DEPARTMENT OF REGULATORY AGENCIES

Office of Direct-Entry Midwifery Registration

MIDWIVES REGISTRATION RULES AND REGULATIONS

4 CCR 739-1

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

1.1 PROFESSIONAL CONDUCT

The purpose of this Rule is to establish the minimum requirements for professional conduct.

A direct-entry midwife shall not aid or knowingly permit any registered or unregistered direct-entry midwife to violate any law or rule governing the practice of direct-entry midwifery care.

1.2 STANDARDS FOR EDUCATION

The purpose of this Rule is to establish the minimum entry level education and training requirements to register as a direct-entry midwife as required by sections 12-225-104(5) and 12-225-108(1)(c), C.R.S.

A. To qualify for a registration as a direct-entry midwife, an applicant shall provide proof of graduation from an accredited midwifery educational program approved by the Midwifery Education and Accreditation Council ("MEAC") and a passing score on the national North American Registry of Midwives ("NARM") Examination.

B. Alternatively, an applicant may demonstrate that the applicant has obtained a "substantially equivalent" education approved by the Director of Professions and Occupations ("Director"), by demonstrating that the applicant has either:

1. A current Certified Professional Midwife ("CPM") credential, in good standing, as established and administered by the NARM and has achieved a passing score on the NARM examination;

2. Certification under NARM's entry-level Portfolio Evaluation Process ("PEP") that determines the applicant has obtained a substantially equivalent education as that required in Colorado, and has achieved a passing score on the NARM examination. All expenses associated with PEP shall be the applicant's responsibility;

3. A credential review performed by the International Credentialing Associates ("ICA") or International Consultants of Delaware ("ICD") that determines the applicant has obtained a substantially equivalent education as that required in Colorado, and has achieved a passing score on the NARM examination. The Director will accept a credential evaluation only from an organization listed in this Rule. All expenses associated with the credential review shall be the applicant's responsibility; or

4. Education, training, or service gained in military services outlined in section 12-20-202(4), C.R.S., that is substantially equivalent, as determined by the Director, to the qualifications otherwise applicable at the time of receipt of application. It is the applicant's responsibility to provide timely and complete evidence for review and consideration. Satisfactory evidence of such education, training, or service will be assessed on a case-by-case basis.

1.3 EDUCATIONAL STANDARDS FOR THE ADMINISTRATION OF OXYGEN

The purpose of this Rule is to establish minimum training requirements for direct-entry midwives with respect to the safe administration of oxygen to clients pursuant to section 12-225-106(13), C.R.S.

The Director has determined that the minimum training requirements for the safe administration of oxygen are included in the entry level education and training requirements for direct-entry midwives as provided in Rule 1.2.

1.4 PRACTICE RESTRICTIONS

The purpose of this Rule is to define and clarify the practice restrictions applicable to a direct-entry midwife pursuant to sections 12-225-106 and 12-225-108(1)(a), C.R.S.

A. The direct-entry midwife shall not provide care to any client who has a medical history of or who exhibits signs or symptoms including but not limited to:

1. Previous diagnosis of diabetes mellitus or a diagnosis of gestational diabetes in the current pregnancy;

2. Hypertensive disease (blood pressure greater than 140/90 at rest);

3. Pulmonary disease or cardiac disease which interferes with activities of daily living;

4. Thrombophlebitis or pulmonary embolism;

5. Hematological or coagulation disorders, i.e., leukemia or sickle cell anemia;

6. Seizures controlled by medication if the client has seized within the last year;

7. Hepatitis B, HIV positive, or AIDS;

8. Current use of psychotropic medications if client is not under the care and monitoring of a physician during the pregnancy;

9. Current substance abuse of drugs or alcohol;

10. Rh sensitization (or any positive antibody titre);

11. Vaginal Birth after Cesarean Section (VBAC) unless compliant with Rule 1.12;

12. Delivery of an infant who was premature or stillborn, or a neonatal death associated with maternal health conditions, i.e., hypertension, Diabetes Mellitus, Rh Sensitization, clotting disorders;

13. Incompetent cervix;

14. Previous uncontrolled postpartum hemorrhage; or

15. Delivery of an infant with a major genetic anomaly as reviewed by a pediatrician, perinatologist, or genetic counselor regarding the likelihood of recurrence unless the mother declines the consultation.

B. The direct-entry midwife shall not:

1. Perform any operative or surgical procedures;

2. Utilize forceps, vacuum extraction or other instruments or mechanical means to facilitate birth;

3. Perform versions; or

4. Administer any medications or IV fluids, except as permitted in section 12-225-107, C.R.S., and in Rules 1.17 and 1.18.

1.5 MINIMUM PRACTICE REQUIREMENTS REGARDING ANTEPARTUM CARE

The purpose of this Rule is to define and clarify the minimum requirements of safe care for women and infants regarding antepartum care pursuant to sections 12-225-106 and 25-4-201, C.R.S., which include but are not limited to:

A. The direct-entry midwife shall schedule client visits at least once a month beginning in the first trimester through 28 weeks; every 2 weeks from 28 weeks through 35 weeks; and weekly from 36 weeks to delivery.

B. At the time of the initial visit, the direct-entry midwife shall at a minimum:

1. Obtain a medical, obstetrical, family and nutritional history;

2. Screen for diabetes if the mother has a previous history of gestational diabetes;

3. Determine the estimated due date and perform a baseline physical examination;

4. Arrange to or obtain laboratory testing including but not limited to: blood group and Rh type, if unknown; an antibody screen test for all Rh negative mothers; CBC with differential; rubella titre; serology for syphilis; hepatitis B screen; urine for protein and glucose, culture if indicated; Gonococcal Culture screen and Chlamydia culture if needed based on social history; ultrasound imaging, if indicated. Additionally, the blood specimen obtained shall be submitted to an approved laboratory for a standard serological test for syphilis and HIV. If the client refuses consent for syphilis or HIV testing the direct-entry midwife shall document such refusal in the client record;

5. Discuss home birth, alternatives to home birth, risk assessment, and referral procedures;

6. Complete the emergency plan.

7. [Expired 05/15/2018 per House Bill 18-1253]

C. Safe care for women and infants during each prenatal visit shall, at a minimum, include but not be limited to:

1. Obtaining vital signs and weight;

2. Performing a urine dipstick for protein and glucose;

3. Assessing for:

a. Edema, headaches, visual disturbances, dizziness or sharp pains in legs, abdomen, chest or head and reflexes if indicated;

b. Mother's psychological and emotional status;

c. Nutritional status;

d. Fundal height; and

e. Fetus for gestational age, presentation and position; estimated fetal weight; fetal activity, listen for fetal heart tones and record when first audible;

4. Record all findings, interventions, and outcomes including the quickening date;

5. Provide teaching, guidance, and referral as appropriate; and

6. Discuss the emergency plan, and revise if needed.

D. Laboratory studies that should be obtained during pregnancy include:

1. An antibody screen test at 28 weeks, if indicated;

2. A Hemoglobin or Hematocrit screening at 28 and 36 weeks;

3. An oral gestational diabetes screening with a minimum of a 50 Gram glucose loading dose shall be offered to the client at 26-28 weeks; and

4. A culture for Group B Streptococci at 35 to 37 weeks, and, if the culture is positive, inform the client about antibiotic treatment options and recommend an appropriate health care provider.

E. At least one home visit shall be made during the third trimester to assure that environmental conditions are appropriate, supplies are procured, and birth participants are prepared for the home birth.

F. The direct-entry midwife shall refer clients for evaluation by a qualified licensed health care provider, and shall not continue as the care provider, when a multiple gestation or a presentation other than vertex at the onset of labor are noted.

G. The direct-entry midwife shall refer a client for evaluation by a qualified licensed health care provider, and shall not continue as the primary care provider when any of the following conditions are noted:

1. Urine glucose of 2+ or greater on two sequential visits or if other signs or symptoms of gestational diabetes occur with the urine glucose;

2. Hyperemesis requiring medical treatment;

3. Hypertension - blood pressure greater than 140/90;

4. Signs and symptoms of preeclampsia including but not limited to persistent edema, increased blood pressure or proteinuria, increased reflexes, persistent headaches, epigastric pain, visual disturbances;

5. Seizures;

6. Vaginal bleeding other than spotting after 20 weeks; or

7. Signs and symptoms of sexually transmitted disease;

8. Oral temperature in excess of 101° F for more than 24 hours accompanied by other signs or symptoms of clinically significant infection or which does not resolve within 72 hours;

9. Laboratory results indicating need for medical treatment, for example, urinary tract or yeast infections not responding to non-prescription treatment;

10. Anemia not responding to over the counter iron therapy as measured by Hemoglobin below 11 grams or Hematocrit below 34% at term;

11. Signs and symptoms of polyhydramnios or oligohydramnios;

12. Suspected fetal demise - lack of fetal movement, inability to auscultate fetal heart tones;

13. Decreased fetal movements;

14. Gestation longer than 42 weeks;

15. Rupture of membranes for:

    a. Longer than 12 hours without labor for Group B Streptococci positive clients and unknown Group B Streptococci status; or

    b. Longer than 18 hours without labor for Group B Streptococci negative clients;

16. Premature labor - less than 37 completed weeks gestation;

17. Active herpes;

18. Intrauterine growth restriction; or

19. Suspected abnormality of pelvis;

H. Once any of the conditions provided in paragraph G. are noted, the direct-entry midwife shall not resume care for the client until a qualified health care provider assesses the client and determines that the client is not exhibiting signs or symptoms of increased risk of medical, obstetrical, or neonatal complications, or problems during the completion of the pregnancy, labor, delivery, or the postpartum period, and is not exhibiting signs and symptoms of increased risk that the infant may develop complications or problems during the first six weeks of life.

I. The registered direct-entry midwife shall perform pelvimetry by 36 weeks gestation.

1.6 MINIMUM PRACTICE REQUIREMENTS REGARDING SAFE INTRAPARTUM CARE

The purpose of this Rule is to define and clarify minimum practice requirements of safe care for women and infants regarding intrapartum care pursuant to section 12-225-106, C.R.S., which include but are not limited to:

A. The direct-entry midwife is responsible for making arrangements to be with the client by the time active labor has been established as determined by contractions occurring every 5 minutes and lasting for 60 seconds or cervical dilation of 6 cm or more. Once labor has been so established, the direct-entry midwife shall remain with the client.

B. When membranes rupture, the direct-entry midwife shall assess fetal wellbeing. In the case of prelabor rupture of the membranes, no further vaginal checks shall be made until active labor.

C. Aseptic technique and universal precautions shall be used while rendering care.

D. The direct-entry midwife is responsible for monitoring the status of the client and fetus during labor and delivery including but not limited to:

1. Maternal vital signs and physical well-being such as:

a. Measurement of maternal temperature, pulse, respirations, and blood pressure at least every 4 hours; and

b. Checking for bladder distention, signs of maternal fatigue, and hydration status;

2. Evaluating fetal vital signs and well-being such as:

a. Fetal heart tones in response to contractions as well as when the uterus is at rest. These tones shall be assessed, at a minimum, every hour during early labor, every half-hour during active labor, and every 5-10 minutes during the second stage of labor, and

b. Normality of fetal lie, presentation, attitude and position;

3. Progress of labor including cervical effacement and dilation, station, presenting part and position;

4. Coaching the birthing family;

5. Checking the placenta and blood vessels and estimating blood loss;

6. Checking the perineum and vaginal vault for tears; and

7. Checking the cervix for tears and, if present, making appropriate referral.

E. The direct-entry midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist:

1. Bleeding other than capillary bleeding (“show”) prior to delivery;

2. Signs of placental abruption including continuous lower abdominal pain and tenderness;

3. Prolapse of the cord;

4. Any meconium staining without reassuring fetal heart tones, moderate or greater meconium staining regardless of status of fetal heart tones;

5. Significant change in maternal vital signs such as;

a. Temperature greater than 101°F,

b. Pulse over 100 with decrease in blood pressure, or

c. Increase in blood pressure greater than 140/90;

6. Failure to progress in labor such as:

    a. Lack of steady progress in dilation and descent after 24 hours in the primipara or 18 hours in the multipara;

    b. Second stage of labor without steady progress of descent through the mid-pelvis and/or pelvic outlet longer than three hours in the primipara or two hours in the multipara, or

    c. Third stage of labor longer than one hour;

7. Fetal heart rate below 110 or above 160 between contractions;

8. Protein or glucose in the urine;

9. Seizures;

10. Atonic uterus;

11. Retained placental fragments; or

12. Client requests transport.

1.7 MINIMUM PRACTICE REQUIREMENTS REGARDING POSTPARTUM CARE

The purpose of this Rule is to define and clarify minimum practice requirements of safe care for women and infants regarding postpartum care pursuant to sections 12-225-106 and 12-225-107, C.R.S., which include but are not limited to:

A. The direct-entry midwife who is authorized to administer medications may administer Oxytocin (Pitocin) in accordance with Rule 1.17.

B. The direct-entry midwife shall remain with the client and infant for a minimum of two hours after the birth or until the client and infant are stable, whichever is longer.

C. At a minimum, the direct-entry midwife shall make follow up visits to assess the progress of the client and infant within 24 to 48 hours postpartum, 3 to 7 days postpartum, 2-4 weeks postpartum and 6 weeks postpartum. If the client is seen by an appropriate health care provider at any of these intervals, the direct-entry midwife need not visit the client for that particular interval. Such visits shall include, but not be limited to, an assessment of the fundus, lochia, perineum, breasts, nutrition, hydration, elimination, emotional adjustment and bonding.

D. The direct-entry midwife shall instruct the client and family in self-care at each follow up visit.

E. The direct-entry midwife who is authorized to administer medications may administer Rh(D) Immune Globulin to Rh negative mothers in accordance with Rule 1.17. Otherwise, the direct-entry midwife shall refer all Rh negative mothers for Rhogam within seventy two hours of the birth if the baby is RH positive.

F. The direct-entry midwife shall arrange for consultation and/or transport when:

    1. There is maternal blood loss of more than 500 cc unless bleeding is controlled and all maternal vital signs are stable;

2. The client has a fever of greater than 101°F on any of the 2nd through 10th days postpartum;

3. The client cannot void within 6 hours after birth;

4. The lochia is excessive, foul smelling, or otherwise abnormal;

5. The client exhibits signs of clinically significant depression (not the “baby blues”);

6. There are vaginal or cervical lacerations requiring repair (unless otherwise addressed in Rule 1.20); or

7. Persistent blood pressure greater than 140/90.

1.8 MINIMUM PRACTICE REQUIREMENTS REGARDING NEWBORN CARE

The purpose of this Rule is to define and clarify minimum practice requirements of safe care for women and infants regarding newborn care pursuant to sections 12-225-107 and 12-225-108, C.R.S.

A. The direct-entry midwife will perform care for the infant including but not limited to:

1. Apgar scores at one minute and five minutes after birth and at 10 minutes if the 5 minute score is below 7;

2. A physical assessment including assessing presence of femoral pulses;

3. Eye prophylaxis within 1 hour after birth as provided by section 25-4-303, C.R.S.;

4. Weigh the infant, measure height and head circumference, and check for normal reflexes;

5. Arrange to or obtain laboratory testing on the infant of an Rh negative mother to include blood type and antibody screen; and

6. Ensure sucking and rooting reflexes are present and ensure baby is fed.

B. The direct-entry midwife shall arrange for or obtain the required newborn screenings required by section 25-4-1004, C.R.S.

C. The direct-entry midwife shall arrange for or obtain the required screening for critical congenital heart defects in accordance with section 25-4-1004.3, C.R.S.

D. The direct-entry midwife authorized to administer medications may administer Vitamin K in accordance with Rule 1.17. Otherwise, the direct-entry midwife shall recommend that the mother arrange for the administration of Vitamin K by a licensed health care provider within seventy-two (72) hours of birth.

E. The direct-entry midwife shall arrange for immediate transport for the infant who exhibits the following signs:

1. Apgar of 7 or less at ten minutes after birth;

2. Respiratory distress exhibited by respirations greater than 60 per minute, grunting, retractions, nasal flaring at one hour of age that is not showing consistent improvement;

3. Inability to maintain body temperature;

4. Medically significant anomaly;

5. Seizures;

6. Fontanel full and bulging;

7. Suspected birth injuries;

8. Cardiac irregularities;

9. Projectile or bilious vomiting;

10. Pale, cyanotic, gray newborn; or

11. Lethargy or poor muscle tone.

F. The direct-entry midwife shall arrange for consultation and possible transport for an infant who exhibits the following:

1. Signs of hypoglycemia including jitteriness;

2. Abnormal cry;

3. Passes no urine or meconium in 24 hours;

4. The baby's gestational age appears to be less than 37 completed weeks;

5. Inability to suck;

6. Pulse greater than 180 or less than 80 at rest,

7. Jaundice within 24 hours of birth; or

8. Positive Antibody Screen.

G. At a minimum, the direct-entry midwife shall make a referral to an appropriate pediatric healthcare provider within 7 days of birth; and shall perform follow up visits to assess the progress of the client and infant within 24 to 48 hours postpartum, 3 to 7 days postpartum, 2-4 weeks postpartum and 6 weeks postpartum. If the client and infant are seen by an appropriate pediatric healthcare provider at any of these intervals, the midwife need not see the client and infant for that particular interval. Follow-up visits shall include assessment of the infant to include umbilical cord, temperature, pulse, respirations, weight, skin color and hydration status, feeding and elimination, sleep/wake patterns, and bonding.

1.9 MINIMUM PRACTICE REQUIREMENTS REGARDING RECORD KEEPING

The purpose of this Rule is to clarify the minimally appropriate records of direct-entry midwifery related activity that are required pursuant to sections 12-225-106(5)(a) and 25-4-201, C.R.S.

A. The direct-entry midwife shall keep appropriate records on all clients. All records shall, at a minimum:

1. Be accurate, current, and comprehensive, giving information concerning the condition and care of the client and associated observations;

2. Provide a record of any problems that arise and the actions taken in response to them;

3. Provide evidence of care required, interventions by professional practitioners and client responses;

4. Include a record of any factors (physical, psychological or social) that appear to affect the client;

5. Record the chronology of events and the reasons behind decisions made;

6. Provide baseline data against which improvement or deterioration may be judged;

7. Reflect any recommendation for, or initiation of, transfer to a hospital;

8. Have a signature and date for each entry; and

9. All records shall be made available to the receiving health care provider in the event of transfer of care or the transport of client or newborn.

B. The client records shall include, at a minimum:

1. The risk assessment as required in section 12-225-106(11), C.R.S.;

2. Mandatory disclosure form;

3. Informed consent form and emergency plan;

4. Assessments, interventions and recommendations for each prenatal visit;

5. Progress of labor and maternal assessments during labor;

6. Fetal assessments during labor;

7. Apgar scores and newborn examination;

8. Administration of any medications and/or intravenous fluids;

9. Refusal of care by the client;

10. Filing the birth certificate as required by section 25-2-112, C.R.S.;

11. Follow-up postpartum visits;

12. Statement of verification that one copy of the record was provided to the client or the health care provider of her choice;

13. Baseline blood pressure determined prior to the end of the second trimester or upon the initial visit if such visit occurs subsequent to the second trimester; and

14. Documentation of laboratory referral for syphilis, HIV, and Group B Streptococci testing, or documentation of the client’s refusal for such tests.

C. A copy of the record shall be provided to the client and/or other health care provider(s) at the completion of care or when requested.

1.10 EMERGENCY PLAN

The purpose of this Rule is to establish the following emergency plan parameters pursuant to section 12-225-106(6), C.R.S.:

A. The time required for transportation to the nearest facility capable of providing appropriate treatment shall not exceed 30 minutes unless the emergency plan prepared by the direct-entry midwife and the client, in a manner approved by the Director, includes an estimate of time for transportation for appropriate treatment for the conditions listed above in Rules 1.5(G), 1.6(E), 1.7(F), 1.8(D), and 1.8(E), and such plan is agreed to by both the client and the direct-entry midwife. A copy of such plan shall be given to the client.

1.11 DECLARATORY ORDERS

The purpose of this Rule is to establish procedures for the handling of requests for declaratory orders filed pursuant to the Colorado Administrative Procedures Act at section 24-4-105(11), C.R.S.

A. Any person registered pursuant to Article 225, Title 12, C.R.S., may petition the Director for a declaratory order to terminate controversies or remove uncertainties as to the applicability of any statutory provision or of any rule or order of the Director.

B. The Director will determine, in the Director's discretion and without notice to petitioner, whether to rule upon such petition. If the Director decides not to rule upon such a petition, the Director shall promptly notify the petitioner and state the reasons for such decision.

C. In determining whether to rule upon a petition filed pursuant to this rule, the Director will consider the following matters, among others:

1. Whether a ruling on the petition will terminate a controversy or remove uncertainties as to the applicability to petitioner of any statutory provisions or rule or order of the Director.

2. Whether the petition involves any subject, question or issue that is the subject of a formal or informal matter or investigation currently pending before the Director or a court involving one or more petitioners.

3. Whether the petition involves any subject, question or issue which is the subject of a formal or informal matter or investigation currently pending before the Director or a court but not involving any petitioner.

4. Whether the petition seeks a ruling on a moot or hypothetical question or will result in an advisory ruling or opinion.

5. Whether the petitioner has some other adequate legal remedy, other than an action for declaratory relief pursuant to Colorado Rule of Civil Procedure 57, that will terminate the controversy or remove any uncertainty as to the applicability to the petitioner of the statute, rule, or order in question.

D. Any petition filed pursuant to this rule shall set forth the following:

1. The name and address of the petitioner and whether the petitioner is registered pursuant to Article 225, Title 12, C.R.S.

2. The statute, rule, or order to which the petition relates.

3. A concise statement of all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule, or order in question applies or potentially applies to the petitioner.

E. If the Director decides to rule on the petition, the following procedures shall apply:

1. The Director may rule upon the petition based solely upon the facts presented in the petition. In such a case:

a. Any ruling of the Director will apply only to the extent of the facts presented in the petition and any amendment to the petition.

b. The Director may order the petitioner to file a written brief, memorandum, or statement of position.

c. The Director may set the petition, upon due notice to petitioner, for a non-evidentiary hearing.

d. The Director may dispose of the petition on the sole basis of the matters set forth in the petition.

e. The Director may request the petitioner to submit additional facts in writing. In such event, such additional facts will be considered as an amendment to the petition.

f. The Director may take administrative notice of facts pursuant to the Colorado Administrative Procedures Act at section 24-4-105(8), C.R.S., and may utilize the Director's experience, technical competence, and specialized knowledge in ruling upon the petition.

2. If the Director rules upon the petition without a hearing, the Director shall promptly notify the petitioner of the decision.

3. The Director may, at the Director's discretion, set the petition for hearing, upon due notice to petitioner, for the purpose of obtaining additional facts or information or to determine the truth of any facts set forth in the petition or to hear oral argument on the petition. The hearing notice to the petitioner shall set forth, to the extent known, the factual or other matters that the Director intends to inquire. For the purpose of such a hearing, to the extent necessary, the petitioner shall have the burden of proving all of the facts stated in the petition, all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule or order in question applies or potentially applies to the petitioner and any other facts the petitioner desires the Director to consider.

F. The parties to any proceeding pursuant to this rule shall be the Director and the petitioner. Any other person may seek leave of the Director to intervene in such a proceeding, and leave to intervene will be granted at the sole discretion of the Director. A petition to intervene shall set forth the same matters as are required by Paragraph D of this rule. Any reference to a "petitioner" in this rule also refers to any person who has been granted leave to intervene by the Director.

G. Any declaratory order or other order disposing of a petition pursuant to this rule shall constitute agency action subject to judicial review pursuant to section 24-4-106, C.R.S.

1.12 STANDARDS FOR VAGINAL BIRTH AFTER CESAREAN SECTION (VBAC)

The purpose of this Rule is to establish parameters for VBAC clients seeking midwifery care during pregnancy in order to safeguard the client's welfare pursuant to section 12-225-106(11), C.R.S.

A. A direct- entry midwife shall not assume primary responsibility for prenatal care and birth attendance for women who have had a previous cesarean section unless all of the following conditions are met:

1. All prospective VBAC women shall sign an informed consent statement, which shall be retained in the client's records and include the following:

a. VBAC educational information including history of VBAC and client's own personal information;

b. Associated risks and benefits of VBAC at home;

c. A workable hospital transport plan;

d. Alternatives to VBAC at home; and

e. Other information as required by the Director.

2. A workable hospital transport plan must be established for home VBAC. The plan shall be in writing and include:

a. Place of birth within 30 minutes of transport to the nearest hospital or emergency medical center able to perform an emergency cesarean;

b. Readily available emergency numbers for the nearest hospital or emergency medical center; and

c. Provision for phone contact with the nearest hospital or emergency medical center prior to any transport notifying the destination that transport is in progress.

3. There has been at least 18 months from the client's cesarean delivery to the due date of the current pregnancy.

4. The client with 2 or more cesarean deliveries has also had a vaginal delivery since the last cesarean delivery.

B. The direct-entry midwife shall obtain prior client cesarean written records, shall analyze the indication for the previous cesarean, and retain the records along with a written assessment of the physical and emotional considerations in the client's files. If the direct-entry midwife is unable to obtain the written records, the direct-entry midwife shall not retain the woman as a client.

C. Records that show a previous classical uterine/vertical incision or any previous uterine surgery which required an incision into the uterine fundus are a contraindication to VBAC at home and shall require immediate transfer of care of the client.

D. Direct-entry midwife shall not induce or augment labor by the use of chemicals or herbal supplements or nipple stimulation.

E. A direct-entry midwife shall be present and manage the VBAC delivery from the onset of active labor throughout the immediate postpartum period.

1.13 REQUIREMENTS FOR REINSTATEMENT

The purpose of this Rule is to state the requirements for reinstatement of a registration that has expired pursuant to sections 12-225-104 and 12-20-202, C.R.S.

A. A direct-entry midwife applying for reinstatement of an expired registration shall complete a reinstatement application and pay a reinstatement fee in the manner approved by the Director.

B. If the registration has been expired for more than two years from the date of receipt of the reinstatement application, but less than five years an applicant shall establish "competency to practice" under sections 12-20-202(2)(c)(II)(A) and (D), and 12-20-105, C.R.S., as follows:

1. Verification of registration in good standing from another state along with proof of active practice in that state for two years of the previous five years from the date of receipt of the application for reinstatement; or

2. Completion of twenty hours of continuing education courses related to the practice of direct-entry midwifery during the two years immediately preceding the application for reinstatement. The continuing education must meet the approval of and shall be attested to in a manner prescribed by the Director; or

3. Retaking and achieving a passing score on the national NARM Examination within two years immediately preceding receipt of an application for reinstatement; or

4. Any other means approved by the Director.

C. An applicant seeking to reinstate a registration that has been expired for more than five years shall demonstrate "competency to practice" as required in sections 12-20-202(2)(c)(II)(B) and (F), C.R.S., by:

1. Verification of registration in good standing from another state along with proof of active practice for two years of the previous five years prior to an application for reinstatement; or

2. Supervised practice for a period no less than six months subject to the terms established by the Director; or

3. Retaking and achieving a passing score on the national NARM Examination within two years immediately preceding receipt of an application for reinstatement; or

4. By any other means approved by the Director.

1.14 REPORTING CONVICTIONS AND OTHER ADVERSE ACTIONS

The purpose of the Rule is to clarify the procedures for reporting convictions, and other adverse actions to include judgments and administrative proceedings pursuant to section 12-225-108(1)(a), C.R.S.

A direct-entry midwife, as defined in section 12-225-103(2), C.R.S., shall inform the Director, within ninety days of any of the following events:

A. The conviction of the registrant of a felony under the laws of any state or of the United States, which would be a violation of section 12-225-109, C.R.S. A guilty verdict, a plea of guilty, or a plea of nolo contendere (no contest) accepted by the court is considered a conviction;

B. A disciplinary action imposed upon the registrant by another jurisdiction that registers or licenses direct-entry midwives, which would be a violation of section 12-225-109, C.R.S., including, but not limited to, a citation, sanction, probation, civil penalty, or a denial, suspension, revocation, or modification of a license or registration whether it is imposed by consent decree, order, or other decision, for any cause other than failure to pay a license or registration fee by the due date or failure to meet continuing professional education requirements;

C. Revocation or suspension by another state board, municipality, federal or state agency of any health services related license or registration, other than a lapsed license or registration for midwifery as described in section 12-225-109, C.R.S.;

D. Any judgment, award or settlement or a civil action or arbitration in which there was a final judgment or settlement against the registrant for malpractice of direct-entry midwifery.

E. The notice to the Director shall include the following information:

1. If the event is an action by governmental agency (as described above), the name of the agency, its jurisdiction, the case name, and the docket, proceeding or case number by which the event is designated, and a copy of the consent decree, order or decision;

2. If the event is a felony conviction, the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court. The registrant shall also provide to the Director a copy of the imposition of sentence related to the felony conviction and the completion of all terms of the sentence with ninety days of such action;

3. If the event concerns a civil action or arbitration proceeding, the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict, the court or arbitration decision, or, if settled, the settlement agreement and court's order of dismissal;

F. The registrant notifying the Director may submit a written statement with the notice to be included in the registrant's records.

1.15 EXCEPTIONS AND DIRECTOR'S REVIEW OF INITIAL DECISIONS Repealed eff. 12/15/2010

1.16 REGARDING THE CONTINUING DUTY TO REPORT INFORMATION TO THE DIRECTOR'S OFFICE.

The purpose of this Rule is to clarify the requirement of registrants to notify the Director of a change in submitted information pursuant to sections 12-225-104(2) and 24-34-107, C.R.S.

A. Each person licensed under this article, upon changing his or her address, shall inform the board of their new address within thirty days after such change.

1.17 ADMINISTRATION OF MEDICATIONS

The purpose of this Rule is to clarify the limited administration of medications by a direct-entry midwife as authorized by sections 12-225-107(1) through (5), C.R.S.

A. A direct-entry midwife may obtain and administer medications only as set forth in this Rule. A direct-entry midwife shall obtain authorized medications only from a Colorado-registered prescription drug outlet, manufacturer, or wholesaler.

B. A direct-entry midwife must receive prior approval from the Director to obtain and administer medications. A direct-entry midwife who seeks such approval must submit a Medication Authority application in a manner approved by the Director and pay the applicable fee.

1. A direct-entry midwife applying for medication authority must have satisfactorily completed a course in pharmacology, within six months prior to submitting an application, that:

a. Is offered by a post-secondary educational institution accredited by an accrediting board recognized by the Council for Higher Education Accreditation of the American Council on Education, is a program or course approved by MEAC, or is a program or course otherwise approved by the Director;

b. Is, at a minimum, eight clock hours in length and includes basic pharmacotherapeutic principles and administration of medications, including the drugs listed in paragraph (C) of this Rule; and

c. Includes the following elements:

(1) Mechanism of Pharmacological Action;

(2) Indications;

(3) Therapeutic Effects;

(4) Side Effects/Adverse Reactions;

(5) Contraindications;

(6) Incompatibilities/Drug Interactions;

(7) Drug administration, including:

(a) Dosage;

(b) Dosage Form and Packaging;

(c) Routes of Administration;

(d) Onset of Action;

(e) Peak Effect; and

(f) Duration of Action;

(8) Administration of medications through injection, which includes:

(a) Universal precautions including the use and disposal of sharps;

(b) Safe injection practices;

(c) Equipment, including:

i. Needles;

ii. Filter Needles (for use with glass ampules);

iii. Syringes;

iv. Skin surface disinfectants; and

v. Medication containers (ampules, single-use vials);

(9) Appropriate injection sites;

(10) Procedures for drawing up and administering drugs;

(11) Proper disposal of hazardous and other contaminated materials; and

(12) Student demonstration of competence in administering medications.

2. An applicant who does not meet the requirements of subparagraph (1) above may request to demonstrate competency to obtain and administer medications by other means. The Director shall consider such a request on a case-specific basis. The decision to approve such a request shall be at the sole discretion of the Director. In considering whether to approve such a request, the Director shall consider public safety and such other factors as the Director deems appropriate. If the Director grants approval under this subparagraph (2) to obtain and administer medications, the Director may subject such approval to lawful conditions the Director finds necessary to protect the public.

C. The preferred drug list of medications a direct-entry midwife may obtain and administer consists of:

1. Vitamin K1 (phylloquinone, phytonadione) to a newborn, as prophylaxis for vitamin K deficiency bleeding. One 1 mg dose of 2 mg / ml concentration vitamin K1 is authorized via intramuscular injection.

2. Rho D immune globulin to Rh-negative, antibody negative mothers, for the prevention of isoimmunization in Rh (D) negative women. One 300 mcg dose (or as recommended by the manufacturer) at 26 – 28 weeks gestation is authorized via intramuscular injection. In addition, one 300 mcg dose (or as recommended by the manufacturer) administered via intramuscular injection to the mother is authorized within 72 hours of delivery of an Rh-positive infant (or an infant with unknown blood type) to an Rh-negative, antibody negative mother.

3. Antihemorrhagic drugs for control of postpartum bleeding, limited to the following:

a. Oxytocin at 10 units/ml administered intramuscularly.

b. Methylergonovine at 0.2 mg/ml administered intramuscularly.

c. Misoprostol at 800 mcg administered rectally or 400 to 600 mcg administered sublingually.

d. Postpartum hemorrhage may be prevented by the administration of one dose of oxytocin following the birth of a baby and before the delivery of the placenta. If bleeding remains normal and maternal signs are stable, immediate transport is not necessary.

e. If a preventative dose of oxytocin has not been given, postpartum hemorrhage may be controlled by administering one dose of oxytocin followed by, if necessary, a second dose of oxytocin or one dose of misoprostol or one dose of methylergonovine. Immediate transport must be initiated if bleeding is not controlled or if the mother displays signs and symptoms of shock.

f. If a preventative dose of oxytocin has been given, postpartum hemorrhage may be controlled by administering one additional dose of oxytocin, or one dose of misoprostol or one dose of one dose of methylergonovine. Immediate transport must be initiated if bleeding is not controlled or if the mother displays signs and symptoms of shock.

4. Erythromycin Ophthalmic Ointment to a newborn, for prophylaxis of neonatal ophthalmia, as provided by Section 25-4-303, C.R.S. A single topical dose of Erythromycin Ophthalmic Ointment USP (0.5%) is to be administered within one (1) hour after birth via topical application of a ribbon of ointment approximately 1 cm in length into each eye.

5. Local anesthetics to perform sutures of first-degree and second-degree perineal tears and limited to lidocaine 1% or 2% for injection with or without epinephrine.

D. Client refusals of medication or treatment.

1. Informed consent. If a client refuses the administration of either Vitamin K1 to her infant or Rho D immune globulin to herself, the direct-entry midwife shall provide the client with an informed consent form containing a detailed statement of the benefits of the medication and the risks of refusal, and shall retain a copy of the form acknowledged and signed by the client.

2. Transport. If a client experiences uncontrollable postpartum hemorrhage, the direct-entry midwife shall immediately initiate the transportation of the client in accordance with the emergency plan.

3. Eye prophylaxis. If a client refuses the administration of eye prophylaxis to her infant, the direct-entry midwife shall:

a. Provide the client with a form setting forth the requirements of Section 25-4-303, C.R.S.; and

b. Retain a copy of the form acknowledged and signed by the client.

E. Medication administration procedures must meet safe and professional standards and must be performed in a manner consistent with generally accepted parameters, including safe injection practices and the standards of the Centers for Disease Control and Prevention (“CDC”).

F. In order to best serve the needs and ensure the safety of their clients, direct-entry midwives who obtain and administer medications shall maintain competency regarding their use through continuing education and other professional development activities.

G. A direct-entry midwife must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this Rule. Failure to provide written documentation is a violation of this Rule, and is prima facie evidence that the direct-entry midwife is not competent and not permitted to obtain or administer medications.

1.18 ADMINISTRATION OF INTRAVENOUS FLUIDS

The purpose of this Rule is to clarify the administration of intravenous fluids by a direct-entry midwife to a client in order to restore fluid volume lost due to dehydration, fatigue, or postpartum hemorrhage, as authorized by sections 12-225-107(1), (4)(b), and (5), C.R.S.

A. A direct-entry midwife may obtain and administer intravenous ("IV") fluids only as set forth in this Rule. A direct-entry midwife shall obtain authorized IV fluids only from a Colorado-registered prescription drug outlet, manufacturer, or wholesaler.

B. A direct-entry midwife must receive prior approval from the Director to obtain IV fluids and administer IV therapy. A direct-entry midwife who seeks such approval must:

1. Submit an IV Authority application in a manner approved by the Director and pay the applicable fee; and

2. Satisfactorily complete an intravenous therapy course, within six months prior to submitting an application, that:

a. Is offered by a post-secondary educational institution accredited by an accrediting board recognized by the Council for Higher Education Accreditation of the American Council on Education, is a program or course approved by MEAC", or is a program or course otherwise approved by the Director;

b. Is at least at least six clock hours in length and includes basic principles of the administration of medications intravenously, including the IV fluids listed in paragraph (C) of this Rule; and

c. Includes the following elements:

(1) Basic principles of intravenous therapy, including when to initiate and when to discontinue IV therapy;

(2) Purpose of IV fluid therapy;

(3) Safe infusion and infection control practices;

(4) Equipment;

(5) Appropriate sites;

(6) Procedure and technique;

(7) Rate of administration;

(8) Care of equipment;

(9) Proper disposal of hazardous and other contaminated materials; and

(10) Student demonstration of competence in the ability to administer IV fluids.

3. A direct-entry midwife who does not meet the requirements of subparagraph (2) above may request to demonstrate completion of an equivalent IV course or program to obtain and administer IV fluids. The Director shall consider such a request on a case-specific basis. The decision to approve such a request shall be at the sole discretion of the Director. In considering whether to approve such a request, the Director shall consider public safety and such other factors as the Director deems appropriate. If the Director grants approval under this subparagraph (3) to obtain and administer IV fluids, the Director may subject such approval to lawful conditions the Director finds necessary to protect the public.

C. The preferred drug list of IV fluids a direct-entry midwife may obtain and administer to restore fluid volume lost due to dehydration, fatigue, or postpartum hemorrhage consists of:

1. 0.9% sodium chloride in sterile water (normal saline); and

2. Lactated Ringer's solution (LR).

D. A direct-entry midwife may administer IV fluids only to restore fluid volume lost due to dehydration, fatigue or postpartum hemorrhage. If vital signs are unstable, if blood loss is not controlled, or if client is not responding to IV therapy, transport must be initiated.

E. IV therapy procedures must meet safe and professional standards and must be performed in a manner consistent with generally accepted parameters, including safe infusion and infection control practices consistent with the standards of the Centers for Disease Control and Prevention ("CDC").

F. In order to best serve the needs and ensure the safety of their clients, direct-entry midwives who obtain and administer IV fluids shall maintain competency regarding their use through continuing education and other professional development activities.

G. A direct-entry midwife must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this Rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the direct-entry midwife is not competent and not permitted to obtain or administer IV fluids.

1.19 IMPOSITION OF FINES

Section 12-225-109(2)(a), C.R.S., provides authority for the Director to impose fines against a direct-entry midwife for violations of the statutory or rule provisions governing direct-entry midwifery or any violation of an Order of the Director. The purpose of this Rule is to establish a fine structure and the circumstances under which fines may be imposed by the Director.

A. The Director may impose a fine in lieu of or in addition to any other disciplinary sanction.

B. The Director may impose a separate fine for each violation of Article 225 of Title 12, C.R.S., any rule adopted by the Director, or any Order issued by the Director.

C. The Director may impose fines consistent with the following structure:

1. For a registrant's first violation, a fine of no more than one thousand dollars ($1000.00).

2. For a registrant's second violation, a fine of no more than two thousand five hundred dollars ($2500.00).

3. For a registrant's third and any additional violations, a fine of no more than five thousand dollars ($5000.00).

D. A total fine amount of five hundred dollars ($500.00) or less imposed by the Director must be paid in full, including the applicable surcharge, at the time the Final Agency Order is entered or a Stipulation is reached between the parties. A total fine amount greater than five hundred dollars ($500.00) imposed by the Director must be paid in full, including the applicable surcharge, in accordance with the time frame set forth in the Final Agency Order or Stipulation. A registrant who fails to pay a fine required pursuant to a Final Agency Order or Stipulation is subject to additional disciplinary action as set forth in section 12-225-109(3)(d), C.R.S., including suspension or revocation of his or her direct-entry midwife registration.

E. Payment of a fine does not exempt the registrant from compliance with the statutes and rules governing the practice of direct-entry midwifery or any orders of the Director.

1.20 SUTURING

The purpose of this Rule is to define perineal tear and various degrees of perineal tears, and to specify the limitations and requirements in order to perform the suturing of first-degree and second-degree perineal tears.

A. "Perineal tear" means a laceration of the skin and other soft tissue structures which, in women, separates the vagina from the anus.

B. "First-degree perineal tear" means a laceration limited to the fourchette and superficial perineal skin or vaginal mucosa.

C. "Second-degree perineal tear" means a laceration extending beyond fourchette, perineal skin and vaginal mucosa to perineal muscles and fascia, but not the anal sphincter.

D. "Third-degree perineal tear" means the tearing of the fourchette, perineal skin, vaginal mucosa, muscles and anal sphincter.

E. "Fourth-degree perineal tear" means the tearing of the fourchette, perineal skin, vaginal mucosa, muscles, anal sphincter and rectal mucosa.

F. A direct-entry midwife may perform the suturing of first-degree and second-degree perineal tears if the following conditions are met:

1. A direct-entry midwife shall apply to the Director, in a form and manner required by the Director, and pay any application fee the Director may impose, for an authorization to perform sutures of first-degree and second-degree perineal tears;

2. A direct-entry midwife shall attend and successfully complete an eight hour live class or workshop, accredited by the Midwifery Education Accreditation Counsel (MEAC), which instructs attendees regarding the: identification of muscles and anatomy of the vagina and perineum including the affected nerves; the selection of appropriate instruments; the suture material and needles types required for suturing; and appropriate techniques for basic repair. This instruction shall include identification of third and fourth-degree perineal tears and the proper referral of such tears; and

3. A direct-entry midwife shall provide proof of the MEAC-accredited training specified in this Rule 1.20(F)(2) to the Director when applying for an authorization to perform sutures of first-degree and second-degree perineal tears.

H. A direct-entry midwife shall arrange for consultation and/or transport all third and fourth-degree perineal tears as required pursuant to Rule 1.7(F)(6).

1.21 [Expired 05/15/2018 per House Bill 18-1253]

1.22 CONFIDENTIAL AGREEMENTS.

A. No later than thirty days from the date a physical or mental illness or condition impacts a direct-entry midwife's ability to practice direct-entry midwifery care with reasonable skill and safety, the direct-entry midwife shall provide the Director, in writing, the following information:

1. The diagnosis and a description of the illness or condition;

2. The date that the illness or condition was first diagnosed;

3. The name of the current treatment provider and documentation from the current treatment provider confirming the diagnosis, date of onset, and treatment plan;

4. A description of the direct-entry midwife's practice and any modifications, limitations or restrictions to that practice that have been made as a result of the illness or condition; and

5. Whether the direct-entry midwife has been evaluated by, or is currently receiving services from qualified treatment provider related to the illness or condition and, if so, the date of initial contact and whether services are ongoing.

B. The direct-entry midwife shall further notify the Director of any significant change in the illness or condition ("change of condition") that impacts the direct-entry midwife's ability to practice direct-entry midwifery care with reasonable skill and safety. The direct-entry midwife must notify the Director of a positive or negative change of condition. Such notification shall occur within thirty (30) days of the change of condition. The direct-entry midwife shall provide the Director, in writing, the following information:

1. The date of the change of condition;

2. The name of the current treatment provider and documentation from the current treatment provider confirming the change of condition, the date that the condition changed, the nature of the change of condition, and the current treatment plan; and

3. A description of the licensee's practice and any modifications, limitations or restrictions to that practice that have been made as a result of the change of condition.

C. Compliance with this Rule is a prerequisite for eligibility to enter into a Confidential Agreement with the Director pursuant to section 12-225-111, C.R.S. However, mere compliance with this Rule does not require the Director to enter into a Confidential Agreement. Rather, the Director will evaluate all facts and circumstances to determine if a Confidential Agreement is appropriate.

D. If the Director discovers that a direct-entry midwife has a mental or physical illness or condition that impacts the direct-entry midwife's ability to practice direct-entry midwifery care with reasonable skill and safety and the direct-entry midwife has not timely notified the Director of such illness or condition, the direct-entry midwife shall not be eligible for a Confidential Agreement and may be subject to disciplinary action pursuant to section 12-225-109(3)(n), C.R.S.

E. A direct-entry midwife who is addicted to, dependent on, or engages in the habitual or excessive use or abuse of intoxicating liquors, a habit-forming drug, or a controlled substance as defined in section 18-18-102(5), C.R.S. is not eligible to enter into a Confidential Agreement with the Director pursuant to section 12-225-111, C.R.S.

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

This Rule is promulgated and adopted by the Director of the Division of Professions and Occupations ("Director"), pursuant to the rulemaking authority in sections 12-20-204, 12-225-108(1)(a), and 24-34-113(3), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health under the authority of section 24-34-113(2), C.R.S.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider as required by section 24-34-113(2), C.R.S.

This Rule applies to health care providers as defined in sections 24-34-113(1)(f) and 10-16-102(56), C.R.S.

A. Disclosure requirements. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix. The health care provider shall provide the disclosure contained in Appendix A at all of the following occasions:

1. After performing an appropriate screening examination and after determining that a client does not have an emergency medical condition or after treatment has been provided to stabilize an emergency medical condition. The disclosure shall be signed by the client or their designated representative;

2. At the time the client consents to care or treatment by the health care provider for nonemergency services. The disclosure shall be signed by the client or their designated representative before the start of services;

3. On billing statements and billing notices issued by the health care provider; and

4. On other forms or communications related to the services being provided pursuant to insurance coverage.

B. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-225-109, C.R.S.

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

A. On or after March 1, 2021, a provider, shall disclose to a patient, as defined in section 12-30-115(1)(a), C.R.S., instances of sexual misconduct, including a conviction or guilty plea as set forth in section 12-30-115 (2)(a) C.R.S., or final agency action resulting in probation or limitation of the provider's ability to practice as set forth is section 12-30-115(2)(b), C.R.S.

B. Form of Disclosure: The written disclosure shall include all information specified in section 12-30-115(3), C.R.S., and consistent with the sample model disclosure form as set forth in Appendix B to these rules. The patient must, through his or her signature on the disclosure form, acknowledge the receipt of the disclosure and agree to treatment with the registrant.

C. Timing of Disclosure: This disclosure shall be provided to a patient the same day the patient schedules a professional services appointment with the provider. If an appointment is scheduled the same day that services will be provided or if an appointment is not necessary, the disclosure must be provided in advance of the treatment.

1. The written disclosure and agreement to treatment must be completed prior to each treatment appointment with a patient unless the treatment will occur in a series over multiple appointments or a patient/patient schedules follow-up treatment appointments.

2. For treatment series or follow-up treatment appointments, one disclosure prior to the first appointment is sufficient, unless the information the provider is required to disclose pursuant to Section 12-30-115, C.R.S., has changed since the most recent disclosure, in which case an updated disclosure must be provided to a patient and signed before treatment may continue.

D. As set forth in section 12-30-115(3)(e), C.R.S., the requirement to disclose the conviction, guilty plea, or agency action ends when the provider has satisfied the requirements of the probation or other limitation and is no longer on probation or otherwise subject to a limitation on the ability to practice the provider's profession.

E. A provider is not required to provide the written disclosure before providing professional services to the patient in the following instances as set forth in section 12-30-115(4), C.R.S.:

1. The patient is unconscious or otherwise unable to comprehend the disclosure and sign an acknowledgment of receipt of the disclosure pursuant to section 12-30-115(3)(d), C.R.S., and a guardian of the patient is unavailable to comprehend the disclosure and sign the acknowledgment;

2. The patient visit occurs in an emergency room or freestanding emergency department or the visit is unscheduled, including consultations in inpatient facilities; or

3. The provider who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

F. The provider who does not have a direct treatment relationship or have direct contact with the patient is not required to make the disclosure required by this section.

APPENDIX A

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing," also known as balance billing.

What is surprise/balance billing, and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a facility or agency that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at facilities or agencies are sometimes referred to as "out-of-network."

Out-of-network facilities or agencies often bill you the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

Not every service provided in an emergency department is an emergency service. If you are receiving emergency services, in most circumstances, the most you can be billed for is your plan's in-network cost-sharing amounts. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider or facility must refund any amount you overpay within sixty days of being notified.
- A provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

APPENDIX B

MODEL SEXUAL MISCONDUCT DISCLOSURE STATEMENT

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

A. Provider information, including, at a minimum: name, business address, and business telephone number.

B. A listing of any final convictions of or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S.

C. For each such conviction or guilty plea, the provider shall provide, at a minimum:

1. The date that the final judgment of conviction or guilty plea was entered;

2. The nature of the offense or conduct that led to the final conviction or guilty plea;

3. The type, scope, and duration of the sentence or other penalty imposed, including whether:

a. The provider entered a guilty plea or was convicted pursuant to a criminal adjudication;

b. The provider was placed on probation and, if so, the duration and terms of the probation and the date the probation ends; and,

c. The jurisdiction that imposed the final conviction or issued an order approving the guilty plea.

D. A listing of any final agency action by a professional regulatory board or agency that results in probationary status or other limitation on the provider's ability to practice if the final agency action is based in whole or in part on:

1. a conviction for or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S., or a finding by the professional regulatory board or Director that the provider committed a sex offense, as defined in as defined in section 16-11.7-102(3), C.R.S.; OR

2. a finding by a professional regulatory board or agency that the provider engaged in unprofessional conduct or other conduct that is grounds for discipline under the part or article of Title 12 of the Colorado Revised Statutes that regulates the provider's profession, where the failure or conduct is related to, includes, or involves sexual misconduct that results in harm to a patient or presents a significant risk of public harm to patients..

E. For each such final agency action by a professional regulatory board or agency the provider shall provide, at a minimum:

1. The type, scope, and duration of the agency action imposed, including whether:

    a. the regulator and provider entered into a stipulation;

    b. the agency action resulted from an adjudicated decision;

    c. the provider was placed on probation and, if so, the duration and terms of probation; and

    d. the professional regulatory board or agency imposed any limitations on the provider's practice and, if so, a description of the specific limitations and the duration of the limitations.

2. The nature of the offense or conduct, including the grounds for probation or practice limitations specified in the final agency action;

3. The date the final agency action was issued;

4. The date the probation status or practice limitation ends; and

5. The contact information for the professional regulatory board or agency that imposed the final agency action on the provider, including information on how to file a complaint.

Sample Signature Block

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

_____

Print Client Name

_____

Client or Responsible Party's Signature **Date**

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

_____

Print Responsible Party Name **Print Relationship to Client**

_____

Provider Signature **Date**

Editor's Notes

History

Rule 1 repealed eff. 07/01/2007.

Rules 2, 4, 10, 12 eff. 07/01/2007.

Entire rule eff. 12/01/2009.

Rule 15 repealed eff. 12/15/2010.

Entire rule eff. 12/30/2011.

Rules 1, 2, 4-9, 11, 17, 18, 20-22 eff. 08/01/2017.

Rule 8 C-G eff. 01/30/2018.

Rule 1.23, Appendix A emer. rules eff. 01/01/2020; expired 04/29/2020.

Rule 1.23, Appendix A eff. 04/30/2020.

Rule 1.24, Appendix B eff. 12/15/2020.

Rules 1.24 E-F eff. 05/30/2021.

Annotations

Rules 5 B.7. and 21(adopted 05/16/2017) were not extended by House Bill 18-1253 and therefore expired 05/15/2018.

Rule 1.24 E.4 (adopted 10/21/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.