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Admitting Privileges in Hospitals: New Idaho Law

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A new Idaho statute confirms that physician assistants and advanced practice nurses may admit patients to hospitals and other healthcare facilities if allowed by the facility's bylaws.

Background. Historically, admitting privileges were usually reserved to physicians; however, such a limitation (whether real or imagined) seems to have become somewhat outdated given the expanding role of physician assistants and advanced practice nurses, whose licensure allows them to perform services traditionally performed by physicians. Many hospitals increasingly rely on midlevel practitioners to care for patients, especially in rural areas where physicians are in short supply or decline to participate in call coverage. The new statute resolves regulatory ambiguity concerning the authority of midlevels to admit patients.

The New Law. Effective July, 1, 2017, Idaho Code § 39-1396 provides:

1. A hospital or facility may grant to physicians, physician assistants and advanced practice nurses the privilege to admit patients to such hospital or facility; provided however, that admitting privileges may be granted only if the privileges are:
    a. Recommended by the medical staff at the hospital or facility;
    b. Approved by the governing board of the hospital or facility; and
    c. Within the scope of practice conferred by the license of the physician, physician assistant or advanced practice nurse.
2. A hospital or facility shall specify in its bylaws the process by which its governing body and medical staff oversee those practitioners granted admitting privileges. Such oversight shall include, but is not limited to, credentialing and competency review.

The new statute is consistent with I.C. § 39-1395, which contemplates that podiatrists may admit patients. It is also consistent with Medicare conditions of participation, which generally allow midlevel practitioners to admit patients to the extent allowed by applicable state law. *See*, *e.g.*, 42 CFR §§ 482.12(c) and 485.631(b)-(c).

Physician Oversight. Although I.C. § 39-1396 will allow midlevels to admit patients, hospital licensing regulations still require that hospital bylaws “specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine.” IDAPA 16.03.14.200.01.h.; *see also* I.C. § 39-1395 (“A member of the medical staff licensed pursuant to chapter 18, title 54, Idaho Code, shall have responsibility for the overall

medical care of the patient while in the hospital."). According to the Idaho Bureau of Facility Standards, this means that there must be evidence that a physician was involved with the patient's care during their hospital stay. This may create problems for small or rural facilities that often staff their emergency department or other services with midlevel practitioners. It is not entirely clear how involved the physician must be in such services to satisfy Bureau surveyors.

The Idaho regulation that requires physician involvement does not distinguish between inpatient and outpatient services; however, the regulation governing hospital outpatient services only requires that "the outpatient service shall be under the overall medical direction of a physician whose authority and responsibilities are defined in writing and approved by the governing body." IDAPA 16.03.14.460.01. This suggests that a physician need only provide oversight of the outpatient service line, not necessarily the particular episode of outpatient care. A contrary interpretation would impose unreasonable burdens on outpatient departments that are commonly staffed by midlevel providers.

The Medicare conditions of participation ("CoPs") for hospitals and critical access hospitals ("CAHs") also impose physician oversight requirements, but they appear to be less stringent than the Idaho licensing standard: they do not require direct physician involvement in all inpatient cases. For example, the hospital CoPs require that:

1. Every Medicare patient is under the care of:
    a. A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism.);
    b. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;
    c. A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;
    d. A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;
    e. A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and
    f. A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.
2. … If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) [set forth above], that patient is under the care of a

doctor of medicine or osteopathy.

42 CFR § 482.12(c). Thus, the hospital CoPs identify certain non-physician providers who may admit and care for patients without direct physician involvement. However, even in those cases, a physician is required if a situation develops that is outside the non-physician's scope of practice:

A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—

1. is present on admission or develops during hospitalization; and
2. is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is—
    a. Defined by the medical staff;
    b. Permitted by State law; and
    c. Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

Id. at 482.12(c)(4).

In recognition of staffing challenges faced by CAHs, the CAH CoPs appear to require even less direct physician supervision:

(b) Standard: Responsibilities of the doctor of medicine or osteopathy. (1) The doctor of medicine or osteopathy—

(i) Provides medical direction for the CAH's health care activities and consultation for, and medical supervision of, the health care staff;

…

(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.

> (c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff—
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> …
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> (ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.
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> (2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy … [p]rovides services in accordance with the CAH's policies.

42 CFR § 485.631(c). In addition:

> Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.

Id. at §485.631(c)(3). The relevant CMS Interpretive Guidelines state,

> The CAH regulations do permit licensed mid-level practitioners, as allowed by the State, to admit patients to a CAH. However, CMS regulations do require that Medicare and Medicaid patients be under the care of an MD/DO if admitted by a mid-level practitioner and the patient has any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner. Evidence of being under the care of an MD/DO must be in the patient's medical record.

State Operations Manual, Appendix W—Interpretive Guidelines for Critical Access Hospitals (Rev'd 12-16-16). Thus, the CAH CoPs appear to only require direct physician involvement if the care required is outside the scope of the admitting midlevel's scope of practice.

Other Practitioners. The new Idaho statute, § 39-1396, only references physicians, physician assistants and advanced practice nurses; it is not clear whether it prohibits granting admitting privileges to other practitioners, but I suspect that was not the intent. For example, I.C. § 39-1395 contemplates that podiatrists may admit patients. Allowing other appropriately licensed practitioners to admit patients would also be consistent with the Medicare CoPs cited above. Nevertheless, this issue may need to be clarified in the future.

Medical Staff Approval. By its express terms, § 39-1396 allows the hospital to expand admitting privileges to midlevels, but “only if the privileges are … [r]ecommended by the medical staff at the hospital or facility…” I.C. § 39-1396(1)(c). Read literally, this may allow a medical staff (which may want to protect its own turf) to derail the expansion of admitting privileges by declining to recommend such to the governing body. It remains to be seen whether the statute would be interpreted or applied in this manner.

Conclusion. Although imperfect, new § 39-1396 will help hospitals and facilities that want to extend admitting privileges to midlevels. In the wake of the new statute, Idaho hospitals and other healthcare facilities should:

1. Review or amend their bylaws to identify those types of clinicians who may be granted admitting privileges, *e.g.*, physicians, physician assistants, and/or advanced practice nurses. Hospitals may deny admitting privileges to midlevels if they so choose.
2. Ensure the bylaws establish a process for credentialing and peer review of clinicians with admitting privileges consistent with statutory requirements.
3. If a particular clinician seeks admitting privileges, ensure that such privileges are recommended by the medical staff and granted by the governing body.
4. Regardless of who admits the patient, ensure that appropriate physician oversight is provided as required to comply with Idaho licensing regulations and Medicare CoPs.

The "physician oversight" requirements in Idaho regulations limit the scope and utility of the new law. Hospitals and other healthcare providers seeking to allow midlevels to practice to the scope of their licensure and reduce the burden on physicians may want to seek modification of the Idaho regulation requiring physician oversight.

For questions regarding this update, please contact:
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might affect the analysis or commentary. Similarly, the analysis may differ depending on the jurisdiction or circumstances. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.