Medicare rules allow broader use of nonphysicians

Hospitals now have the flexibility under federal law to include practitioners other than physicians on their medical staffs. That’s one provision of Medicare’s revised Conditions of Participation (COP) for hospitals and critical access hospitals, which take effect July 16, 2012.

The revision is the first major overhaul of the COPs in over 25 years.

Among other changes, hospitals will have the option of using either stand-alone nursing care plans or single interdisciplinary care plans by nursing and other disciplines. The government also put its stamp of approval on use of standing orders, provided certain conditions are met.

In addition, the COPs make permanent the requirement that all orders, including verbal orders, must be dated, timed, and authenticated.

The government says its intent in revising the COPs is to “reduce outmoded or unnecessarily burdensome rules.”

Medical staff broadened

The final COPs take a more straightforward approach to the medical staff issue than the proposed COPs did.

In the final version, hospitals have flexibility to include other practitioners, such as advanced practice RNs (APRNs) and physician assistants (PAs), as candidates for the medical staff, with privileges to practice in accord with state law. All would function under the medical staff rules.

The medical staff must examine the credentials of all eligible candidates (as defined by the hospital’s governing body) and then make recommendations for privileges.

The Centers for Medicare and Medicaid Services (CMS) says hospitals that choose this option might see “significant savings” because these other practitioners will enable physicians to focus on more complex patients.

Change from proposal

The proposed COPs had said hospitals could grant privileges both to physicians and nonphysicians, even if they were not appointed to the medical staff, though they would have been subject to medical staff requirements.

CMS says the majority of comments to the proposed COPs published in October 2011 supported broadening the medical staff. Physician groups mostly disagreed, while nonphysicians generally expressed support but urged CMS to go further.

A “significant number of comments” adamantly opposed allowing practitioners to have privileges without being members of the medical staff, expressing concern about the lack of medical staff oversight, the agency notes.

The final version essentially says hospitals can broaden the types of practitioners they include on the medical staff and grant them privileges, within state law.

But CMS declined to go further by requiring hospitals to guarantee that nonphy-
sician practitioners be represented on the medical staff and to give them specific rights. It also declined to be more prescriptive about credentialing and privileging.

Here are highlights of other revisions.

**Single governing board**
One governing board is allowed to oversee multiple hospitals in a system.

**Medical staff leadership**
Podiatrists can now be leaders of the medical staff.

**Self-administered medications**
Hospitals may have an optional program for patients and/or their support persons to self-administer appropriate medications. The program must:
- address the safe and accurate administration of specified medications
- ensure a process for medication security
- address training and supervision for self-administration
- document self-administration of medications.

**Blood, IV transfusions**
The requirement for nonphysicians to have special training in administering blood transfusions and IV medications is eliminated. Those who perform those functions must do so in accord with state law and medical staff policies and procedures.

**Drug, biologic orders**
Drugs and biologicals may be prepared and given on the orders of practitioners other than physicians in accord with hospital policy and state law. The orders may also be documented and signed by practitioners other than physicians, also in accord with policy and state law.

**Standing orders**
The COPs give hospitals flexibility to use standing orders with the requirement that medical staff, nursing, and pharmacy approve written and electronic standing orders, order sets, and protocols. Orders and protocols must be based on nationally recognized and evidence-based guidelines and recommendations.

**Verbal orders**
The requirement for authentication of verbal orders within 48 hours is eliminated, deferring to state law regarding time frames.

**Authentication of orders**
The new COPs make permanent the temporary requirement that all orders, including verbal orders, must be dated, timed, and authenticated. This must be done by either the ordering practitioner or another practitioner responsible for the care of the patient and authorized to write orders by hospital policy in accord with state law.

**Infection control log**
The outmoded requirement to keep an infection control log is eliminated. Hospitals are already required to monitor infections and use a variety of surveillance systems to do so.
Transplant verification process
The new COPs eliminate the requirement for an organ recovery team working for the transplant center to conduct a “blood type and other vital data verification” before recovery when the recipient is known. CMS says this is duplicative because verification is completed at 2 other times in the transplant process.

Critical access hospitals
Among other changes, the revised COPs eliminate the requirement that critical access hospitals must give certain services directly, instead allowing them to provide such services under arrangement. This includes diagnostic and therapeutic services, laboratory, radiology, and emergency procedures.

The COPs clarify that surgical services is an optional service for critical access hospitals, which is already understood.

The revised COPs (CMS-3244-F) were published in the May 16, 2012 Federal Register and are available at www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/CMS-3244-F.pdf