

Advanced Practice Professionals: Governance Structures and Practice Considerations



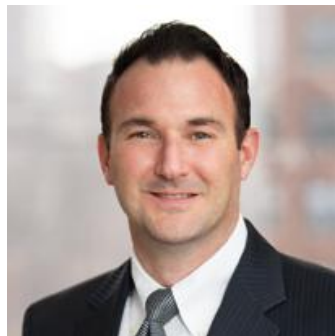
MEDICAL STAFF SEMINAR 2025

Empowering Medical Staff. Enabling Excellence.

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Agenda

- Trends
- Scope of Practice
- Credentialing
- Privileging
- Reimbursement and Compliance



**MEDICAL STAFF
SEMINAR 2025**

Advanced Practice Professionals, aka...

- NPs, PAs, Midwives, CRNAs are often referred to as any of the following: Allied Health Professionals, Mid-Level Providers, Physician Extenders ...
- **What labels do your organizations use/prefer?**

Trends – Data

- There are more than 385,000 nurse practitioners (NPs) licensed in the U.S.
- An estimated 39,000 new NPs completed their academic programs in 2022
- 83.2% of full-time NPs are seeing Medicare patients and 81.9% are seeing Medicaid patients
- 88.0% of NPs are certified in an area of primary care
 - This is shifting to specialties/subspecialties
- 45% of NPs hold hospital privileges
- NPs hold prescriptive privileges in all 50 states and D.C.
- Malpractice rates remain low; less than 2% have been named as primary defendant in a malpractice case

Trends – Data

- Physician Assistants
 - 2017 115,500 certified PAs
 - 2009 75,000 certified PAs
 - 2014 102,000 certified PAs
 - 2020 148,560 PAs in active practice.
 - 2035 Predication - 214,000
 - Top 5 states by number: New York, California, Texas, Pennsylvania, Florida

Considerations for Medical Staff “Membership”

- Trends
- Cultural Reluctance
- Medicare Conditions of Participation:

§ 482.22 Condition of participation: Medical staff.

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

- (a) *Standard: Eligibility and process for appointment to medical staff.* The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.

Considerations for Medical Staff “Membership”

- Medicare Conditions of Participation (State Operations Manual):

For Information Only – Not Required/ Not to be Cited

CMS expects that all practitioners granted privileges are also appointed as members of the medical staff. However, if State law limits the composition of the hospital’s medical staff to certain categories of practitioners, e.g., only physician practitioners, there is nothing in the CoPs that prohibits hospitals and their medical staffs from establishing certain practice privileges for those specific categories of non-physician practitioners excluded from medical staff membership under State law, or from granting those privileges to individual practitioners in those categories, as long as such privileges are recommended by the medical staff, approved by the governing body, and in accordance with State law. (79 FR 27114 - 27115, May 12, 2014)

Considerations for Medical Staff “Membership”

- Medical Staff Membership can be tailored to category
 - Qualifications can be specified
 - Example: Inpatient presence
 - Prerogatives can be specified
 - Example: Right to attend meetings and Serve on Committees
- State Law Considerations and Limitations
 - Example: Pennsylvania

Medical Staff Governance Structures

- Medical Executive Committee:

- (b) *Standard: Medical staff organization and accountability.* The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.
 - (1) The medical staff must be organized in a manner approved by the governing body.
 - (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.

Medical Staff Governance Structures

- Other considerations:
 - Scope of Practice (Practical and Cultural Considerations)
 - Accreditation Requirements
 - Example: Joint Commission – Department Chairs:

Qualifications:

- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process

Roles and responsibilities:

- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department

Medical Staff Governance Structures

- **How do you incorporate APPs into your governance structures?**
- **What is working well? What is not?**

Medical Staff Governance Structures

- How do you incorporate APPs into your governance structures?
- What is working well? What is not?
- **What structures does your organization use to complete FPPE and OPPE in relation to APPs?**

Considerations for Clinical Privileges

- **Per the State Operations Manual:**

- Non-physician practitioners**

- Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The corresponding regulation at 42 CFR 482.22(a) allows hospitals and their medical staffs to take advantage of the expertise and skills of all types of practitioners who practice at the hospital when making decisions concerning medical staff privileges and membership. Granting medical staff privileges and membership to non-physician practitioners is an option available to the governing body; **it is not a requirement.**

- **In addition to NPs, PAs, AAs, Clinical Nurse Specialists, CRNAs, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Registered Dieticians:**

- Other types of licensed healthcare professionals have a more limited scope of practice and usually are not eligible for hospital medical staff privileges, **unless their permitted scope of practice in their State makes them more comparable to the above listed types of non-physician practitioners.** Some examples of types of such licensed healthcare professionals who might be eligible for medical staff privileges, depending on State law and medical staff bylaws, rules and regulations include, but are not limited to:

- Physical Therapist (as defined at §410.60 and §484.4);
 - Occupational Therapist (as defined at §410.59 and §484.4); and
 - Speech Language Therapist (as defined at §410.62 and §484.4).

Clinical Privileges – Admitting Patients

- Per the State Operations Manual:

A-0066

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

[...the governing body must ensure that the following requirements are met:]

§482.12(c)(2) (continued)

If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy.

Interpretive Guidelines §482.12(c)(2)

CMS hospital regulations do permit licensed practitioners (e.g., nurse practitioners,

midwives, etc), as allowed by the State, to admit patients to a hospital, and CMS does not require these practitioners be employed by a MD/DO. **However, CMS regulations do require that Medicare and Medicaid patients admitted by these practitioners be under the care of an MD/DO. Evidence of being under the care of an MD/DO must be in the patient's medical record.** If a hospital allows these practitioners to admit and care for patients, as allowed by State law, the governing body and medical staff would have to establish policies and bylaws to ensure that the requirements of 42 CFR §482 are met.

Clinical Privileges – H&Ps

- **Per the State Operations Manual:**

The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

Section 1861(r) defines a physician as a:

- Doctor of medicine or osteopathy;
- Doctor of dental surgery or of dental medicine;
- Doctor of podiatric medicine;
- Doctor of optometry; or a
- Chiropractor.

In all cases the practitioners included in the definition of a physician must be legally authorized to practice within the State where the hospital is located and providing services within their authorized scope of practice. In addition, in certain instances the Social Security Act attaches further limitations as to the type of hospital services for which a practitioner is considered to be a “physician.” For example, a chiropractor is considered a physician only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation).

Other qualified licensed individuals are those licensed practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H&P and who are also formally authorized by the hospital to conduct an H&P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

More than one qualified practitioner can participate in performing, documenting, and authenticating an H&P for a single patient. When performance, documentation, and authentication are split among qualified practitioners, the practitioner who authenticates the H&P will be held responsible for its contents. (71 FR 68675)

Medical Staff Governance Structures

- **Does your organization permit APPs to admit patients?**
- **How do you ensure patients remain “under the care of” a MD or DO?**

Medical Staff Governance Structures

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- **Does your organization permit APPs to perform H&Ps? Any limitations?**

Medical Staff Governance Structures

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- How do you ensure patients remain “under the care of” a MD or DO?
- Does your organization permit APPs to perform H&Ps? Any limitations?
- **Does your organization permit APPs to round on patients? Do you require a physician’s co-signature?**

EMTALA

- Call Coverage is a “physician” obligation; accordingly, physicians must be identified on the call schedule
 - Limited exception for critical access hospitals in relation to NPs/PAs to respond

- **§ 485.618 Condition of participation: Emergency services.**

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

- (d) *Standard: Personnel.*

- (1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

EMTALA

- **In acute care setting, may utilize non-practitioners to assist with call obligation. Per State Operations Manual (Tag A-2404):**

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, **i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual.** This determination should be based on the individual's medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the **designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance.** Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, **then the on-call physician is required under EMTALA to appear** in person. Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

Questions?



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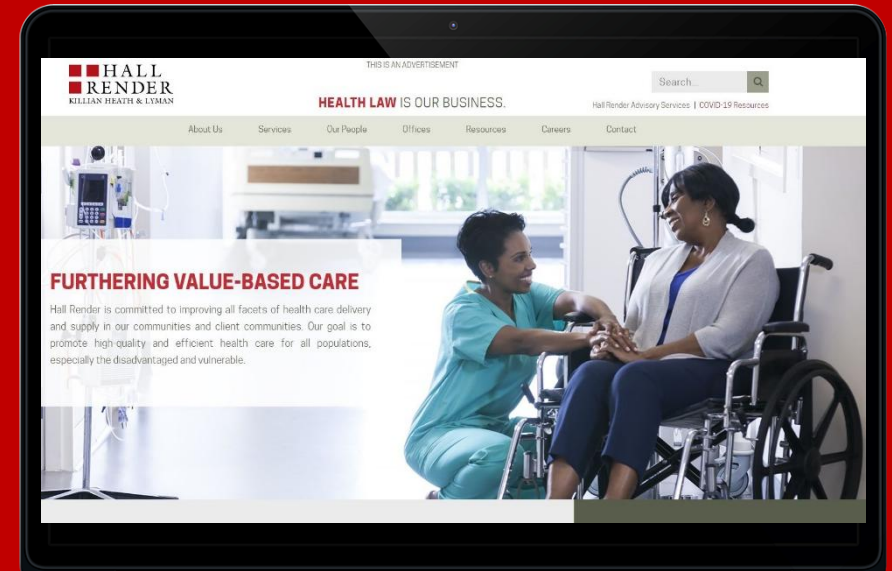
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