pediatric patients and radiology nurses if they take care of trauma patients without the Emergency Department nurse present.

IV. ASSUMPTIONS
Advanced Trauma Life Support cost for 25 staff x $600.00 = $15,000.00

**Pediatric Advanced Life Support cost for 100 staff x $100.00 = $10,000.00
Emergency Nurse Pediatric Course or Trauma Nurse Core Course for 100 staff x $56.25 = $5,625.00**

Total cost = $30,625.00

FISCAL NOTE
PRIVATE COST

I. Department Title: Missouri Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 40-Comprehensive Emergency Medical Services System Regulations:

Rule Number and Title:	**19 CSR 30-40.430**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
9	**Level I Trauma Center**	**$275,625.00 annually.**
11	**Level II Trauma Centers**	**$101,750.00 annually.**
8	**Level III Trauma Centers**	**$34,600.00 annually.**
	Total cost=	**$411,975.00 annually.**

III. WORKSHEET
There are 28 private Trauma Centers, 9 Level I, 11 Level II and 8 Level III.

Advanced Trauma Life Support costs $600.00/full course and $200.00 to recertify. This is required for Certified Registered Nurse Anesthetists, resident staff and general trauma surgeons.

Pediatric Advanced Life Support costs $100.00/year. This is required for Emergency Department nurses, Intensive Care Unit nurses caring for pediatric patients and radiology nurses if they take care of trauma patients without the Emergency Department nurse present.

Emergency Nurse Pediatric Course and Trauma Nurse Core Course cost $56.25/ yr. is required for Emergency Department nurses, Intensive Care Unit nurses caring for pediatric patients and radiology nurses if they take care of trauma patients without the Emergency Department nurse present.

IV. ASSUMPTIONS
Advanced Trauma Life Support cost for 25 staff x $600.00 = $15,000.00

Pediatric Advanced Life Support cost for 100 staff x $100.00 = $10,000.00
Emergency Nurse Pediatric Course or Trauma Nurse Core Course for 100 staff x $56.25= $5,625.00
Total cost = $30,625.00 per Level I trauma center per year
$30,625.00 x 9 = $275,625.00 for Level I trauma centers

Advanced Trauma Life Support cost for 5 staff x $600.00 = $3,000.00
Pediatric Advanced Life Support cost for 40 staff x $100.00 = $4,000.00
Emergency Nurse Pediatric Course or Trauma Nurse Core Course for 40 staff x $56.25 = $2250.00
Total cost = $9,250.00 per Level II trauma center
$9,250.00 x 11 = $101,750.00 for Level II trauma centers

Advanced Trauma Life Support cost for 2 staff x $600.00 = $1,200.00
Pediatric Advanced Life Support cost for 20 staff x $100.00 = $2,000.00
Emergency Nurse Pediatric Course or Trauma Nurse Core Course for 20 staff x $56.25 = $1,125.00
Total cost = $4,325.00 per Level III trauma center
$4,325.00 x 8 =$34,600.00 for Level III trauma centers

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

PROPOSED RULE

19 CSR 30-40.528 Application and Licensure Requirements; Standards for the Licensure and Relicensure of Stretcher Van Services

PURPOSE: This rule provides the requirements and standards related to the licensure and relicensure of stretcher van services.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Application requirements for stretcher van service licensure—

(A) Each applicant for a stretcher van service license shall submit an application for licensure to the Emergency Medical Services (EMS) Bureau no less than thirty (30) days or no more than one hundred twenty (120) days prior to their desired date of licensure or relicensure.

(B) An application shall include, but is not limited to, the following information: trade name of the stretcher van service; location of vehicles; number of vehicles to be operated by the stretcher van service; name, address, telephone numbers, and email address (if applicable) of manager; name, address, telephone numbers, and email address (if applicable) of proposed licensee of the stretcher van service; name, address, telephone numbers, and email address (if applicable) of licensee's chief executive officer; all stretcher van service licensure and related administrative licensure actions taken against the stretcher van service or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentation or falsifications and that the information given by them is true and complete to the best of their knowledge and that the stretcher van service has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo. The stretcher van application form, included herein, is available at the EMS Bureau office or by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.

(C) Each stretcher van service that meets the requirements and standards of the statutes and regulations shall be licensed for a period of five (5) years.

(2) Passengers may be transported in a stretcher van provided the passenger—

(A) Needs no medical equipment (except self-administered medications, including oxygen);

(B) Needs no medical monitoring; and

(C) Needs routine transportation to or from a medical appointment or service if that passenger(s) is convalescent or otherwise nonambulatory and does not require medical monitoring, aid, care, or treatment during transport.

(3) Stretcher van services shall not transport patients currently admitted to a hospital or patients being transported to a hospital for admission or emergency treatment. A stretcher van shall not transport a patient or passenger whom—

(A) Is acutely ill, wounded, or medically unstable;

(B) Is experiencing an emergency medical condition as defined in section 190.100, RSMo, an acute medical condition, an exacerbation of a chronic medical condition, or a sudden illness or injury; and

(C) Was administered a medication that might prevent the person from caring for him/herself.

(4) Vehicle design and specifications for stretcher vans—

(A) Delivery of each stretcher van vehicle will include documentation that the vehicle's design and construction will afford safety, comfort, and avoid aggravation of the passenger's(s') present condition. The vehicle shall be complete and furnished with such modifications and attachments as may be necessary to enable the vehicle to function reliably and efficiently in sustained operation. All vehicles shall be constructed by a qualified vehicle manufacturer, designed and built to meet or exceed (at date of vehicle manufacture) Federal Motor Vehicle Safety Standards (FMVSS) and regulations included in 49 CFR 571.1 through 571.500. Federal regulations 49 CFR 571.1 through 571.500 revised October 1, 2007, are incorporated by reference in this rule as published in the *Code of Federal Regulations* and are available at the United States Government Printing Office, 732 North Capitol Street NW, Washington, DC 20401, contact center via telephone at 1-866-512-1800 or online at www.gpoaccess.gov. This rule does not incorporate any subsequent amendments or additions;

(B) Stretchers and mounting must meet or exceed KKK-A-1822 specifications or Ambulance Manufacturers Division (AMD) Standards 004 – litter retention system. The KKK-A-1822 specifications are incorporated by reference in this rule as published in 2007 by the General Services Administration and are available at Chief, Automotive Engineering & Commodity Management Branch (QMDAA), Office of Motor Vehicle Management, General Services Administration, 2200 Crystal Drive, Suite 1006, Arlington, VA 22202. This rule does not incorporate any subsequent amendments or additions. The Ambulance Manufacturers Division Standards are incorporated by reference in this rule as published in 2007 by the Ambulance Manufacturers Division and are available at Ambulance Manufacturers Division, 37400 Hills Tech Drive, Farmington Hills, MI 48331-3414. This rule does not incorporate any subsequent amendments or additions. The operation of the stretcher shall follow manufacturer's specifications and guidelines;

(C) No emergency warning lights are allowed on vehicle;

(D) No "ambulance" lettering or "Star of Life" may be displayed on vehicle;

(E) Store or secure all equipment, including passengers' own oxygen delivery system, in a readily accessible and protected manner to limit its movement during a crash; and

(F) To facilitate cleaning and disinfecting, the stretcher compartment shall be impervious to soap and water, disinfectants, mildew, fire resistant, and comply with FMVSS 302; be easily cleaned/disinfected (carpeting, cloth, and fabrics are not acceptable); and all exposed surfaces shall be free of vent devices that would permit the entrapment of biological contaminates.

(5) Vehicle and equipment operation and maintenance standards—

(A) Each service shall ensure that all vehicle drivers possess a valid Class E, Missouri chauffeurs driver license;

(B) Each service shall ensure that all vehicle drivers complete a driver safety education program or vehicle operations course and be able to provide documentation of completion. These records shall be available for inspection by the EMS Bureau during normal business hours;

(C) Each vehicle shall maintain a current motor vehicle safety inspection from a certified inspector mechanic;

(D) Each service shall establish a preventive maintenance program for their vehicles, and each vehicle shall receive periodic maintenance as recommended by the qualified vehicle manufacturer. The records shall be available for inspection by the EMS Bureau during normal business hours; and

(E) Each service shall comply with the stretcher manufacturer's guidelines for maintenance of the stretchers.

(6) Vehicle staffing requirements—

(A) Each vehicle shall be staffed with a minimum of two (2) persons when transporting a passenger(s).

(B) At a minimum, stretcher van personnel shall have completed a nationally recognized course in cardiopulmonary resuscitation (CPR) and be certified at the community and workplace level.

(7) Vehicle communications requirements—Each service shall establish a policy for notification of 911 in an emergency and each vehicle shall be equipped to allow stretcher van personnel to communicate by voice with the service's own dispatching agency or 911 operator.

(8) On-board equipment standards—Each vehicle shall be equipped with body substance isolation (BSI) supplies in accordance with section 191.694, RSMo.

(9) Each service shall maintain accurate records and reports on the following—

(A) A passenger transport report to record information on each request for service and transportation;

(B) Stretcher van service license;

(C) Vehicle maintenance records;

(D) Vehicle driver education records;

(E) Equipment maintenance records;

(F) Records required by other regulatory agencies; and

(G) Each service shall be able to produce these records for inspection during normal business hours.

(10) Each service shall have public liability insurance or proof of self-insurance, conditioned to pay losses and damage caused by or resulting from the negligent operation, maintenance, or use of stretcher van services under the service's operating authority or for loss or damage to property of others. Documents submitted as proof of insurance shall specify the limits of coverage and include the stretcher van service license number. Liability coverage for stretcher van services shall meet or exceed—

(A) Two hundred fifty thousand dollars ($250,000) for bodily injury to, or death of, one (1) person;

(B) Five hundred thousand dollars ($500,000) for bodily injury to, or death of, all persons injured or killed in any one (1) accident, subject to a minimum of two hundred fifty thousand dollars ($250,000) per person; and

(C) One hundred thousand dollars ($100,000.00) for loss or damage to property of others in one (1) accident, excluding cargo.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
STRETCHER VAN APPLICATION

FOR DHSS OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ **INITIAL LICENSURE**	**STRETCHER VAN LIC. #** ☐☐☐☐☐☐	**DATE PASSED INSPECTION** ☐☐ ☐☐ ☐☐
☐ **RELICENSURE**	**DATE APPLICATION RECEIVED** ☐☐ ☐☐ ☐☐	**DATE LICENSED** ☐☐ ☐☐ ☐☐
INSPECTOR ASSIGNED	**DATE INSPECTOR ASSIGNED** ☐☐ ☐☐ ☐☐	**EXPIRATION DATE** ☐☐ ☐☐ ☐☐
____________________	**DATE OF FIRST INSPECTION** ☐☐ ☐☐ ☐☐	

APPLICANT MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

1. **TRADE NAME OF STRETCHER VAN SERVICE** *(Name on vehicle)*	**NUMBER OF VEHICLES**
LOCATION OF VEHICLES *(STREET, ROUTE, CITY, STATE, ZIP)*	

2. **OPERATOR OF STRETCHER VAN SERVICE**				
NAME OF OPERATOR		NAME OF MANAGER (LAST, FIRST, MI)		TELEPHONE NUMBER-BUSINESS ( )
OPERATOR MAILING ADDRESS *(STREET, ROUTE, ETC.)*				TELEPHONE NUMBER-EMERGENCY CONTACT ( )
CITY	STATE	ZIP CODE	E-MAIL	FAX NUMBER ( )

3. **STRETCHER VAN SERVICE LICENSEE**				
NAME OF CORPORATION		NAME OF CEO		TELEPHONE NUMBER-BUSINESS ( )
BUSINESS MAILING ADDRESS *(STREET, ROUTE, ETC.)*				TELEPHONE NUMBER-EMERGENCY CONTACT ( )
CITY	STATE	ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Stretcher Van Service has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo.

I have attached all Stretcher Van Service licensure and related administrative licensure actions taken against this stretcher van service or owner by any state agency in any state.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF STRETCHER VAN SERVICE LICENSEE	DATE

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. §575.060.RSMo

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102

MO 580- (R 01/08) EMS

AUTHORITY: sections 190.528 and 190.537, RSMo Supp. 2007. Original rule filed May 19, 2008.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities eight hundred ninety-nine thousand four hundred dollars ($899,400) for a one (1)-time cost and one hundred twenty-one thousand five hundred dollars ($121,500) annually.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Kimberly O'Brien, Director, Department of Health and Senior Services, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PRIVATE COST

I. Department Title: TITLE 19 - DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division Title: Division 30 – Division of Regulation and Licensure
Chapter Title: Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

Rule Number and Title:	**19 CSR 30-40.528 Application and Licensure Requirements; Standards for the Licensure and Re-licensure of Stretcher Van Services**
Type of Rulemaking:	**Proposed**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Estimated to be 20 vehicles	**Stretcher Van Service**	**$899,400.00 one time cost.**
20 vehicles	**Stretcher vans**	**$ 114,700.00 annual cost.**
20	**Stretcher Van services**	**$6,800.00 annual cost.**
	Total cost=	**Total one time cost of $899,400.00 and $121,500.00 annually thereafter.**

III. WORKSHEET

Though there is no known number of Stretcher Van services at this time, the assumption is that 20 services will be licensed in the coming years.

The cost for each vehicle will be approximately $44,970.00
$44,970.00 x 20 vehicles = $899,400.00

IV. ASSUMPTIONS

Vehicle	**$35,000.00**
Stretcher	**$ 3,500.00**
Stretcher Hardware	**$ 600.00**
Class E License	**$ 35.00**
Vehicle License	**$ 35.00**
Drivers Safety Class	**$ 50.00**
CPR Class	**$ 50.00**
Communication Radio	**$ 1,200.00**
Annual vehicle Insurance	**$ 4,500.00**
	$44,970.00