Texas Medical Association
Physicians Caring for Texans

The ABCs of NPPs: Tips for Effective Integration of Nonphysician Practitioners

Notice

The Texas Medical Association (TMA) provides this information with the express understanding that (1) no attorney-client relationship exists, (2) neither TMA nor its attorneys are engaged in providing legal advice, and (3) the information is of a general character. **This is not a substitute for the advice of an attorney.**

While every effort is made to ensure that content is complete, accurate and timely, TMA cannot guarantee the accuracy and totality of the information contained in this presentation and assumes no legal responsibility for loss or damages resulting from the use of this content. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought. Any legal forms are only provided for the use of physicians in consultation with their attorneys.

The information and opinions presented as part of this presentation should not be used or referred to as primary legal sources, nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. The standard of care is dependent upon the particular facts and circumstances of each individual case, and no generalization can be made that would apply to all cases.

CME Disclosure

Policies and standards of the Texas Medical Association, the Accreditation Council for Continuing Medical Education, and the American Medical Association require that speakers and planners for continuing medical education activities disclose any relevant financial relationship they may have with commercial entities whose products, devices or services may be discussed in the content of the CME activity.

The content of this material does not relate to any product of a commercial interest; therefore, there are no relevant financial relationships to disclose.

About Me

Juliana Stanley, MBA, CMPE

Agenda

- Determine if your practice is ready for an NPP
- Establish recruitment and onboarding processes
- Learn how to incorporate an NPP into your practice and how to introduce him or her to patients
- Overview of supervision and delegation of duties responsibilities
- Understand NPP compensation models and appropriate billing for NPP services

Who Are NPPs?

- Physician assistant (PA)
- Advanced practice registered nurse (APRN)
  - Nurse practitioner (NP)
  - Nurse midwife (CNM)
  - Clinical nurse specialist (CNS)
  - Certified registered nurse anesthetist (CRNA)

Scope of Practice

Tex. Health & Safety Code §62.1551

Nurse practitioners may provide medical aspects of care pursuant to protocols or other written authorization that are jointly developed by the NP and a physician. NPs are recognized as primary care providers in Texas.

Tex. Occupations Code Ann. §204.202

Medical services are delegated by the supervising physician and must be within the education, training and experience of the PA.

Is Your Practice Ready for an NPP?

Why Add an NPP?

- Patient access
- Physician work/life balance
- Fill a gap (female or male care provider)
- Additional billable services (first assistants)
- Addition of ancillary services

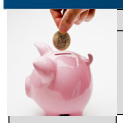
NPP Considerations

- How will the practice use the NPP?
- When will the NPP reach full capacity?
- If/When will additional staff be required?
- Will the NPP take volume away from physicians?
- Does the NPP start before being credentialed with all payers?
- In group practices, who will use the NPP and how will cost/revenue be split?

Costs of Adding an NPP

- Wages
- Benefits
- Medical liability insurance
- Credentialing
- Licensure fees
- CME
- Electronics/Software
- Staff
- Marketing
- Overhead – supplies/space
- Miscellaneous

NPP Salaries



	Annual Mean Wage per MSA*			
	Dallas-Plano-Irving	Houston-The Woodlands-Sugarland	Austin-Round Rock	San Antonio-New Braunfels
Nurse Practitioner	$106,610	$121,670	$103,410	$100,860
Physician Assistant	$103,680	$124,950	$108,030	$93,440

*MSAs consist of one or more counties and contain a core area with a substantial population that has a high degree of economic and social integration with the surrounding areas.

Source: Bureau of Labor Statistics, May 2018, www.bls.gov/bls/blswage.htm

Perks You Can Offer

- Incentive plan to motivate production
- Allowance for CME – with time off
- Payment of NPP licenses, professional liability coverage, association memberships, etc.
- Some autonomy and responsibility for clinical operations or staff

Median NPP Collections

	Nurse Practitioner	
	Gross Charges	Gross Collections
Family Medicine Benchmark Median*	$482,051	$245,195
OB-Gyn Benchmark Median*	$376,088	$265,368
Neurology Benchmark Median*	$289,600	$141,240

*Southern geographic region

Source: 2017 MGMA Physician Compensation & Production Survey, by Specialty and Geographic Region

Proforma Example

Proforma			
Expenses			
Salary	$110,000.00		Based on MSA Average
Marketing	$3,000.00		Proposed budget
Credentialing	$8,000.00		
Malpractice	$3,000.00		
Total	$124,000.00		
Revenue			
Visits to breakeven at projected collections			Average payment per visit of $125
992			

Proforma Error – Staffing

Proforma			Actual Numbers	
Expenses			**Expenses**	
Salary	$110,000.00		Salary	$110,000.00
Marketing	$3,000.00		Marketing	$3,000.00
Credentialing	$8,000.00		Credentialing	$8,000.00
Malpractice	$3,000.00		Malpractice	$3,000.00
Total	$124,000.00		Extra Staff	$35,000.00
			Total	$159,000.00
Revenue			**Revenue**	
Visits to breakeven at projected collections of $125			Visits to breakeven at average payment per visit of $125	
992			1,272	

Proforma Error – Incident-to

Proforma			Actual Numbers	
Expenses			**Expenses**	
Salary	$110,000.00		Salary	$110,000.00
Marketing	$3,000.00		Marketing	$3,000.00
Extra Staff	$35,000.00		Extra Staff	$35,000.00
Credentialing	$8,000.00		Credentialing	$8,000.00
Malpractice	$3,000.00		Malpractice	$3,000.00
Total	$159,000.00		**Total**	$159,000.00
Revenue			**Revenue**	
Visits to breakeven at average collections of $125			Visits to breakeven at incident-to rate $125 * 85% $106.25	
1,272			1,496	

Recruitment and Onboarding

Find the Right Fit

- Training and skills match services the NPP is to provide
- Specialty-specific experience
- Similar philosophy
- Match the practice's culture
- Exceptional bedside manner

Where to Recruit

- Contact the career center of the local NP and PA schools.
- Contact NPP associations and advertise your openings via direct mail, job board, etc.
- Word of mouth; ask pharmaceutical representatives and other vendors to spread the word and provide recommendations.
- Use job posting websites like Indeed, LinkedIn, Zip Recruiter, etc.

Onboarding Process

Very rarely will an NPP hit the ground running on day one:

- Payer contracting
- Visibility and introduction to patients
- Building trust with the patients
- Staff training

Determine what the NPP will do during down time while he or she builds a presence in the practice.

Scheduling and Patient Introduction

Marketing

Start marketing efforts months before an NPP's first day of patient care.

- Post signs/flyers in the practice.
- Introduce the NPP on your website and on social media.
- Instruct staff and other care providers to spread the word.
- Introduce the NPP to referring physicians.

Introduction to Patients

Patients may be apprehensive, especially if they have an established relationship with a physician.

- Allow the NPP to "shadow" the physician.
- Provide a warm hand-off with a personal introduction.
- Reinforce with patients that …
  - You are not abandoning them, and
  - Their insurance benefits should not change.
- Host an open house or a "meet our care team" event.

Scheduling

Train staff on the type of care and services the NPP will provide. Provide to scheduling staff:

- List of payers with whom the NPP is contracted
- Types of patients the NPP can see:
  - New and/or established patients
  - Follow-up only and/or new problems
- NPP's background
  - Education
  - Procedures for which the NPP is trained
- Scheduling parameters
  - Days and hours
  - Does a supervising physician need to be on site?

Supervision and Delegation of Duties

Supervising Physician

- Required for NPPs to practice
- Physician accepts responsibility
- Physician confirms NPP possesses proper qualifications and training to perform delegated duties

Supervision

APRN Practice Authority

Tex. Admin. Code §22-11-221.13

- Written, signed, agreement is required between the NP and the supervising physician.
- Protocols should be jointly developed, and reviewed and re-signed annually.
- Agreement must be maintained in the practice and made available as necessary to verify authority.

Supervision

PA Supervision Requirements

Tex. Occupations Code Ann. §204.204

- Continuous (not constant) supervision by a physician is required.
- *"The supervising physician oversees the activities of, and accepts responsibility for, medical services provided by the physician assistant."*

Delegation of Duties

Texas Medical Practice Act

Tex. Occ. Code §157.001(a)

*"A physician may delegate to a qualified and properly trained person **acting under the physician's supervision** any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate"*

Delegation of Duties

Delegated acts must be performed by qualified and properly trained persons, regardless of their title or credential.

Tex. Occ. Code §157.001(b)

Though physicians may delegate, they "*remain responsible for the medical acts*" delegated.

TMA Whitepaper

Advanced Practice Registered Nurse

- Texas Board of Nursing
- Scope of practice depends on the nurse's education, experience, and accepted scope of professional practice of the particular specialty area.
- Can make limited diagnoses, but only under a physician's delegation of duties while under a physician's supervision

Physician Assistant

- Texas Physician Assistant Board
- Physician Assistant Licensing Act
  - Defines scope of practice for PAs
    - Provide medical services delegated by a supervising physician that are within their education, training and experience
    - Provides a nonexclusive list of duties a PA can perform

Physician Assistant

- The supervising physician is responsible for notifying TMB of the intent to supervise a PA
- A supervising physician retains legal responsibility for a PA's patient care activities
- TMB website contains instructions and requirements for online registration
  - www.tmb.state.tx.us/page/supervision-and-prescriptive-delegation

Delegation of Prescriptive Authority

- Physicians may delegate the act of prescribing or ordering a drug or device.
- Must have a prescriptive authority agreement (PAA) that:
  - Can and should be customized and/or limited to the needs of the practice
  - Documents elements of the physician-APRN/PA relationship and supervision

Sample

Delegation of Prescriptive Authority

- Limited to ***no more*** than 7 combined APRNs/PAs, except in:
  - Medically underserved area/designated rural health clinic/federally qualified health clinic
  - Facility-based practice (hospital, long-term care facility)

Controlled Substances

The schedule of a controlled substance determines what requirements must be met in order to delegate prescriptive authority.

Controlled Substances

- Schedule II
  - Physicians cannot delegate prescriptive authority for Schedule II narcotics and must write or co-sign all prescriptions
  - Hospital-based facility practice
    - Admissions with intended stay of 24+ hours
    - Only per hospital medical staff bylaws
    - In emergency department
  - Patients receiving hospice care, subject to legal requirements and certified in writing

Controlled Substances

- Schedules III, IV, and V
  - Prescription and refills for ≤ 90 days
  - Refill is authorized only after consulting the delegating physician
    - Consult is noted in patient's chart
  - For patients < 2 years old, a prescription is written only after consulting the delegating physician and noted in the patient's chart

Prescriptive Authority Agreement

- Be in writing
- Be signed and dated
- Include names, addresses, and license numbers
- Indicate nature of the practice and locations
- Identify drugs and devices that may/may not be delegated
- Include general plan for consultation and referral
- State plan for addressing patient emergencies

Prescriptive Authority Agreement

- State general process for communicating and sharing information about patient care and treatment
- If alternate physician supervision is used, designate one+ alternate physician(s) who may provide supervision on a temporary basis
  - Following PAA requirements
- Describe quality assurance and improvement plan
  - Specify methods for documenting implementation of the plan
- Provide executed copy

Prescriptive Authority Agreement

- Register with TMB within 30 days of signing
- Review annually
- Retain for 2 years after the date the agreement is terminated

Quality-Assurance Meetings

Required meetings between supervising physician and NPP must:

- Be face-to-face
- Include discussions of:
  - Patient treatment and care
  - Any changes needed in care plans
  - Issues relating to referrals
  - Patient care improvement
- Be documented with minutes or a summary

Quality-Assurance Meetings

Meetings must occur:

- Monthly for the first three years of executed PAA
- After three years, quarterly face-to-face meetings, and remote monthly meetings in between.
  - (e.g., by video conferencing)

If the APRN/PA has had delegated prescriptive authority at least 5 of the last 7 years:

- Meetings must occur monthly for the first year.
- After the first year, quarterly face-to-face meetings, and remote monthly meetings in between.

Remember to …

- Check the OIG exclusion list
- Keep TMB updated with the NPP(s) a physician is supervising
- Verify NPP guidelines with specific health plans: type of services provided and specialty
- Search multiple terms and/or specific NPP types
- Check policies, provider manuals, and health plan newsletters

Billing for NPP Services

Incident-to Billing

- Medicare concept
- Allows the services provided by certain NPPs to be billed under the name and NPI of the supervising physician
- Results in payment at 100% of the physician contracted rate

Incident-to Billing

- A physician in the same group practice must provide “direct supervision” during the time of service.
- Patient must have an established plan of care for an established problem known by the practice
- No new patients
- No new problems
- The services must be performed in an office setting (POS 11) or patient’s home (POS 12).

What the Physician Must Do

- Personally perform the patient's initial service
- Establish a plan of care for the particular condition
- Provide direct supervision:
  - Must be physically present in the office suite – does not have to be in the treatment room
  - Must be readily available to assist and direct the NPP – does not have to actually see the patient
- Remain actively involved in the patient's treatment

Shared Visits

- Equivalent to 'incident-to' service in a hospital setting
- Applies only to E&M visits
  - Inpatient, ED, observation, hospital outpatient departments
  - Excludes:
    - Critical care
    - Consultations
    - Procedures
    - Visits in skilled nursing or nursing facilities
  - Place of service ***other than*** [11 – Office]

Shared Visits

- Must involve two qualified professionals performing an E&M service for a patient as a "team." Both must:
  - Have a face-to-face visit with the patient
    - On the same date of service
  - Perform a 'substantive' portion of the service
    - Substantive: At least some portion of the history, exam, and medical decision making components of the E/M service.
- Allows the service to be paid at 100% of the physician contacted rate.

Test Your Knowledge

How Do You Bill This Visit?

John, an established patient, presents for his regularly scheduled follow-up visit for an established chronic condition. During the visit, the NPP determines a joint injection is medically necessary to control a flare in the disease.

How Do You Bill This Visit?

Can an exacerbation of a chronic condition (e.g.: asthma) be billed "incident to" if the NPP changes or prescribes a new prescription?

Can This Visit Be Billed as "Incident-to"?

NPP sees a new patient with a new complaint of fatigue and nausea.

Can This Visit Be Billed as "Incident-to"?

NPP performs a medication check for a patient with an established plan of care for chemotherapy.

Can This Be Billed as a Shared Visit?

An NPP sees and examines a hospital inpatient in the morning and documents the encounter. The physician stops by later that same day and reviews the patient's medical record.

Is This Shared Visit Process Appropriate?

At the hospital, NPPs are normally first to see our patients. The physicians see the patient during rounding, document that they agree with the NPP's findings, and sign off on the note. These visits are billed under the physician's NPI.

Thank You

TMA Practice Consulting
practice.consulting@texmed.org
(800) 523-8776

Texas Medical Association
Physicians Caring for Texans

NOTICE: The Texas Medical Association provides this information with the express understanding that (1) no attorney-client relationship exists, (2) neither TMA nor its attorneys are engaged in providing legal advice and (3) the information is of a general character. **This is not a substitute for the advice of an attorney.** While every effort is made to ensure that content is complete, accurate and timely, TMA cannot guarantee the accuracy and totality of the information contained in this publication and assumes no legal responsibility for loss or damages resulting from the use of this content. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought. Any legal forms are only provided for the use of physicians in consultation with their attorneys.

Prescription Authority Agreement — Sample Form

Delegating and supervising physician:

Name _____ License No. _____

Address _____

Advanced practice registered nurse (APRN) or physician assistant (PA) to whom prescriptive authority is being delegated pursuant to this agreement:

Name _____ License No. _____

Address _____

Nature of practice (primary care, OB-Gyn) _____

Practice location(s) _____

_____

_____

The following types or categories of drugs or devices may be prescribed:

☐ All dangerous drugs (nonschedule) ☐ All schedule III-V controlled substances

OR

Permitted drugs or devices _____

_____

Limitations _____

_____

1. Describe general plan for addressing consultation and referral of patients.*

_____

_____

_____

2. Describe general plan for addressing patient emergencies.*

_____

_____

_____

3. Describe general process for communication and sharing information regarding patient care (e.g., consultation, physician availability in person/by phone).*

_____

_____

_____

*Attach additional protocol or instructions, if applicable.

4. Describe a prescriptive-authority quality assurance and improvement plan, and specify methods for documenting implementation of the plan that include chart review, and number or percentage of charts to be reviewed. Attach quality assurance and improvement plan, or describe below.

5. Quality assurance meetings are held with delegating physician and/or alternate supervising physicians

   ☐ Monthly ☐ Quarterly (as allowed by law) ☐ Other _____

   (*Documentation of QA meetings should be maintained as attachments to this agreement.*)

6. OTHER REQUIREMENTS (by physician)

7. Alternate supervising physician(s) (optional, IF group practice) name and license number. Signature recommended.

   Name License No. Signature

8. The APRN listed in this agreement hereby acknowledges that the Texas Board of Nursing (TBON) has approved his or her authority to prescribe or order a drug or device as authorized under Chapter 157, Texas Occupations Code.

9. The APRN or PA listed in this agreement hereby acknowledges that he or she:
   a. Holds an active license to practice in Texas as an APRN or PA and is in good standing in this state; and
   b. Is not currently prohibited by TBON or the Texas Physician Assistant Board (TPAB) from executing a prescriptive authority agreement; and
   c. Has disclosed to the physician any prior disciplinary action by TBON or TPAB, as follows:

10. The physician listed in this agreement hereby acknowledges that he or she has disclosed to the APRN or PA any prior disciplinary action by the Texas Medical Board.

Delegating physician

APRN/PA

Date of agreement

PAA PERIODIC REVIEW

This agreement must be reviewed periodically, at least annually.

Delegating physician

APRN/PA

Date of review

Copies to be maintained by PHYSICIAN and delegated APRN/PA.

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

VISION: To improve the health of all Texans.

MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Delegation of Duties by a Physician to a Nonphysician

FEBRUARY 2017 DOCUMENT #0002-NA

TMA Office of the General Counsel

This article provides general information regarding those acts a physician may "delegate" to nonphysicians. Generally, latitude is given to a supervising physician in the physician's delegation authority, but which acts a physician may delegate greatly depends upon the education and experience of the person to whom the acts are being delegated. However, a physician who authorizes standing delegation orders or standing medical orders that authorize independent medical judgment may have his or her license suspended or revoked.[1] Furthermore, a physician must adequately supervise the activities of those acting under the physician's supervision, and may not delegate professional medical responsibility or acts to a person if the delegating physician knows or has reason to know the person is not qualified by training, experience, or licensure to perform the responsibility or acts.[2]

A physician must take into account ethical considerations when delegating medical acts. It is imperative that patients not be misled into believing that a person performing the medical acts is a physician, if the person is not in fact a physician holding an unrestricted license issued by the state of Texas. Likewise, a physician should ensure no other misleading information be provided to the patient pertaining to the licensure or nonlicensure of an individual performing the delegated medical acts. The Texas Medical Association Board of Councilors issued an opinion on this topic:

> **Delegation of Medical Acts.** A licensed physician who delegates medical acts to an unlicensed individual should assure that there are no misleading communications to patients that denote or connote licensure when such person is not licensed by the State of Texas.[3]

The following information provides an overview of the types of acts physicians may delegate, and the individuals to whom they may delegate such acts. This information, however, is of a general nature and should not be used in place of retained legal counsel.

General Delegation Clause

The Medical Practice Act (MPA) establishes the general parameters for physician delegation in Texas. The MPA authorizes physicians to delegate *"any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate*" (emphasis added).[4] Acts delegated "must comply with other applicable laws."[5] The delegated acts must be performed by qualified and properly trained persons, and each of the conditions specified at section 157.001 of the Texas Occupations Code must be met.[6] The general delegation clause, containing the required conditions, is as follows:

> **§ 157.001. General Authority of Physician to Delegate**
> (a) A physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician:

1. 22 Tex. Admin. Code §193.5(c). See also Tex. Occ. Code §157.002(d).
2. Tex. Occ. Code §164.053(a)(8)-(9).
3. TMA Board of Councilors Opinion: Delegation of Medical Acts. Available at www.texmed.org/Template.aspx?id=392&terms=ethics%20opinions#DELEGATION.
4. Tex. Occ. Code §157.001(a).
5. Tex. Occ. Code §157.007.
6. Tex. Occ. Code §157.001.

(1) the act:
(A) can be properly and safely performed by the person to whom the medical act is delegated;
(B) is performed in its customary manner; and
(C) is not in violation of any other statute; and
(2) the person to whom the delegation is made does not represent to the public that the person is authorized to practice medicine.

(b) The delegating physician remains responsible for the medical acts of the person performing the delegated medical acts.

(c) The board may determine whether:
(1) an act constitutes the practice of medicine, not inconsistent with this chapter; and
(2) a medical act may be properly or safely delegated by physicians.[7]

The person to whom a physician delegates the performance of a medical act generally is not considered to be practicing medicine without a license by performing the medical act.[8] The Texas Medical Board (TMB) may determine whether "an act constitutes the practice of medicine" and whether a medical act may be "properly or safely delegated by physicians."[9] A physician shall be permitted to exercise his or her professional judgment to decide which medical acts may be safely delegated, and TMB will not adopt rules containing global prohibitions or restrictions on the delegation of medical acts, except as absolutely necessary.[10] Though physicians may delegate, they "remain responsible for the medical acts" delegated.[11]

Traditionally, the scope of what a physician may delegate to a nonphysician, be that person a registered nurse (RN), licensed vocational nurse (LVN), physician assistant (PA), or medical assistant (MA), is governed by this general rule, and regardless of that person's title, the law specifies that the person to whom the act is delegated must be "qualified and properly trained." The individual's title merely provides some indication that the person has met some set of qualifications and training. The physician must nevertheless determine if the skill set underlying those certifications or licenses makes the person qualified and trained to perform the delegated medical activity. Conversely, persons without licenses or certifications may have the qualifications and training to perform some delegated medical acts.

Thus, a physician may delegate to nonphysicians the tasks of performing injections, taking blood pressure, checking temperature, or performing other tasks that do not involve the exercise of independent medical judgment, as long as the physician is satisfied that the person is qualified and adequately trained. Those persons need not be RNs when they are employed in a physician's private medical office but must be qualified and trained to perform the medical act.

Consider the following three scenarios and the factors TMB considered in determining that medical care was delegated improperly.

7. Id.
8. Tex. Occ. Code §157.005.
9. Tex. Occ. Code §157.001(b)-(c).
10. Tex. Occ. Code §157.006.
11. Tex. Occ. Code §157.001(b).

Case 1
TMB sanctioned Dr. K for improperly delegating authority to individuals he knew were unqualified by training, experience, or licensure to perform the responsibilities or acts. Dr. K left presigned, blank prescription pads in his office and allowed two advanced practice registered nurses (APRNs) to fill out the presigned prescription pads. Neither APRN had prescriptive authority as required by the Texas Board of Nursing (BON). Further, evidence of his improper delegation included his lack of knowledge about the operating policies and procedures or the day-to-day operations of the clinics he was supervising.

Case 2
TMB sanctioned Dr. A for improperly delegating duties to her medical assistant. While Dr. A was not in the office, she allowed her medical assistant to take vital signs and perform a preliminary evaluation of patients seeking refills on their medications, including controlled substances and dangerous drugs. If the medical assistant determined a patient was eligible for a refill, she would seek permission from Dr. A. The medical assistant had no licensure or certification that supported the delegation of responsibility to make limited evaluations of patients in regard to renewal of their prescription. Further, Dr. A did not have any standing orders that would have given the medical assistant protocols for the duties of taking vital signs, making observations, and making evaluations of patients in Dr. A's absence.

Case 3
TMB sanctioned Dr. J for improperly delegating medical care to a nonlicensed medical doctor. Dr. J employed a staff member who was licensed as a physician in Mexico but did not have a Texas license to practice as a physician or any other practitioner. Despite this, Dr. J referred to him as his physician assistant. Dr. J allowed the unlicensed individual to examine patients while Dr. J was not in the office. Dr. J had not been in the office for several months and consulted with the unlicensed individual through telephone conversations. TMB found that Dr. J delegated professional medical responsibility or acts to a person who he knew or had reason to know was not qualified by training, experience, or licensure to perform the responsibilities or acts.

Delegation to Advanced Practice Registered Nurses Generally

All APRNs in Texas initially are RNs. The Nursing Practice Act (NPA) defines an APRN as an RN who is approved by the Texas Board of Nursing to practice as an APRN after completing an advanced educational program.[12] The Texas Medical Practice Act regulating physicians adopts this definition.[13] The scope of practice applicable to an APRN is addressed in general terms by BON in its rules.[14] These rules provide that the scope depends on the nurse's education, the nurse's experience, and the accepted scope of professional practice of the particular specialty area (defined by national professional specialty organizations or advanced practice nursing organizations recognized by BON).[15] The term "advanced practice registered nurse" includes a nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist.[16] The term is synonymous with "advanced nurse practitioner" and "advanced practice nurse."[17] Standards governing APRNs are found in Title 22 of the Texas Administrative Code, Chapters 221 and 222.

An APRN "acts independently and/or in collaboration with other health care professionals in the delivery of health care services."[18]

12. Tex. Occ. Code §301.152(a).
13. Tex. Occ. Code §157.051(1).
14. 22 Tex. Admin. Code §221.12.
15. Id.
16. Tex. Occ. Code §301.152(a); 22 Tex. Admin. Code §221.1(3).
17. Id.
18. 22 Tex. Admin. Code §221.1(3).

The NPA provides some guidance on the scope of duties encompassed in the definition of "professional nursing" but specifically excludes "diagnosis."[19] The NPA bars nurses from making medical diagnoses.[20] An APRN can make *limited* diagnoses, *but only under a physician's delegation of prescriptive authority, and pursuant to a physician's supervision.* The delegation of prescriptive authority to APRNs and PAs is discussed later in this paper.

Note that vocational nurses, registered nurses, and APRNs are required to wear a nametag when interacting with the public in a nursing role that identifies them as a registered or vocational nurse.[21]

Billing for APRNs

Generally, the Medicare program allows an APRN to bill the Medicare program directly using the APRN's National Provider Identifier (NPI), or to have an employer or contractor bill for the APRN's services using the APRN's NPI for reassigned payment.[22] There are coverage requirements in this billing arrangement. For example, a nurse practitioner or a clinical nurse specialist must be legally authorized and qualified to furnish the services in Texas; the services must not be otherwise precluded due to a statutory exclusion; they must be reasonable and necessary; they must be of the type considered physician's services if furnished by a physician; and they must be performed in collaboration with a physician.[23]

For certified nurse midwives (CNMs), the Medicare coverage requirements are as follows: the CNM must be legally authorized and qualified to furnish the services in Texas; the services must not be otherwise precluded due to a statutory exclusion; they must be reasonable and necessary; they must be of the type considered physician's services if furnished by a physician; and the CNM's services are performed without physician supervision and without association with a physician or health care provider, unless otherwise required by state law.[24] For certified registered nurse anesthetists (CRNAs), several of the same Medicare criteria apply as for other APRNs, with several notable additional requirements. The CRNA must be legally authorized and qualified to furnish the services in Texas; the services must not be otherwise precluded due to a statutory exclusion; and they must be reasonable and necessary.[25] Additionally, when the anesthesia is administered in a hospital, the CRNA must be under the supervision of the operating practitioner performing the procedure or of an anesthesiologist who is immediately available if needed, unless the CRNA is located in a state that has opted out of the supervision requirements.[26]

19. According to the Nursing Practice Act in Tex. Occ. Code §301.002(2) (emphases added): "Professional nursing" means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. **The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:**
    (A) the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes;
    (B) the maintenance of health or prevention of illness;
    (C) the administration of a medication or treatment as ordered by a physician, podiatrist, or dentist;
    (D) the supervision or teaching of nursing;
    (E) the administration, supervision, and evaluation of nursing practices, policies, and procedures;
    (F) the requesting, receiving, signing for, and distribution of prescription drug samples to patients at practices at which an advanced practice registered nurse is authorized to sign prescription drug orders as provided by Subchapter B, Chapter 157;
    (G) **the performance of an act delegated by a physician under Section 157.0512, 157.054, 157.058, or 157.059;** and
    (H) the development of the nursing care plan.
20. Tex. Occ. Code §301.002(2).
21. Tex. Occ. Code §301.351(c).
22. See, e.g., *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants,* (October 2016), pg. 8 (Nurse Practitioners), pg. 11 (Certified Nurse-Midwives), pg. 13 (Clinical Nurse Specialists), Medicare Learning Network, Centers for Medicare & Medicaid Services, Dep't of Health & Hum. Svcs., at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf.
23. Id. at pg. 8 (NPs), pg. 12 (CNSs).
24. Id. at pg. 10. Note that Texas law requires an APRN, when providing medical aspects of care, to use mechanisms including protocols or other written authorization, jointly developed by the APRN and the appropriate physician(s). See 22 Tex. Admin. Code §221.13(d).
25. Id. at pg. 4.
26. Id. Texas is not on the list of opt-out states.

The Medicaid provider manual addresses payment for certain types of APRNs. In addition to specific licensure and certification requirements, Medicaid requires that all CRNA services be billed with a CRNA individual or group provider identifier; no payment for CRNA services will be made under a hospital or physician provider identifier.[27] A CRNA will be paid under the Medicaid program the lesser of either billed charges or 92 percent of the payment for the same service paid to a physician anesthesiologist.[28]

On Jan. 1, 2017, Texas Medicaid reduced the payment for anesthesiologists providing medical direction of CRNAs/anesthesiologist assistants to 75 percent of the 2016 payment rate. The rate will decline again on Jan. 1, 2018, to 25 percent of the 2016 payment rate for anesthesiologists. The reduction does not alter payment rates for CRNAs.

Texas Medicaid requires that CNMs submit their bills for maternity services in one of two ways: itemized on one claim form and billed at the time of delivery, or itemized and submitted as the services are rendered.[29] The Medicaid rate for CNMs is the lesser of 92 percent of billed charges or the rate paid to a physician for the same service (except for x-ray, laboratory, or injections, which are paid at 100 percent of the physician fee schedule).[30] This is also the payment rate for nurse practitioners and clinical nurse specialists.[31]

Delegation to a Licensed (Direct-Entry) Midwife Generally

Lay midwifery is not the practice of medicine. It is regulated by the Texas Midwifery Act.[32] Childbirth is a natural process of the human body and not a disease.[33] Nevertheless, a physician can delegate acts to a midwife pursuant to the general delegation authority provided by the general delegation clause.[34] Furthermore, the legislature specifically provides delegation authority for eye prophylaxis. A physician may delegate to a midwife the possession and administration of eye prophylaxis for the prevention of ophthalmia neonatorum.[35] A physician who issues a standing delegation order to a midwife is not liable in connection with an act performed under that standing delegation order if the midwife provides proof of licensure under the Texas Midwifery Act before the order is issued.[36]

Delegation to Pharmacists Generally

A physician may delegate the performance of specific acts of drug therapy management to a properly trained and qualified pharmacist acting under adequate physician supervision.[37] This delegation must be authorized by the physician through the physician's order, standing medical order, standing delegation order, or other order or protocol as defined by TMB rule.[38] However, the order or protocol may *not* permit the delegation of medical diagnosis.[39] "Drug therapy management" is the performance of specific acts by pharmacists as authorized by a physician through written protocol, but it does not include the selection of drug products not prescribed by the physician unless the drug product is named in the physician-initiated protocol or physician-initiated record of deviation from a standing protocol.[40] Drug therapy management may include: (1) collecting and reviewing patient drug-use histories; (2) ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration; (3) ordering drug therapy-related laboratory tests; (4) implementing or modifying drug therapy, including the authority to sign a prescription

27. See January 2017 Texas Medicaid Provider Procedures Manual, Vol. 2, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook, §4.4.1, available at www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf.
28. Id. at §4.4.2.
29. Id. at §3.2.7, citing 1 Tex. Admin. Code §355.8161(a).
30. Id.
31. 1 Tex. Admin. Code §355.8281(a).
32. Tex. Occ. Code Ch. 203.
33. Tex. Occ. Code §203.003.
34. Tex. Occ. Code §157.001(a).
35. Tex. Occ. Code §157.004.
36. Id.
37. Tex. Occ. Code §157.101(b); 22 Tex. Admin. Code §193.15(b).
38. Id.
39. Tex. Occ. Code §157.101(f).
40. 22 Tex. Admin. Code §193.15(c).

drug order for dangerous drugs as provided in §157.101(b-1) of the MPA, following diagnosis, initial patient assessment, and ordering of drug therapy by a physician, as detailed in the protocol (and pursuant to certain requirements and limitations[41]); (5) selecting generically an equivalent drug if the physician's signature does not clearly indicate the prescription must be dispensed as written; or (6) "any other drug therapy related act delegated by a physician."[42]

Certain restrictions to the delegation of drug therapy apply. The physician is responsible for the formulation of the order or protocol, and must periodically review the order or protocol and the services provided under it; must have established a patient-physician relationship with the patient; must be able to be physically present daily to provide medical care and supervision; must, as appropriate, receive a periodic status report on each patient; and must be available through direct telecommunication for consultation, assistance, and direction.[43]

Furthermore, at least annually the physician shall review, and modify if necessary, the written protocols.[44]

Immunizations or Vaccinations

Physicians also may delegate the administration of immunizations and vaccinations to a properly qualified and trained pharmacist acting under adequate supervision.[45] The physician may make this delegation through the physician's order, standing medical order, standing delegation order, or other order or protocol.[46] This delegation does not include the selection of drug products not prescribed by the physician, unless the product is named in the physician-initiated protocol.[47]

The physician must adequately supervise the pharmacist. For proper supervision, the physician:

(1) is responsible for the formulation or approval of the physician's order, standing medical order, standing delegation order, or other order or written protocol and periodically reviews the order or protocol and the services provided to the patient under the order or protocol on a schedule defined in the written protocol;
(2) has established a physician-patient relationship with each patient under 14 years of age and referred the patient to the pharmacist;
(3) is geographically located so as to be easily accessible to the pharmacist administering the immunization or vaccination;
(4) receives, on a schedule defined in the written protocol, a periodic status report on the patient, including any problem or complication encountered; and
(5) is available through direct telecommunication for consultation, assistance, and direction.[48]

A written protocol for the administration of immunizations and vaccinations by a pharmacist must contain, at a minimum, the following elements:

- A statement identifying the delegating physician;
- A statement identifying the individual pharmacist authorized to administer immunizations or vaccinations as delegated by the physician;
- A statement identifying the location(s) at which the pharmacist may administer immunizations or vaccinations (which may not be the patient's residence, except for a licensed nursing home or hospital);
- A statement identifying the immunizations or vaccinations that may be administered by the pharmacist;

41. The pharmacist must practice in a hospital, hospital-based clinic, or academic health care institution; must provide the pharmacist's and delegating physician's name on each prescription signed by the pharmacist; and must provide a copy of the protocol to the Texas State Board of Pharmacy. 22 Tex. Admin. Code §193.15(c)(4)(A)-(C).
42. 22 Tex. Admin. Code §193.15(c).
43. Tex. Occ. Code §157.101(c).
44. 22 Tex. Admin. Code §193.15(f).
45. 22 Tex. Admin. Code §193.16(b).
46. Id.
47. 22 Tex. Admin. Code §193.16(c).
48. 22 Tex. Admin. Code §193.16(d).

- A statement identifying the activities the pharmacist must follow during the administration, including procedures for responding to reactions; and
- A statement that describes the content and means for the pharmacist to report the administration within 24 hours to the physician issuing the written protocol.[49]

Written protocols shall be reviewed, and modified if necessary, by the physician at least annually.[50] The physician must also, pursuant to protocol, review documentation of the pharmacist's administration of immunizations and vaccinations.[51]

Delegation to Physician Assistants Generally

The scope of PA practice historically was governed by the general delegation clause quoted above. In 1993, the Texas Legislature enacted the Physician Assistant Licensing Act.[52] Initially, the act established a Physician Assistant Advisory Council as an advisory board to TMB (then named the Texas State Board of Medical Examiners). After several statutory changes, the advisory council became known as the Texas Physician Assistant Board (TPAB), with a 13-member governing board consisting of seven practicing PAs, three Texas-licensed physicians who supervise PAs, and three public members. It continues to be an advisory board to TMB. TMB approves or rejects each rule adopted by TPAB; if TMB rejects the rule, it returns the rule to TPAB for revision.[53]

The act does several things of note. Specifically, it: (1) requires licensure of PAs, (2) creates TPAB as an advisory board to TMB, and (3) clarifies the scope of PA practice and responsibility therefor.[54] As to the latter, the act states that the practice of a physician assistant includes providing medical services delegated by a supervising physician that are within the education, training, and experience of the physician assistant.[55] It also provides a nonexclusive list of things a PA can do, as long as they are: (1) within the education, training, and experience of the PA, and (2) delegated by the supervising physician.[56] The portion of that section, providing the nonexclusive list of services a PA can provide, is as follows:

> (b) Medical services provided by a physician assistant may include:
>
> (1) obtaining patient histories and performing physical examinations;
> (2) ordering or performing diagnostic and therapeutic procedures;
> (3) formulating a working diagnosis;
> (4) developing and implementing a treatment plan;
> (5) monitoring the effectiveness of therapeutic interventions;
> (6) assisting at surgery;
> (7) offering counseling and education to meet patient needs;
> (8) requesting, receiving, and signing for the receipt of pharmaceutical sample prescription medications and distributing the samples to patients in a specific practice setting in which the physician assistant is authorized to prescribe pharmaceutical medications and sign prescription drug orders as provided by Section 157.0512 or 157.054;
> (9) prescribing or ordering a drug or device as provided by Subchapter B, Chapter 157; and
> (10) making appropriate referrals.[57]

PAs may perform these listed activities in any place authorized by a supervising physician, including a clinic, hospital, ambulatory surgical center, patient home, nursing home, or other institutional setting.[58]

49. 22 Tex. Admin. Code §193.16(e)(1).
50. 22 Tex. Admin. Code §193.16(f)(1).
51. 22 Tex. Admin. Code §193.16(f)(2).
52. Codified at Tex. Occ. Code Ch. 204.
53. Tex. Occ. Code §204.102(b).
54. Tex. Occ. Code §§204.151, 204.051, 204.202.
55. Tex. Occ. Code §204.202(a).
56. Tex. Occ. Code §204.202(a), (b).
57. Tex. Occ. Code §204.202(b).
58. Tex. Occ. Code §204.202(c).

A PA must be supervised by a supervising physician, and the PA may have more than one supervising physician.[59] A supervising physician retains legal responsibility for a PA's patient care activities.[60] PAs employed by health care facilities also must be supervised by physicians, and the legal liability for the acts or omissions of such PAs is shared between the supervising physician and the employing health care facility.[61] As for the supervision requirement, the act provides that the supervising physician oversees the activities of, and accepts responsibility for, medical services the PA provides.[62] The physician's supervision must be "continuous" but does not require his or her constant physical presence at the place where the PA is performing services; however, the supervising physician and PA must be able to "easily be in contact with one another by radio, telephone, or another telecommunication device."[63] The PA is the agent of the supervising physician for any medical services physician has delegated and that are: (1) within the PA's scope of practice, and (2) delineated by protocols, practice guidelines, or practice directives established by the supervising physician.[64]

Physicians wishing to employ PAs must notify TMB of the physician's intent to supervise them.[65] A supervising physician must submit a statement to TMB that the physician will supervise the PA according to TMB rules and retain professional and legal responsibility for the care rendered by the PA.[66] TMB previously had used a paper form for registering PA supervision, which was available online for downloading and completion by those physicians who intended to supervise PAs. However, the TMB website notes that **"[h]ard copy supervision and delegation forms are no longer be *(sic.)* accepted (except as required)"** (emphasis in the original).[67] Instead, physicians and PAs should go to the TMB website and access the Supervision and Prescriptive Delegation Registration System portal, which contains instructions and requirements for completion of registration via the online system.[68]

Billing for Physician Assistants

Texas law does not give detailed guidance on the practice of billing for a PA's services. The ability of physicians to bill for services rendered by a PA is governed by rules adopted by TMB. At one time, TMB rules prohibited separate billing for the services of a PA (former 22 Texas Administrative Code section 185.10[1]) on grounds that the PA's services were "part of the global services provided by the supervising physician," but that rule has been changed. Now, TMB rules provide that the "physician assistant may not independently bill patients for the services provided by the physician assistant except where provided by law."[69] Medicare may be one area in which this is allowable. However, Medicare will make payment only to the actual employer of a PA or to the PA's contractor.[70]

Under the Texas Medicaid program, PAs are not required to obtain an independent provider number. Rather, they may bill under the supervising physician's provider number. However, if PA services are billed by the physician, the claim must include a U7 modifier. Physicians billing on behalf of a PA will be paid 92 percent of the physician fee schedule except if the physician makes a decision regarding the client's care or treatment on the same date of service as the billable medical visit. In the latter scenario, no modifier is needed, and Medicaid will pay 100 percent of the physician fee schedule. But the physician's medical decisionmaking should be clearly documented in the medical record. The 92

59. Tex. Occ. Code §204.204(a).
60. Tex. Occ. Code §204.207(a).
61. Tex. Occ. Code §204.207(b).
62. Tex. Occ. Code §204.204(a).
63. Tex. Occ. Code §204.204(b).
64. Tex. Occ. Code §204.202(e).
65. Tex. Occ. Code §204.205.
66. Id.
67. See TMB, Online Supervision and Prescriptive Delegation Registration System at www.tmb.state.tx.us/page/renewal-supervisor-online-registration.
68. See Supervision and Prescriptive Delegation Registration System Instructions at www.tmb.state.tx.us/idl/414CA8D5-692E-242E-7F0A-824709DFE8FC.
69. 22 Tex. Admin. Code §185.16.
70. See, e.g., *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants*, (October 2016), pg. 15, Medicare Learning Network, Centers for Medicare & Medicaid Services, Dep't of Health & Hum. Svcs., at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf.

percent payment limit does not apply to laboratory services, x-ray services, or injections provided by a PA.[71] The Texas Medicaid program also requires that services performed by PAs meet certain criteria for coverage. These include criteria relating to scope, consistency with TMB rules, a requirement that the service would be covered by Texas Medicaid if provided by a licensed Texas physician, and a requirement that the service be "reasonable and medically necessary."[72]

In certain settings, a PA's services may be billed "incident to" the services of a physician. It is important to note that the requirements for supervision may differ from supervision requirements under the Medical Practice Act. For example, billing for incident-to services under the Medicare program requires the direct supervision of the physician.[73] Direct supervision under the Medicare program requires, among other things, that the physician is physically present in the office suite and is immediately available to provide assistance and direction.[74] Texas Medicaid does not have policies specifically discussing incident-to billing but abides by Medicare rules in this regard. However, the Medicaid program allows a physician to bill for the services of other providers in specific settings, as noted.[75] Further, since PAs practice under protocols developed by supervising physicians, Texas Medicaid indicates it does not expect many PA services to meet the incident-to billing requirements.

Physicians who use the services of PAs should review the pertinent Medicare and Medicaid requirements carefully, as well as any applicable requirements of other payers. Questions concerning the scope and applicability of these requirements should be addressed by the physician's legal counsel.

Delegation to Medical Assistants Generally

Most MAs are persons who have completed a course of training and, upon graduation, have been given a certificate or diploma declaring them to be a medical assistant. Most MA training programs are conducted by junior colleges and private, proprietary trade schools, so the competency of persons calling themselves MAs may vary widely. Some MAs are persons who have worked for physicians for a long time and have personally adopted that title to identify themselves.

The term "medical assistant" has no real legal significance in Texas. MAs are not licensed, certified, or registered by any agency of the state of Texas, nor are they recognized under federal Medicare or Medicaid laws as a type of "provider." There is no reference to MAs in the MPA or any other Texas statute. Thus, there is no specific legal regulation of MAs.

What can an MA do? With no specific legal regulation of MAs in Texas statute, one has to look to the general delegation clause in the MPA, cited above. The scope of MA "practice" is governed by this general provision, meaning MAs' education and experience are matters the supervising physician must take into consideration when giving them direction. The supervising physician may delegate tasks to an MA when the physician is satisfied the MA is "qualified and properly trained" and the task delegated (1) can be "properly and safely performed," (2) is performed in its customary manner, and (3) is not in violation of any other statute.[76] One additional caveat prohibits the delegate from representing that he or she is authorized to practice medicine.[77]

In addition, MAs have banded together to form the American Association of Medical Assistants, which has a Texas chapter. It has a certification program, which may present evidence of an MA's qualifications. In any event, a physician should review an MA's course curriculum, as well as the MA's qualifications and experience, to satisfy himself or herself that the MA is capable and qualified to safely perform any tasks contemplated.

71. See January 2017 *Texas Medicaid Provider Procedures Manual, Vol. 2, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook*, §10.4.2, at www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf.
72. Id. at §10.2.
73. *Medicare Benefit Policy Manual (Rev. 228, 10-13-16)*, Ch. 15, 60.1, Incident to Physician's Professional Services, at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.
74. Id.
75. See January 2017 *Texas Medicaid Provider Procedures Manual, Vol. 2, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook*, §10.2, at www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf.
76. Tex. Occ. Code §157.001(a)(1).
77. Tex. Occ. Code § 157.001(a)(2).

Billing for Medical Assistants

TMB has adopted no specific rules addressing the ability of physicians to bill for services rendered by an MA. It is probably the case that most insurers regard the MA's work as being part of the overall service rendered by the physician and thus not separately billable.

Medicare payment for services performed by employees, including MAs, does require direct supervision by the physician and must meet all the additional incident-to billing requirements.[78] There must be direct supervision by the physician as an integral part of the physician's personal in-office service, and the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary. Further, the physician must have seen the patient initially and provided subsequent services of a frequency that reflect the physician's active participation in and management of the course of treatment. It is important to note that the incident-to supervision requirements are different if the services are provided outside the office setting. The complete Medicare policy for incident-to services may be found in the online CMS *Medicare Benefit Policy Manual*.[79]

Texas Medicaid abides by Medicare incident-to rules. Additionally, Texas Medicaid specifies that "physician services include those reasonable and medically necessary services ordered and performed by physicians or *under physician supervision* (emphasis added) that are within the scope of practice of their profession as defined by state law."[80] Taken together, it appears services provided by medical assistants may be payable under Texas Medicaid when provided incident to. For additional information, contact Texas Medicaid and Healthcare Partnership or the Medicaid managed care plan(s) with which you contract.[81] Independent billing by MAs is not permitted.

Use of Nonlicensed Physicians in the Medical Setting

TMA often receives questions about the use of nonlicensed physicians in medical settings in Texas. The question most often asked is whether a nonlicensed physician can be employed as a "physician assistant" or "medical assistant." Usually this occurs where the nonlicensed physician is foreign-trained and, for various reasons, is having difficulty obtaining a Texas license. Since a person who would call himself or herself a "physician assistant" must be licensed as such by TMB, employment as a PA is not possible without this licensure. Employment as an MA might be possible under the general delegation clause set out in the beginning of this paper, but there are problems.

Historically, TMB has viewed with disapproval situations involving nonlicensed physicians living in Texas on a permanent basis who provide medical services under delegation of a Texas licensed physician. The concerns expressed by TMB are numerous. Among these is the fact that a person who has an MD or DO degree typically will want to exercise independent medical judgment. Such exercise could easily lead to a violation of the MPA. Further, the board is mindful of its mandate from the Texas Legislature to focus on patient safety and well-being. Therefore, it often views a situation not from the viewpoint of a physician but from the viewpoint of the patient. A person who is not licensed in Texas but who has an MD or DO degree may well be introduced to a patient as "doctor." The patient in all likelihood would assume the person is a licensed physician and correspondingly be misled as to the care he or she is receiving. TMB has disciplined physicians for improper delegation to unlicensed MDs or DOs as evidenced by Case 3 presented earlier in this paper.

Thus, where a Texas licensed physician is employing or using a nonlicensed physician in rendering medical care, TMB would have a heightened review and concern. This behavior, upon appropriate proof, is subject to criminal sanctions ranging from misdemeanors to felonies in addition to any administrative sanctions TMB may bring.

78. CMS, *Medicare Benefit Policy Manual*, Chapter 15 — Covered Medical and Other Health Services (2016) at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.
79. Id.
80. See January 2017 *Texas Medicaid Provider Procedures Manual, Vol. 2, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook*, §9.2, at www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf.
81. Contact the Texas Medicaid and Healthcare Partnership at (800) 925-9126, or visit http://www.tmph.com/.

When using nonlicensed doctors under the delegated authority of a Texas licensed physician, one should review that relationship carefully with an attorney.

General Delegation of Administration of Dangerous Drugs

A physician may delegate the act of administering or providing dangerous drugs[82] in the physician's office, as ordered by the physician and under the physician's supervision.[83] The drugs must be used or required to meet the immediate needs of the physician's patients.[84] The physician may make this delegation to "any qualified and properly trained person acting under the physician's supervision."[85]

Delegation for the administration of dangerous drugs may be through physician's orders, standing medical orders, standing delegation orders, or other orders as defined by TMB.[86]

Delegation of Prescriptive Authority to Physician Assistants and Advanced Practice Registered Nurses

The Medical Practice Act authorizes physicians to delegate to an APRN or PA the act of prescribing or ordering a drug or device.[87] In 2013, the Texas Legislature **replaced the site-based requirements** for the delegation and supervision of prescriptive authority with a framework of delegation and supervision that uses prescriptive authority agreements (PAAs).[88] "Prescriptive authority agreement" is defined as "an agreement entered into by a physician and an advanced practice registered nurse or physician assistant through which the physician delegates to the advanced practice registered nurse or physician assistant the act of prescribing or ordering a drug or device."[89] A key feature of these PAAs is that they can be individually tailored — "customized" — to fit the needs and circumstances of the practice relationship between the physician and the PA or APRN. The physician who is delegating and supervising the APRN or PA must enter into a PAA, which addresses and documents various elements of the relationship and supervision, to delegate prescriptive authority in **non**facility-based practice settings.

A PAA must contain certain elements. Specifically, it must (1) be written, signed, and dated by the parties to the PAA; (2) state the name, address, and all professional license numbers of the parties to the PAA; (3) state the nature of the practice, practice locations, or practice settings; (4) identify the types or categories of drugs or devices that may or may not be prescribed; (5) provide a general plan for consultation and referral; (6) provide a plan for addressing patient emergencies; (7) state the general process for communicating and sharing information about patient care and treatment between the physician and the APRN or PA; (8) designate one or more alternate physicians to provide supervision, if alternate physician supervision is to be used on a temporary basis, and require that the alternate physician participate in the prescriptive authority quality assurance and improvement plan; and (9) describe a prescriptive authority quality assurance and improvement plan, specifying methods for documenting the implementation of the plan (including chart review and periodic face-to-face meetings).[90] There are requirements applicable to the frequency, documentation, and content of the periodic face-to-face meetings.[91]

In the delegation of prescriptive authority, a physician is limited to no more than seven combined APRNs or PAs or the full-time equivalent of seven combined APRNs or PAs.[92] This limit does not apply to a PAA if it is being exercised in a

82. "Dangerous drug" has the meaning assigned to that term by §483.001 of the Texas Health and Safety Code. Tex. Occ. Code §157.051(3).
83. Tex. Occ. Code §157.002(b).
84. Id.
85. Id.
86. Tex. Occ. Code §157.002(e).
87. Tex. Occ. Code Ch. 157, Subch. B.
88. See Tex. SB 406, 83rd Leg., R.S (2013).
89. Tex. Occ. Code §157.051(14).
90. Tex. Occ. Code §157.0512(e).
91. Tex. Occ. Code §157.0512(f).
92. Tex. Occ. Code §157.0512(c).

practice serving a medically underserved population, or a facility-based practice in a hospital under certain conditions.[93] The term "practice serving a medically underserved population" is defined in statute.[94]

Furthermore, there are requirements applicable to the use of a PAA in a facility-based practice; these should be reviewed carefully.[95] One of the requirements states that "[p]hysician supervision of the prescribing or ordering of a drug or device must conform to what a reasonable, prudent physician would find consistent with sound medical judgment but may vary with the education and experience of the particular advanced practice registered nurse or physician assistant. A physician shall provide continuous supervision, but the constant physical presence of the physician is not required."[96]

The MPA also requires the physician and the APRN or PA who are parties to the PAA to retain a copy of the PAA until the second anniversary of the date the agreement is terminated.[97] TMB is authorized to conduct an inspection or audit of the records or activities related to the implementation of the PAA.[98] After the PAA is finalized, the parties to the PAA must review and again sign and date it at least annually.[99] There are other statutory provisions relating to the use and contents of a PAA.[100] One of these is a requirement, in the case of an APRN acting under a PAA, that the Texas Board of Nursing approve the APRN's authority to prescribe or order a drug or device.[101]

Physicians who enter into PAAs with APRNs or PAs must register with TMB within 30 days of signing the PAA.[102] The following information must be registered: (1) the name and license number of the APRN or PA to whom the delegation has been made, (2) the date on which the PAA was executed, (3) the address(es) at which the APRN or PA will be prescribing under the PAA, and (4) whether the prescriptive authority being exercised under the PAA is in a practice serving a medically underserved population.[103]

The question arises: What is the difference between a PAA and a protocol? TMB's rules define a protocol as "written authorization delegating authority to initiate medical aspects of patient care, including delegation of the act of prescribing or ordering a drug or device at a facility-based practice."[104] Note that this definition further states that "[t]he term protocols is separate and distinct from prescriptive authority agreements as defined under" the MPA and related rules.[105] However, PAAs "may reference or include the terms of a protocol(s)."[106] The rules contain the following additional requirements for protocols: "The protocols must be agreed upon and signed by the physician, the physician assistant and/or advanced practice registered nurse, reviewed and signed at least annually, and maintained on site."[107] Finally, there are requirements for these protocols regarding types of drugs permitted or prohibited, limitations on dosages or refills, and patient instructions for follow-up.[108] The protocols need not describe the *exact* steps that an APRN or PA must take regarding each specific disease, condition, or symptom.[109] It may state the types or categories of medications that may or may not be prescribed.[110]

93. Tex. Occ. Code §157.0512(d).
94. Tex. Occ. Code §157.051(11).
95. See Tex. Occ. Code §157.054.
96. See Tex. Occ. Code §157.054(c).
97. Tex. Occ. Code §157.0512(j).
98. Tex. Occ. Code §157.0514.
99. Tex. Occ. Code §157.0512(m).
100. See Tex. Occ. Code §157.0512.
101. Tex. Occ. Code §157.0512(b)(1).
102. 22 Tex. Admin. Code §193.10(b).
103. 22 Tex. Admin. Code §193.10(b)(1)-(4).
104. 22 Tex. Admin. Code §193.2(18).
105. Id.
106. Id.
107. Id.
108. Id.
109. Id. Also, see Tex. Occ. Code §157.055(1).
110. Tex. Occ. Code §157.055(2).

The MPA provides qualified immunity for the delegating physician. Contained within Subchapter B (regarding delegation to APRNs and PAs) of Chapter 157 of the MPA is the following statement: "Unless the physician has reason to believe the physician assistant or advanced practice registered nurse lacked the competency to perform the act, a physician is not liable for an act of a physician assistant or advanced practice registered nurse solely because the physician signed a standing medical order, a standing delegation order, or another order or protocol, or entered into a prescriptive authority agreement, authorizing the physician assistant or advanced practice registered nurse to administer, provide, prescribe, or order a drug or device."[111]

Prescriptive Authority for Controlled Substances

The Texas Controlled Substances Act defines a "controlled substance" as a substance, including a drug, an adulterant, and a dilutant, listed in Schedules I-V or Penalty Group 1, 1-A, 2, 2-A, 3, or 4.[112] As a reminder, note that, generally, the lower the number of a drug as a scheduled controlled substance, the greater the drug's potential for abuse or dependence. For example, a Schedule II drug (such as a hydrocodone combination product) is seen as having greater potential for abuse or dependence than a Schedule III drug (such as an anabolic steroid). The schedule of a controlled substance for which prescriptive authority is delegated determines what requirements a physician must meet to delegate the authority to prescribe the controlled substance to an APRN or PA.[113]

A physician may delegate prescriptive authority for **Schedule II** controlled substances only (1) in a hospital-based facility practice (and only for a patient with an intended length of stay of 24 hours or greater, or for a patient receiving services in the hospital's emergency department), or (2) as part of a treatment plan for a person who has executed a written certification of a terminal illness, has elected to receive hospice care, and is receiving hospice treatment from a qualified provider.[114] If a physician delegates prescriptive authority for Schedule II controlled substances in a hospital-based facility practice, the delegation must be in accordance with policies approved by the hospital's medical staff or a committee of the hospital's medical staff as provided by the hospital bylaws to ensure patient safety.[115] TMB has addressed the question whether Schedule II authority can be delegated in a freestanding emergency department that is affiliated with a hospital.[116] According to TMB, the answer is: "No. A free standing emergency department is not located within the hospital and does not qualify as an eligible site for delegation of schedule II authority. The physician may only delegate authority to prescribe controlled substances in schedules III through V in this setting. Authority to prescribe dangerous drugs, nonprescription drugs and devices may be delegated in any setting."[117]

A physician may delegate prescriptive authority for **Schedules III, IV, and V** controlled substances only if the following requirements are met: (1) the prescription, including any refills, is for a period not to exceed 90 days; (2) a refill is authorized only after the APRN or PA consults with the delegating physician, and the consultation is noted in the patient's chart; and (3) as to a prescription for a child younger than 2 years of age, the prescription is made after the APRN or PA consults with the delegating physician and the consultation is noted in the patient's chart.[118]

Delegation Regarding Certain Obstetrical Services

A physician may delegate the act of administering or providing controlled substances during intrapartum and immediate postpartum care.[119] This delegation may be only for a term not to exceed 48 hours.[120] The delegation may be to a PA offering obstetrical services and certified by the board as specializing in obstetrics or to an APRN recognized by BON as a nurse midwife. This delegation must be under a physician's order, medical order, standing delegation order, or protocol that requires adequate and documented availability for access to medical care.[121]

111. Tex. Occ. Code §157.060.
112. Tex. Health and Safety Code §481.002(5).
113. Tex. Occ. Code §157.0511(b), (b-1).
114. Tex. Occ. Code §157.0511(b-1); 22 Tex. Admin. Code §193.6(c).
115. Tex. Occ. Code §157.0511(b-1)(1); 22 Tex. Admin. Code §193.6(c).
116. FAQs for Licensees, Texas Medical Board, at www.tmb.state.tx.us/page/laws-GC-FAQs-Licensees.
117. Id.
118. Tex. Occ. Code §157.0511(b)(2)-(4); 22 Tex. Admin. Code §193.6(b).
119. Tex. Occ. Code §157.059(b).
120. Id.
121. 22 Tex. Admin. Code §193.14(b).

The authority of a physician to delegate in the obstetrical-services context is limited to seven nurse midwives or PAs (or their full-time equivalents), and to the designated facility at which the nurse midwife or PA provides care.[122] There are labeling requirements for the container supplying the controlled substance to the patient.[123] There also are restrictions on the delegation: The physician may not delegate the use of a prescription sticker or an official prescription form, nor may the physician delegate the authority to issue an electronic prescription.[124] Furthermore, the physician's orders or delegation orders must provide for reporting or monitoring of a patient's progress and provision of controlled substances by the nurse midwife or PA.[125]

Standing Delegation Orders

TMB allows for standing delegation orders and provides specific examples of what may be delegated under such standing orders.[126] However, this rule does not apply to patient care delivered by PAs or APRNs acting under a prescriptive authority agreement. According to the TMB delegation rules, "standing delegation orders are separate and distinct from prescriptive authority agreements as defined in this chapter."[127] The rules provide further that the limitations on the physician's use of standing delegation orders "shall not apply to patient care delivered by physician assistants or advanced practice registered nurses, as authorized" under the MPA and rules relating to prescriptive authority.[128]

> Providing the authorizing physician is satisfied as to the ability and competence of those for whom the physician is assuming responsibility, and with due regard for the safety of the patient and in keeping with sound medical practice, standing delegation orders may be authorized for the performance of acts and duties **which do not require the exercise of independent medical judgment.**"(Emphasis added.)[129]

For your information, the complete text of Rule 193.4 is as follows:

> Providing the authorizing physician is satisfied as to the ability and competence of those for whom the physician is assuming responsibility, and with due regard for the safety of the patient and in keeping with sound medical practice, standing delegation orders may be authorized for the performance of acts and duties which do not require the exercise of independent medical judgment. Limitations on the physician's use of standing delegation orders which are stated in this section shall not apply to patient care delivered by physician assistants or advanced practice nurses, as authorized by the §§157.051-157.060 of the Act [i.e., MPA] or §§193.6-193.14 of this title (relating to Delegation of Prescribing and Ordering Drugs and Devices; Prescriptive Authority Agreements Generally; Prescriptive Authority Agreements: Minimum Requirements; Delegation of Prescriptive Authority at a Facility-Based Practice Site; Registration of Delegation and Prescriptive Authority Agreements; Prescription Forms; Prescriptive Authority Agreement Inspections; Delegation to Certified Registered Nurse Anesthetists; and Delegation Related to Obstetrical Services). When care is delivered under other circumstances, standing delegation orders may include authority to undertake the following as listed in paragraphs (1)-(8) of this section:

122. Tex. Occ. Code §157.059(f).
123. Tex. Occ. Code §157.059(g).
124. Tex. Occ. Code §157.059(c).
125. 22 Tex. Admin. Code §193.14(c).
126. See 22 Tex. Admin. Code §193.4.
127. 22 Tex. Admin. Code §193.2(19).
128. 22 Tex. Admin. Code §193.4.
129. 22 Tex. Admin. Code §193.4.

(1) the taking of personal and medical history;
(2) the performance of appropriate physical examination and the recording of physical findings;
(3) the ordering of tests appropriate to the services provided under such orders, such as tuberculin tests, skin tests, VD tests, VDRL tests, gram stains, pap smears, and serological tests;
(4) the administration or providing of drugs ordered by direct personal or voice communication by the authorizing physician who shall assume responsibility for the patient's welfare, providing such administration or provision of drugs shall be in compliance with other state or federal laws and providing further that pre-signed prescriptions shall be utilized by the authorizing physician only under the following conditions shown in subparagraphs (A)-(D) of this paragraph.

(A) The prescription shall be prepared in full compliance with the Texas Health and Safety Code, §483.001(13) except for the inclusion of the name of the patient and the date of issuance.
(B) The prescription shall be for one of the following classes or types of drugs:

(i) oral contraceptives;
(ii) diaphragms and contraceptive creams and jellies;
(iii) topical anti-infectives for vaginal use;
(iv) oral anti-parasitic drugs for treatment of pinworms;
(v) topical anti-parasitic drugs; or
(vi) antibiotic drugs for treatment of venereal disease.

(C) The prescriptions may not be issued for any controlled substance.
(D) The providing of the drugs shall be in compliance with the Texas Pharmacy Act and rules adopted by the Texas State Board of Pharmacy.

(5) the administration of immunization vaccines providing the recipient is free of any condition for which the immunization is contraindicated;
(6) the providing of information regarding hygiene and the administration or providing of medications for health problems resulting from a lack of hygiene, including the institution of treatment for conditions such as scabies, ringworm, pinworm, head lice, diaper rash and other minor skin disorders, provided the administration or providing of drugs adheres to paragraph (4) of this section;
(7) the provision of services and the administration of therapy by public health departments as officially prescribed by the Department of State Health Services for the prevention or treatment of specific communicable diseases or health conditions for which the Department of State Health Services is responsible for control under state law;
(8) the issuance of a nonprescription drug for the symptomatic relief of minor illnesses provided that such medications are packaged and labeled in compliance with state and federal laws and regulations.[130]

Again, a physician may not delegate an act authorizing the exercise of independent medical judgment. Any physician authorizing standing delegation orders or standing medical orders that authorize the exercise of independent medical judgment or treatment shall be subject to having his or her license to practice medicine in Texas revoked or suspended.[131]

130. 22 Tex. Admin. Code §193.4.
131. 22 Tex. Admin. Code §193.5(c).

Physician Assistants and Mental Health Facilities

As a general rule, a person may not be admitted for voluntary inpatient or outpatient mental health services unless:

(1) a proper request for voluntary inpatient or outpatient services is filed, and
(2) the facility administrator or the administrator's authorized, qualified designee determines:

(a) from a preliminary examination that the person has symptoms of mental illness and will benefit from the inpatient or outpatient services;
(b) that the person has been informed of the person's rights as a voluntary patient; and
(c) that the admission was voluntarily agreed to by the person if 16 years of age or older, or by the person's parent, managing conservator or guardian, if the person is younger than 18 years of age.[132]

The question has been raised: Can a PA perform the evaluation and/or sign the admitting order as a "delegated act?"

A voluntary patient may not be accepted formally for treatment in a treatment facility unless the facility has a physician's order admitting the prospective patient and the order is signed by the physician.[133]

In 2003, the Texas attorney general's office expanded on the issue. The attorney general opined that a physician must personally perform the examination required for admission and may not delegate the duty to a nonphysician pursuant to the MPA.[134]

Thus, to formally accept and admit a patient, a PA may not perform the psychiatric evaluation and/or medical examination required for admission, nor may a PA execute the actual written order for hospital admission. A physician must perform both tasks. However, the evaluation and examination may be performed in person or through telecommunication.[135]

Physical Therapy in a Physician's Office

An often-asked question concerns a physician's employees performing "physical therapy" (PT) within the confines of a physician's office, and whether a physician (or the employee) who does so violates Chapter 453 of the Occupations Code (formerly, the Physical Therapy Licensure Act). The Texas statute prohibits any person from practicing or representing himself or herself as being able to practice physical therapy unless licensed by the Texas Board of Physical Therapy Examiners.[136] However, the statute also specifically states that this rule "does not restrict the holder of a license issued by another state agency from performing health care services within the scope of the applicable licensing act."[137]

Physicians, who are licensed by TMB, fit this exception. The Texas attorney general's office reached essentially the same opinion in 1986. The attorney general opined that a doctor may perform medical acts that come within the definition of physical therapy.[138] Further, the attorney general opined that if the requirements of the above-cited provision of the Medical Practice Act are met, then a person who is not a licensed physical therapist, but who is acting under a physician's supervision, may perform medical acts that come within the definition of physical therapy.[139]

132. Tex. Health and Safety Code Ann. §572.002.
133. Tex. Health and Safety Code Ann. §572.0025(f)(1).
134. Op. Tex. Att'y Gen. No. GA-0066 (2003), citing Tex. Health and Safety Code §572.0025(f)(1).
135. Tex. Health and Safety Code Ann. §572.0025(f)(1)(A).
136. Tex. Occ. Code §453.201(a).
137. Tex. Occ. Code §453.004(a).
138. Op. Tex. Att'y Gen. No. JM-421 (1986).
139. Id.

However, the licensing statute for physical therapists has changed since that time. It does not apply to physicians *as long as* physicians do not represent (e.g., advertise) to others that they are physical therapists or that they perform "physical therapy."[140] It is also a violation of the PT licensing statute to advertise the ability to perform physical therapy unless the person actually providing the physical therapy is licensed as a physical therapist.[141] In addition, the PT board provides licenses to and regulates "physical therapy facilities" (any place where the practice of physical therapy takes place).[142] It is perhaps for this reason that some physicians have "physical medicine and rehabilitation clinics" and other permutations that do not advertise "physical therapy." A physical therapist, employed by a physician, was disciplined by the PT board because of failure to comply with PT board rules regarding charting, patient assessment, and other matters. The Executive Council of Physical Therapy and Occupational Therapy Examiners, in an FAQ regarding PTs and PT assistants in a physical medicine setting, states the following:

> The services a PT may provide, and the rules under which they are provided, are the same regardless of setting. The presence of a physician, or a licensee of any board besides this one, does not effect *(sic.)* the requirements for the provision of physical therapy services. If physical therapy is being provided, the facility must be registered if it is not exempt (See [22 Tex. Admin. Code] §347.6, Exemptions to Registration) and a PT or PTA [i.e., a physical therapist assistant] must be onsite when treatment occurs. If a PTA is providing services, they must work from a PT Plan of Care developed by a PT, and must be supervised by a PT.[143]

Physicians who employ licensed physical therapists should consult legal counsel regarding these matters.

Delegation of Administration of Anesthesia

Although the statutory provisions regarding the delegation of the administration of anesthesia are contained in the same subchapter (Subchapter B) of Chapter 157 of the MPA that addresses PAAs, there is no limit to the number of certified registered nurse anesthetists to whom a physician may delegate the ordering of drugs or devices in a licensed hospital or an ambulatory surgical center (ASC).[144] Indeed, BON does not require that CRNAs hold prescriptive authority to administer anesthesia or anesthesia-related services, nor are they required to register with TMB.[145] The delegation is limited, however, to the hospital or ASC in which the CRNA is credentialed to practice.[146] A physician in a licensed hospital or ASC may delegate to a CRNA the "ordering of drugs and devices necessary" to administer an anesthesia or anesthesia-related service *ordered by a physician*.[147] The physician's order for anesthesia or anesthesia-related services does not have to be drug-, dose-, or administration-technique specific.[148] The CRNA may select, obtain, and administer the drugs and medical devices necessary to accomplish the physician's order pursuant to (1) the physician's order, *and* (2) facility policies or medical staff bylaws.[149]

In opinion JC-0117, the Texas attorney general held that the Board of Nurse Examiners (now BON) may regulate the selection and administration of anesthesia and the maintenance of anesthetized patients by CRNAs where anesthesia-related tasks have been delegated by a physician.[150] BON has adopted rules addressing the provision of anesthesia services by CRNAs in hospitals and ASCs,[151] as well as in outpatient settings.[152] The Medical Practice Act does not require that a physician directly supervise the CRNA's selection and administration of the anesthesia.[153] Rather, the extent of physician involvement is left to the physician's professional judgment in light of other federal and state laws, facility policies, medical staff bylaws, and ethical standards.[154]

140. Tex. Occ. Code §453.004(a)(1).
141. Tex. Occ. Code §453.201.
142. Tex. Occ. Code §453.213.
143. See PT Practice FAQs — PT Scope of Practice at www.ptot.texas.gov/faq.
144. Tex. Occ. Code §157.058.
145. See Frequently Asked Questions — Advanced Practice Registered Nurse," Texas Board of Nursing, at www.bon.texas.gov/faq_practice_aprn.asp.
146. Tex. Occ. Code §157.058(a).
147. Id.; 22 Tex. Admin. Code §193.6(k)(1).
148. Tex. Occ. Code §157.058(b).
149. Tex. Occ. Code §157.058(c).
150. Op. Tex. Att'y Gen. No. JC-0117 (1999).
151. 22 Tex. Admin. Code §221.15.
152. 22 Tex. Admin. Code §221.16.
153. Tex. Occ. Code §157.058.
154. Op. Tex. Att'y Gen. No. JC-0117 (1999).

Pronouncement of Death

An RN or PA may determine and pronounce a person dead in situations, other than those involving artificial means of support, if permitted by written policies of a licensed health care facility, institution, or entity providing services to that person.[155]

TMB rules allow physicians to receive information from Texas licensed vocational nurses through electronic communication, such as telephone, fax, or email, for the purpose of making a pronouncement of death.[156] To make a pronouncement of death through electronic communication, a physician must receive, at a minimum, information regarding absence, for a minimum of 60 seconds, of: palpable pulse, discernible blood pressure, respiration, and heartbeat.[157] The rules also provide that the physician may require other information to make the pronouncement.[158] If a physician makes a pronouncement of death based on this information received through electronic communication, the physician retains responsibility for all acts related to this pronouncement.[159]

Responsibility for Delegated Acts

In any event, regardless of whether one contemplates delegating acts to nonphysicians under either the general delegation clause or one of the more context-specific delegation clauses, the general principle remains that a physician is legally responsible for the acts delegated. Furthermore, "[a]ny physician authorizing standing delegation orders or standing medical orders which authorize the exercise of independent medical judgment or treatment shall be subject to having his or her license to practice medicine in the State of Texas revoked or suspended."[160] A physician commits unprofessional or dishonorable conduct if the physician fails to supervise adequately the activities of those acting under the supervision of the physician,[161] or if the physician delegates professional medical responsibility or acts to a person if the delegating physician knows or has reason to know the person is not qualified by training, experience, or licensure to perform the responsibility or acts.[162]

A physician is not liable for an act of a PA or an APRN, however, *solely* on the basis of having signed a standing medical order, a standing delegation order, or other order or protocol, or having entered into a PAA, authorizing a PA or APRN to administer, provide, prescribe, or order a drug or device, *unless* the physician has reason to know such persons lacks the competency to perform the act.[163] Furthermore, a physician who issues a standing delegation order to a licensed midwife is not liable in connection with an act performed under that standing delegation order if the midwife provides proof of licensure before the order is issued.[164]

155. Tex. Health and Safety Code §671.001(d).
156. 22 Tex. Admin. Code §19318(a).
157. 22 Tex. Admin. Code §193.18(c).
158. Id.
159. 22 Tex. Admin. Code §193.18(d).
160. 22 Tex. Admin. Code §193.5(c).
161. Tex. Occ. Code §164.053(a)(8).
162. Tex. Occ. Code §164.053(a)(9).
163. Tex. Occ. Code §157.060.
164. Tex. Occ. Code §157.004(c).