Updated Edition

Advanced Practice Practitioners in Michigan

Physician's Assistants, Advanced Practice Registered Nurses, and Certified Registered Nurse Anesthetists

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Introduction

On March 22, 2017, the practice of physician's assistants (PAs) changed in Michigan as a result of PA 379 of 2016, which permits a PA to practice without delegation and supervision from a physician or podiatrist, provided there is a signed, compliant practice agreement between the PA and a participating physician or podiatrist. A few weeks later, on April 9, 2017, Public Act 499 of 2016 designated a new category of specialty-certified registered nurses called the advanced practice registered nurse ("APRN"), comprised of certified nurse midwives ("CNMs"), nurse practitioners ("NPs"), and clinical nurse specialists ("CNSs"). Public Act 499 further granted APRNs the authority to undertake specified medical tasks independent of physician delegation and supervision, including, most importantly, the authority to prescribe non-controlled substances. In 2018, the State Bar of Michigan – Health Care Law Section published a paper titled "New Roles for the Physician's Assistant and Advanced Practice Registered Nurse in Michigan," explaining those changes and their implications for health care providers and facilities in Michigan. The first edition of this paper also includes additional historical background on the scope of practice of and educational requirements for these providers.

Since 2018, the Michigan Department Health and Human Affair's Licensing and Regulatory Affairs agency ("LARA") has updated Board of Medicine and Board of Nursing rules to implement these changes to the Michigan Public Health Code (the "Code"). Also, in 2021, the Legislature enacted Public Act 53, which updated the scope of practice of certified registered nurse anesthetists ("CRNAs") in Michigan, and gave CRNAs with certain credentials authority to practice without physician supervision in specified situations. The purpose of this paper is to provide updated information and analysis on the legal scope of practice of PAs, APRNs, and CRNAs in Michigan.

SCOPE OF PRACTICE

Physician's Assistant

PA Scope of Practice

The Code defines "practice as a physician's assistant" ("PA") as "the practice of medicine with a participating physician under a practice agreement."[1] This definition of PA practice, which became effective in 2017 under Public Act 379 of 2016, constituted a paradigm shift away from defining PA practice under the delegation and supervision provisions of the Code, to defining PA practice as the practice of medicine under a written practice agreement. However, as discussed below, many elements of the old delegation/supervision paradigm were incorporated into the required elements of a practice agreement, and into the statutory obligations of the PA and the participating physician. It is also important to note that these changes to the legal scope of PA practice did not change the PA's status as a "subfield" health professional licensee.[2] This means that although a PA is considered to be practicing medicine, the PA may not himself or herself delegate medical tasks to or supervise another individual's performance of medical tasks.[3]

In addition to eliminating the requirements for compliance with the Code's delegation and supervision provisions, the 2017 changes to the Code also eliminated other technical barriers to more independent practice by the PA. First, the Code no longer restricts the PA to treating patients who are already under the physician's "case management responsibility."[4] This means that the PA may see and treat a patient before the participating physician sees the patient. This is of great practical importance in urgent care, emergent care, and rural and telemedicine settings. Second, Public Act 379 removed the prohibition against the physician's delegating ultimate responsibility for the quality of medical care services to the PA.[5] Regardless of whether this change has had any practical effect on the participating physician's legal liability for care provided by a PA, it is symbolic of the increased independence and responsibility of the PA for the care he/she provides. Third, a PA is now officially included in the definition of "prescriber" and is no longer required to record on a prescription, or on a receipt for starter doses, the name and Drug Enforcement Administration ("DEA") registration number (for controlled substances) of the participating physician.[6] Finally, Public Act 379 eliminated the requirement that the physician keep a written log of the number of PAs practicing with the physician and eliminated the strict maximum number of PAs with whom a physician may practice.[7]

While the 2017 changes to the Code may have deleted many indicia of delegation and supervision, it imposed other requirements on PA practice and on the relationship between the PA and the collaborating physician. The most significant requirement is that the PA enter into and practice within the terms of a compliant, written practice agreement with a participating physician.[8] This requirement is incorporated directly into the definition of practice as a PA, so that practicing without a written practice agreement, or in violation of the terms of a practice agreement, may subject both the PA and the participating physician to penalties for professional misconduct.[9] The requirements for a compliant practice agreement are described in the next section.

The Code now also includes a requirement on the relationship between the PA and the participating physician that may make the scope of collaborative tasks more restricted than was possible under the old delegation/supervision paradigm. Under the previous delegation/supervision paradigm, a physician could delegate to a PA any task that was within the scope of the delegating physician's license, even if the physician did not have training in or experience with the specific delegated task.[10] Under the current paradigm, a practice agreement may not include "an act, task, or function that the physician's assistant or the participation physician is not qualified to perform by education, training, or experience" as a duty or responsibility of the PA or the participating physician.[11] Thus, both the participating physician and the PA must have education, training, and expertise for a given task before it may be included within the practice agreement and performed by the PA. A PA and a physician may no longer collaborate on a task for which the PA has experience, but the physician does not, or vice versa. This requirement will be important for healthcare institutions to consider when granting clinical privileges to PAs and their participating physicians.

The Code gives the Boards of Medicine, Osteopathic Medicine and Surgery, and Podiatric Medicine and Surgery (a "Board" or the "Boards") authority to prohibit or restrict tasks from being included in a practice agreement if a Board finds that a particular medical care service "requires extensive training, education, or ability or poses serious risks to the health or safety of patients."[12] Although these Boards have promulgated some rules pertaining to PA prescribing (see below) these Boards have not, as of this writing, promulgated rules prohibiting or restricting specific task from being performed by a PA.

Practice Agreement Requirements

The Code prohibits a PA from practicing except under the terms of a practice agreement that meets all of the following requirements:[13]

(a) includes a process between the PA and the participating physician for communication, availability, and decision making when providing treatment to a patient. The process must use the knowledge and skills of the PA and the participating physician based on their education, training, and experience;

(b) includes a protocol for designating an alternative physician for consultation in situations when the participating physician is not available;

(c) is signed by the PA and the participating physician;

(d) includes a termination provision that allows the PA or the participating physician to terminate the agreement by providing written notice at least 30 days prior to the termination date;

(e) shall not include as a duty or responsibility of the PA or the participating physician an act, task, or function that the PA or the participating physician is not qualified to perform by training, education or experience and that is not within the scope of the license held by the PA or participating physician; and

(f) includes a requirement that the participating physician verify the PA's credentials.

There is no requirement that a PA report or submit a copy of practice agreement to LARA, a licensing board, or to any other regulatory body. However, federal controlled substance regulations require all midlevel practitioners with a DEA registration, including PAs, to maintain all documents evidencing the practitioner's authority to prescribe controlled substances, including practice agreements, and to make them readily available for inspection and copying by DEA officials.[14] This federal requirement and general good recordkeeping practices suggest that the PA maintain signed copies of all applicable practice agreements in a secure but accessible location.

The Code does not specifically restrict how many PAs with whom a physician may enter into a practice agreement, but does make the physician's decision regarding that number "subject to Section 16221."[15] Presumably, this means that a physician who enters into practice agreements with more PAs than the applicable medical standard of care would suggest is reasonable may be subject to discipline for professional misconduct under Section 16221 of the Code. The Code also does not restrict the PA from entering into practice agreements with more than one participating physician.[16] However, the PA should use caution to avoid entering into multiple practice agreements where the agreements create confusion or inconsistency with regard to which medical tasks the PA is performing in collaboration with each participating physician.

Prescribing Authority and Practice

The Code defines "prescriber" to include a PA.[17] This means that a PA may write prescriptions for drugs, including controlled substances, independently under the PA's own name and DEA number, without using or otherwise recording the name or DEA number of the participating physician. Because a PA prescribes controlled substances independently, a PA who wishes to prescribe controlled substances must also obtain his or her own Michigan controlled substance license.[18] A PA who prescribes controlled substances without his or her own Michigan controlled substance license may be in violation of the controlled substance provisions and the professional misconduct provisions of the Code.[19] Additionally, federal controlled substance regulations and the DEA also require PAs to obtain and use their own DEA registration number when prescribing controlled substances.[20]

The Code authorizes LARA, in consultation with the Boards, to promulgate rules concerning prescribing activity by PAs, including designations of drugs or classes of drugs that a PA may not prescribe, or "other procedures or protocols necessary to promote consistency with federal and state drug control and enforcement laws."[21] Accordingly, effective April 26, 2021, LARA amended the Board of Medicine, Osteopathic Medicine and Surgery, and Podiatric Medicine and Surgery rules to align with Code's provisions on PA practice. Under the amended rules, a PA may prescribe a drug, or order, receive, and dispense a complimentary starter dose (i.e., a sample) of a prescription drug, including controlled substances in schedules 2 to 5, subject to the following requirements:

(a) the PA's name is used, recorded, or otherwise indicated in connection with the prescription or the complimentary starter dose order, receipt or dispensing; and

(b) if the drug is a schedule 2 to 5 controlled substance, the PA's DEA registration number is used, recorded, or otherwise indicated in connection with the prescription or the complimentary starter dose order, receipt or dispensing.[22]

As an independent prescriber, a PA is also eligible to obtain a Michigan drug control license from LARA, which permits the PA to dispense prescription drugs, including controlled substances, to the PA's own patients.[23] Dispensing under a drug control license must be performed in compliance with the labeling, storage and security, recordkeeping, patient notice and other requirements set out in Code.[24]

Professional Misconduct by a PA or Participating Physician

Because "practice as a PA" is defined as the practice of medicine with a participating physician pursuant to a compliant practice agreement, a PA who practices without a practice agreement or practices with a non-compliant practice agreement may be considered practicing outside the scope of a PA license.[25] Practicing outside the scope of a PA license may subject a PA to discipline for professional misconduct.[26] Additionally, the PA and the participating physician may both be subject to professional discipline for failure to comply with the terms of a practice agreement.[27] Problematic activity might include failure to follow the protocol for collaboration and coverage, undertaking tasks not contemplated under the practice agreement, or failure of the participating physician to verify the PA's credentials. Additionally, as mentioned above, the appropriateness of the number of PAs with whom a participating physician enters into a practice agreement is a matter that may be subject to professional discipline.[28] The Boards have the authority to deny or limit a PA's or a physician/podiatrist's ability to enter into a practice agreement based on a determination of professional misconduct by the PA or the physician/podiatrist, respectively.[29] For a PA, such a determination could have a devastating effect on the PA's practice, because a PA is unable to practice without a practice agreement in place.[30]

Advanced Practice Registered Nurse

Who Qualifies as an Advanced Practice Registered Nurse?

Public Act 499 of 2016 created a new category of specialty-certified registered nurse ("RN") in Michigan, the Advanced Practice Registered Nurse ("APRN"). The APRN category includes the following types of specialty-certified RNs: [31]

- Certified Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists – Certified

Note that this list does not include certified registered nurse anesthetists (CRNAs), a type of specialty certification available to RNs in Michigan. Accordingly, the scope of practice available to APRNs described in this Section of the paper does not apply to CRNAs. CRNA scope of practice is described separately in the next section of the paper.

APRN Scope of Practice

With the exception of CRNAs as described below, specialty certification in and of itself, does not expand the specialty-certified nurse's scope of practice beyond the legal scope of practice for an RN. Specialty certification does, however, provide evidence of training, education, and experience that makes the specialty-certified RN qualified to accept delegation of medical tasks from a physician under Section 16215 of the Code. For all specialty certified nurses who fall into the category of APRN (NP, CNM, and CNS) the Code gives them authority to perform the following specific tasks independently, without physician delegation or supervision:

(a) write a prescription for a non-scheduled prescription drug;[32]

(b) order, receive, and dispense complimentary starter doses of non-controlled substances using, recording, or otherwise indicating only the name of the APRN;[33]

(c) refer a patient to a speech-language pathologist for assessment, treatment, therapy, and services related to swallowing disorders and medically-related communication disorders;[34]

(d) prescribe physical therapy services;[35]

(e) provide notice of HIV test results and counseling to marriage license applicants;[36]

(f) make and document a determination that it is medically contraindicated to provide a patient or resident in a licensed health facility or agency information about his or her medical condition, proposed course of treatment, and prospects for recovery;[37]

(g) make and document a determination that it is medically contraindicated to permit a patient or resident in a licensed health facility or agency to have private communications with individuals of his or her choice, or to send or receive unopened private mail;[38]

(h) make and document a determination that it is medically contraindicated to permit a patient or resident in a licensed health facility or agency to meet with and participate in the activities of social, religious, and community groups at his or her discretion;[39]

(i) authorize the use of chemical or physical restraints for a patient or resident in a licensed health facility or agency, in accordance with permitted parameters;[40]

(j) make and document a determination that it is medically contraindicated for married residents of a nursing home or home for the aged to share a room;[41]

(k) make and document a determination that it is medically contraindicated for a resident of a licensed nursing home or home for the aged to retain and use his or her personal clothing and possessions;[42]

(l) make and document a determination that it is medically contraindicated for a resident of a licensed nursing home or home for the aged to be fully informed about the resident's medical condition;[43]

(m) make and document a determination that it is medically contraindicated for a nursing home resident to receive treatment by a licensed health care provider that has been requested by the resident;[44] and

(n) make and document a determination that a nursing home resident is terminally ill for purposes of permitting the resident's parents (if a minor), spouse, next of kin or patient representative (if adult) to stay at the facility 24 hours a day.[45]

There are no limitations on the locations at which an APRN may conduct this independent scope of practice, and there are no restrictions or requirements regarding the timing or frequency with which a physician or an APRN visits the patient.[46] Under the Code, an APRN "may make calls or go on rounds in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, health maintenance organizations, nursing homes or other healthcare facilities."[47]

The expanded scope of APRN practice beyond what is permitted for a RN under the Code is limited to the specific tasks enumerated above. Thus, an APRN in Michigan may independently (without delegation and supervision from a physician or dentist) perform any task that is considered within the Code's definition of the practice of a RN, plus any of the specific tasks listed above.[48] Other tasks that may be commonly performed by APRNs, including making diagnoses and ordering lab tests and other diagnostic procedures, are not within an APRN's legal scope of practice as defined under the Code, and must be delegated and supervised by an individual licensed to perform that task.[49] This creates a practical problem because some of the tasks which an APRN may perform independently are necessarily reliant upon or associated with tasks that an APRN may only perform as a delegated and supervised task. For example, while an APRN may prescribe insulin for a patient on an independent basis, it is not within the APRN's independent legal scope of practice as defined in the Code to make the medical diagnosis of diabetes upon which the insulin prescription is based.[50] This suggests that many APRNs will be practicing in a hybrid scenario, where some of their tasks may be performed independently and some may only be performed under the delegation and supervision of a physician.

<u>APRN Prescribing Authority and Practice</u>

The Code permits an APRN to prescribe a non-controlled drug independently and includes an APRN within the definition of "prescriber" for purposes of prescribing non-controlled drugs.[51] This means the APRN may prescribe a non-controlled prescription drug without delegation or supervision by a physician, and without having to record a physician's name or obtain a physician's signature in connection with the non-controlled drug prescription. Additionally, an APRN may order, receive, and dispense complimentary starter doses of non-controlled drugs independently, without delegation from a physician.[52] Only the APRN's name is required to be used or recorded in connection with the order, receipt or dispensing complimentary starter doses of non-controlled drugs.[53]

In contrast, an APRN may prescribe Schedule II–V controlled substances only as a *delegated* act of a physician.[54] When prescribing a controlled substance as a delegated act, the APRN must record or use both the APRN's and the delegating physician's name and DEA registration number in connection with the prescription.[55] Similarly, an APRN may order, receive, and dispense complimentary starter doses of controlled substances (Schedule II–V) only as a delegated act of a physician and must use, record, or otherwise indicate both the APRN's and the physician's name and DEA number in connection with ordering, receipt, and dispensing of controlled complimentary starter dose drugs.[56] This delegation mechanism for APRN controlled substance prescribing is further described in FAQs posted on LARA's website.[57] In response to email queries, LARA advises that an APRN who is writing controlled substance prescriptions using the DEA registration of the institution where the APRN is employed or under contract (as permitted by controlled substance federal regulations[58]) may use or record that institutional DEA registration number on the controlled substance prescription. LARA's FAQs further clarify that an APRN is not required (or permitted) to obtain a Michigan controlled substance license, because the APRN may prescribe controlled substances only as a delegated task under the physician's Michigan controlled substance license.[59]

Under Board of Medicine rules, a physician may delegate authority to prescribe Schedule II-V controlled substances to an RN with a specialty certification, except a CRNA (*i.e.*, an APRN) only pursuant to a written authorization that contains the following information:

(a) name, license number and signature of the delegating/supervising physician;

(b) name, license number and signature of the APRN;

(c) the limitations or exceptions to the delegation; and

(d) the effective date of the delegation.[60]

The delegating/supervising physician must review and update the written authorization annually (based on the date of the physician's signature), noting the review date on the written authorization.[61] Any amendment to the written authorization must meet the requirements of the rule.[62] The delegating/supervising physician must maintain a copy of the written authorization at the physician's primary place of practice, and provide a copy to the APRN.[63] The rule permits the physician to authorize the APRN to issue multiple prescriptions allowing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance.[64] The Code further limits all prescriptions for opioids, regardless of who is prescribing, to a 7-day supply within a 7-day period when being used to treat acute pain.[65] Finally, the rule specifies that a physician may not delegate the prescription of a drug or device individually, in combination, or in succession for a known-pregnant woman with the intent to cause a miscarriage or fetal death.[66]

As an independent prescriber of non-controlled drugs, an APRN is also eligible to obtain a Michigan drug control license from LARA, which permits the APRN to dispense non-controlled prescription drugs to the APRN's own patients.[67] Because an APRN may not prescribe controlled substances independently, an APRN may not dispense controlled substances under the authority of a drug control license. The APRN's dispensing of non-controlled drugs under a drug control

license must be performed in compliance with the labeling, storage and security, recordkeeping, patient notice and other requirements set out in Code.[68]

Use of a Collaboration Agreement

Neither the APRN independent practice provisions of the Code[69] nor the delegation and supervision provisions of the Code[70] require an APRN to have any form of written collaboration agreement between the APRN and a physician. The only legal requirement for a written memorialization of collaborative practice between an APRN and a physician is the requirement in the Board of Medicine rules for a written authorization of the delegation of prescriptive authority for controlled substances mentioned above.[71] Thus, an APRN whose practice includes both independent acts (e.g., prescribing non-controlled substances) and delegated/supervised acts (diagnosing) is not required by the Code or Michigan administrative rules to have any form of written collaboration agreement with a physician, *unless* the APRN is prescribing controlled substances.

Despite the lack of a legal requirement for a written collaboration agreement (except for delegation of controlled substance prescribing), both Medicare and Michigan Medicaid impose requirements regarding collaboration agreements for certain types of APRNs. In the case of Michigan Medicaid, the Michigan Medicaid Provider Manual requires that CNM "services must be administered within the framework of an alliance agreement that provides for physician consultation and referral as indicated by the health of the beneficiary."[72] This requirement would be difficult, if not impossible, to meet without a written collaboration or alliance agreement.

NPs or CNSs who are enrolled in Michigan Medicaid must attest during the enrollment process that he/she has a valid collaborative practice agreement with a Medicaid-enrolled physician.[73] Michigan Medicaid uses essentially the same elements required under the Code for a PA-physician practice agreement to define the required elements of a valid collaboration agreement for a NP and CNS, as follows:

(a) a process between the NP or CNS and the collaborating physician for communication, availability, and decision making, including an emergency plan;

(b) a protocol for designating an alternative physician for consultation in situations when the collaborating participating physician is not available;

(c) a description of the duties and responsibilities of the practitioner and collaborating physician based on their education, training and experience;

(d) a provision that allows the NP or CNS to terminate the agreement; and

(e) the signatures of the collaborating physician and the NP or CNS.[74]

The NP or CNS must notify the Michigan Department of Health and Human Services if the collaborative practice agreement is terminated.[75] Termination of the collaborative practice

agreement by either party or termination of the collaborating physician's Michigan Medicaid enrollment may lead to disenrollment of the NP/CNS from Michigan Medicaid.[76]

In contrast, the Michigan Medicare requirements regarding a written collaborative agreements are less clear. With regard to CNMs, the Medicare Benefits Policy Manual provisions on coverage of CNM services does not specifically reference collaboration agreements, stating only that the CNM must meet all state requirements regarding physician supervision and collaborative practice.[77] For both NPs and CNSs, the Medicare manual provisions require compliance with state law on collaboration.[78] The Manual provisions state "in the absence of state law governing collaboration, collaboration is to be evidenced by" the CNS's or the NP's documenting "their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice."[79] Because Michigan does not have any specific law addressing written collaboration arrangements between CNSs/NPs and physicians (other than the written authorization for controlled substance prescribing), these Medicare manual provisions suggest that Medicare expects written collaboration agreements for NPs and CNSs practicing in Michigan.

Even for APRNs who do not bill Medicare or Michigan Medicaid, use of a written, signed collaboration agreement with a physician may be considered a legal "best practice" for APRNs for several reasons. The most important reason to use a collaboration agreement is to document that the APRN is practicing within the APRN's legal scope of practice. The collaboration agreement may be used to document which medical tasks the physician is delegating to the APRN and who is supervising the APRN's performance of the delegated tasks in accordance with the Code. This may be useful in avoiding claims against the APRN for the unlicensed practice of medicine. This may also be useful in supporting a certification of compliance with applicable "laws, regulations, and program instructions" that an APRN may be required to make when submitting claims to Medicare, Michigan Medicaid or other government payers.[80] Second, in addition to Medicare and Michigan Medicaid, some other third party payers may require an APRN to have a written collaboration agreement in place as a condition to reimbursement. Third, many APRNs will be prescribing controlled substances and will need a written authorization with the delegating physician, which may be incorporated into a written collaboration agreement. Fourth, from a both a legal and logistical perspective, it is generally a good practice for parties who are working collaboratively to document their respective responsibilities and expectations prior to beginning collaborative practice.

Certified Registered Nurse Anesthetist

CRNA Scope of Practice

In 2021, the Michigan legislature enacted Public Act 53, significantly changing the sections of the Code regulating the practice of CRNAs. Effective October 11, 2021, the Code defines the practice of a CRNA in Michigan as the following anesthesia and analgesia services when performed in accordance with the American Academy of Nurse Anesthetists Standards for Nursing Anesthesia Practice:

(a) development of a plan of care;

(b) performance of all patient assessments, procedures, and monitoring to implement the plan of care or to address patient emergencies that arise during implementation of the plan of care; and

(c) selection, ordering, or prescribing and the administration of anesthesia and analgesic agents, including pharmacological agents that are prescription drugs, including controlled substances.[81]

While Public Act 53 also amended the Code's definition of "prescriber" to include a CRNA when practicing within the scope of practice described above, it specifically limits the authority of a CRNA to prescribe drugs to the situations listed below.[82]

(a) In a health care facility if the health care facility has a policy in place allowing for the provision of anesthesia and analgesia services and ensuring that a qualified health care professional is immediately available in person or through telemedicine to address urgent or emergent clinical concerns.[83] (A health care facility is defined as a hospital inpatient or outpatient facility, a freestanding surgical outpatient facility, or an office of a physician, dentist or podiatrist.[84] A qualified health professional is defined as a Michigan-licensed physician, dentist, or podiatrist who has completed the necessary training, education and experience in anesthesia care or pharmacology, or who has experience with procedures requiring anesthesia.[85])

(b) During and for the perioperative, periobstetrical, or periprocedural period.[86]

(c) Prescribing by a CRNA who is practicing independently, without physician supervision, as described below.[87]

If a health care facility uses a CRNA to provide analgesia or anesthesia services who is not an employee of the health care facility, the health care facility must ensure that the CRNA or the CRNA's employer maintains malpractice insurance for the CRNA.[88]

Importantly, the Code does not grant a CRNA authority to perform any activity that would permit a patient to self-administer, obtain, or receive drugs, including prescription drugs or controlled substances, outside of the facility in which the anesthetic or analgesic service is performed or beyond the perioperative, periobstetrical, or periprocedural period.[89] Further, the Code is clear that a CRNA who is providing pain management services in freestanding pain clinic must practice under the supervision of a physician.[90]

<u>Independent CRNA Practice</u>

The Code now permits a CRNA to provide the full scope of anesthesia and analgesia services described above independently, without physician supervision, if the CRNA meets both of the following two requirements:

(a) the CRNA holds either of the following credentials:

(i) has practiced in the health profession specialty field of nurse anesthetist for 3 or more years and has practiced in that health profession specialty field in a health care facility for a minimum of 4,000 hours; or

(ii) has a doctor of nurse anesthesia practice degree or doctor of nursing practice degree.

(b) The CRNA is collaboratively participating in a patient-centered care team.[91]

The Act defines "patient-centered team" as "a group of health care professionals, which must include, but is not limited to, a qualified health care professional (defined above), who directly or indirectly care for a patient by each contributing his or her specialized knowledge, skill, and experience to the care of the patient."[92] "Collaboratively participating" is defined as "practicing and communicating with health care professionals involved in the patient-centered care team to optimize the overall care delivered to the patient."[93] Thus, while the independently practicing CRNA does not require formal delegation and supervision as defined in the Code, the CRNA is not entirely independent. Instead, the CRNA must practice in collaboration with at least one qualified physician, dentist, or podiatrist when providing services "independently." This qualified physician, dentist, or podiatrist may, and is likely to be, the operating practitioner.

These new Code provisions require hospitals and other health care facilities where CRNAs are permitted to prescribe medications, including controlled substance, to have policies and procedures in place regarding the administration of anesthesia in the facility. Therefore, health care facilities wishing to implement the expanded scope of CRNA practice should consider updating their policies and procedures on prescribing, including controlled substance prescribing, as well as their policies on credentialing and privilege granting to align with the Code's new parameters. Health care facilities that wish to use independent CRNAs must develop policies regarding collaborative practice, patient-centered care teams, and qualified health professionals.

IMPLICATIONS FOR REIMBURSEMENT

Medicare

Medicare coverage for services provided by an APRN, CRNA or a PA is limited to (otherwise covered and medically necessary) services that the APRN or PA is legally authorized to perform in accordance with state law.[94] In terms of Michigan law, "legally authorized" includes services included within the APRN's or PA's statutorily-defined scope of practice described above, and services which are appropriately delegated to an APRN under Article 15, Section 16215 of the Code. Medicare permits APRNs to bill Medicare directly, or to reassign their service payment rights to their contractors or employers.[95] Please see "Use of a Collaboration Agreement" in the APRN section of this paper, above, for a discussion of Medicare's requirements for use a collaboration agreement for NPs and CNSs. Effective January 1, 2022, Medicare now also permits PAs to bill Medicare directly, or to reassign their service payment rights to their contractors or employers.[96] (Previous to January 1, 2022, a PA was not permitted to bill Medicare directly or to

reassign the right to receive payment for his or her services, and only the PA's employer or contractor was permitted to bill Medicare for the PA's services.)

Relative to CRNAs, the Medicare conditions of participation for hospitals require a CRNA to be supervised by the operating surgeon or by an anesthesiologist who is immediately available.[97] Similarly, the Medicare conditions of participation for ambulatory surgery centers ("ASCs") and critical access hospitals ("CAHs") require a CRNA be supervised by the operating physician.[98] However, the Centers for Medicare and Medicaid Services ("CMS") will permit a hospital, ASC or CAH to opt out of the Medicare physician supervision requirement for CRNAs if the state in which the hospital, CAH, or ASC is located submits a letter to CMS, signed by the governor following consultation with the state boards of medicine and nursing, requesting exemption from the physician supervision requirement.[99] In this letter, commonly referred to as an "opt-out letter," the state's governor must attest that:

> (a) he or she has consulted with the state's boards of nursing and medicine about issues relating to the access to and quality of anesthesia services in the state;
>
> (b) he or she has concluded that it is in the best interests of the state's citizens to opt-out of the current Medicare physician supervision requirement; and
>
> (c) an opt-out is consistent with state law.[100]

CMS noted in its commentary to the final rules establishing the opt-out option that hospitals, ASCs and ASCs are always free to require stricter supervision standards than are required under state law.[101] "The final rule would not require hospitals under any circumstance, to eliminate physician supervision if they deem this appropriate."[102] In other words, even in a state that has opted-out of physician supervision of CRNAs for Medicare compliance purposes, individual hospitals, ASCs, and CAHs may choose to continue to require that CRNAs be supervised by a physician in their facilities.

Michigan Governor Gretchen Whitmer submitted an opt-out letter to CMS Administrator Ms. Brooks-LaSure on April 18, 2022. CMS acknowledged receipt and acceptance of the Michigan opt-out letter on May 10, 2022, making the physician-supervision requirement optional for Michigan health facilities for Medicare billing purposes as of that same date.

Michigan Medicaid

The Michigan Medicaid Provider Manual ("Medicaid Manual") provides that Michigan Medicaid covers anesthesia services provided by a Medicaid-enrolled CRNA that are in compliance with Michigan scope of practice licensing laws and regulations.[103] Michigan Medicaid will make payment for such services to the CRNA or to the entity with which the CRNA has an employment or contractual relationship.[104]

Michigan Medicaid will cover medically necessary services provided by NPs and CNSs that are the type commonly provided by physicians, that the NP or CNS is legally authorized to provide and Michigan Medicaid policy does not require be provided only by a physician, and that are provided pursuant to a valid collaborative practice agreement (see description above).[105] A NP or CNS may enroll in Medicaid either as (i) a "rendering/servicing-only provider," in which case Michigan Medicaid makes payment for NP/CNS services to the physician or physician group who employs and supervises the NP/CNS, or (ii) as an "individual/sole provider," in which case Michigan Medicaid makes payment directly to the NP/CNS.[106] Please see "Use of a Collaboration Agreement" in the APRN section of this paper, above, for a discussion of Michigan Medicaid's requirements for use a collaboration agreement for NPs and CNSs.

Michigan Medicaid will cover medically necessary services provided by CNMs that are the type commonly provided by physicians, that the CNM is legally authorized to provide under state law, that Michigan Medicaid policy does not require provided only by a physician, and that are "administered within the framework of an alliance agreement that provides for physician consultation and referral as indicated by the health of the beneficiary."[107] Unlike for NPs and CNSs, Michigan Medicaid does not define what constitutes a "alliance agreement." Michigan Medicaid will reimburse CNMs directly, provided the claim for service includes the CNM's National Provider Identification number ("NPI") in the "rendering provider" field and the supervising physician's NPI in the "supervising provider" field.[108]

Michigan Medicaid will cover medically necessary PA services that that are the type commonly provided by physicians, that the PA is legally authorized to provide and Michigan Medicaid policy does not require be provided only by a physician, and that are provided pursuant to a valid practice agreement (see description above).[109] However, PAs may only enroll in Michigan Medicaid as a "rendering/servicing only" provider, and is not, therefore, eligible to receive direct reimbursement from Michigan Medicaid.[110] Michigan Medicaid issues payment for PA services only to the PA's participating physician or physician group.[111]

Commercial Insurance

In an effort to address the requirement that each practicing PA have a compliant practice agreement with a participating physician, Blue Cross and Blue Shield of Michigan ("BCBSM") required all enrolled PAs to re-enroll in BCBSM prior to January 31, 2018.[112] As part of the re-enrollment, each PA was required to complete a Physician Assistant Re-Enrollment Form, a Physician Assistant/Physician Practice Agreement Attestation Form, and a BCBSM Physician Assistant Combined Signature Document.[113] PAs who re-enrolled with BCBSM prior to January 31, 2018, or who enrolled for the first time after January 31, 2018, are eligible for reimbursement for services within the scope of their license.[114]

While Public Act 499 of 2016 expanded the scope of practice of APRNs in Michigan to include several tasks that an APRN may perform independently, the Code specifies that such expansion does not require new or additional third-party reimbursement or mandated worker's compensation benefits relating to an APRN's ability to prescribe non-controlled drugs independently, or controlled substances as a delegated task.[115] Thus, commercial and government payers are not required to provide reimbursement for prescriptions (controlled or non-controlled) written by APRNs, and are free to impose their own requirements as to who may write covered prescriptions.

For this reason, it is important for an APRN to consult individual commercial insurers' coverage and reimbursement requirements for APRN services prior to writing a prescription for an insured. BCBSM, for example, has indicated that it considers an APRN to be an appropriate prescriber for non-controlled and Schedule II–V controlled substances prescriptions, provided both the APRN's and the delegating prescriber's names and DEA numbers appear on all Schedule II–V controlled substances, as required under Michigan law.[116]

ORGANIZING IN A LEGAL ENTITY

Physician's Assistants

In general, the fact that a PA and a participating physician have entered into a practice agreement together does not, itself, necessitate that the PA and the participating physician be shareholders, employees, agents, or otherwise affiliated with the same legal entity. However, because PAs are considered to be providing the same professional service (medicine and surgery) as individuals licensed to practice medicine, osteopathic medicine and surgery, or podiatric medicine and surgery (collectively, "physicians"), Chapter 2A of the Business Corporation Act – Professional Service Corporations (the "PC Act") and the Professional Limited Liability Company provisions of the Limited Liability Company Act (the "LLC Act"), respectively, permit a PA to hold equity with physicians in the same professional corporation ("PC") or professional limited liability company ("PLLC") formed to provide professional medical and surgical services.[117] To the extent that one or more PAs organize a professional services corporation, a PC, or a PLLC with one or more physicians, the physicians who are parties to a practice agreement with such PAs must be shareholders or members of the PC or PLLC.[118] In other words, a PA who holds equity in a PC or PLLC with physicians must have a practice agreement with a physician who also holds equity in the same PC or PLLC.

A PA who is a shareholder in a PC or a member in a PLLC must disclose the following information when renewing his or her PA license: (a) whether any MDs, DOs, or DPMs are also shareholders in the PC or members in the PLLC; (b) the name and license number of the MD, DO or DPM who is a party to a practice agreement with the PA; and (c) whether the MD, DO or DPM who is a party to the PAs practice agreement is a shareholder or member in the same PC or PLLC as the PA.[119]

Specialty Certified RNs (NP, CNM, CNS, CRNA)

As a health professional licensed under the Code as an RN, one or more specialty certified nurses may become shareholders or members in a PC or a PLLC, respectively, formed to provide professional nursing services.[120] However, because specialty certified RNs provide a different professional service from other professionals licensed under the Code (e.g., physicians, PAs, physical therapists, occupational therapists), the PC Act and the PLLC Act do not permit RNs to hold equity in the same PC or PLLC with these other licensed health professionals.[121] RNs are not, however, limited to using a PC or PLLC when forming a legal entity to provide professional nursing services. Under the PC Act and the LLC Act, only "learned professionals" are required to use a PC or PLLC to provide their professional services in corporate form.[122] A RN does not fall within the definition of "learned professional,"[123] so may choose to incorporate as a PC or PLLC,

or as a business (profit) corporation or limited liability company ("LLC").[124] When preparing articles of incorporation for a PC or articles of organization for a PLLC, a RN should be careful not to use any name, assumed name, or statement of corporate purpose for the entity that suggests the entity may be providing professional medical services, as LARA is likely to reject the articles for filing. Further, once incorporated, an RN entity should refraining from providing professional medical services, as such activity may subject the entity to regulatory scrutiny.

ENDNOTES

[1] MCL §§ 333.17001(1)(k), 333.17501(1)(g), and 333.18001(1)(e).
[2] MCL §§ 333.17008, 333.17508, and 333.18008.
[3] MCL § 333.16215(1).
[4] MCL § 333.17049(2), 333.17549(2), and 333.18049(2) (prior versions).
[5] MCL §§ 333.17048(4) and 333.17548(4) (prior versions).
[6] MCL §§ 333.17708(2), 333.17076(2), 333.17548(4) and (5), 333.18051(2) and (3).
[7] MCL §§ 333.17048, 333.17549(4), and 333.18049(4) (prior versions).
[8] MCL §§ 333.17001(1)(k); 333.17047(1), 333.17501(1)(g), 333.17547(1), 333.18001(1)(e), and 333.18047(1).
[9] MCL §§ 333.16221(u).
[10] MCL §§ 333.16215, prior version of MCL 333.17049(2), 333.17549(2), and 333.18049(2).
[11] MCL §§ 333.17047(2)(e), 333.17547(2)(e), and 333.18047(2)(e).
[12] MCL §§ 333.17048(1), 333.17548(1), and 333.180048.
[13] MCL §§ 333.17047(2), 333.17547(2), and 333.18047(2).
[14] 21 CFR. § 1304.03(e).
[15] MCL §§ 333.17047(3), 333.17547(3), and 333.18047(3).
[16] MCL §§ 333.17047, 333.17547, and 333.18047.
[17] MCL § 333.17708(2).
[18] MCL §§ 333.7303(1) and 333.7303a.
[19] MCL §§ 333.7303(1) and 333.16621(c)(iv).
[20] 21 CFR §§ 1301.02 and 1301.11(a).
[21] MCL §§ 333.17048(2) and 17548(3).
[22] Mich. Admin. Code R 338.2409.
[23] MCL § 333.17745.
[24] MCL §§ 333.17745, 333.17757a.
[25] MCL §§ 333.17001(1)(k), 333.17047(1), 333.17501(1)(g), 333.17547(1), 333.18001(1)(e), 333.18047(1).
[26] MCL § 333.16221(c)(iii).
[27] MCL § 333.16221(u).
[28] MCL §§ 333.17047(3), 333.17547(3), and 333.18047(3).
[29] MCL §§ 333.17050, 333.17550, and 333.18050(1).
[30] MCL §§ 333.17047(1), 333.17547(1), and 333.18047(1).
[31] MCL § 333.17201(1)(a).
[32] MCL § 333.17211a(1)(a).
[33] MCL § 333.17212(2).
[34] MCL § 333.17607(3).
[35] MCL § 333.17820(1).
[36] MCL § 333.5119(3).
[37] MCL § 333.20201(2)(e).
[38] MCL § 333.20201(2)(k).
[39] *Id*.
[40] MCL § 333.20201(2)(l).
[41] MCL § 333.20201(3)(b).
[42] MCL § 333.20201(3)(c).
[43] MCL § 333.20201(3)(d).
[44] MCL § 333.20201(3)(i).
[45] MCL § 333.20201(3)(j).

[46] MCL § 333.17214.
[47] *Id*.
[48] MCL §§ 333.17201(1)(c), 333.17211a and 333.17212.
[49] MCL §§ 333.16215, 333.17201(1)(c), 333.17211a and 333.17212.
[50] MCL§§ 333.16215, 333.17001(1)(h), 333.17201(1)(c), 333.17211a, 333.17212, 333.17501(1)(f), and 333.18001(1)(f).
[51] MCL §§ 333.17708(2) and 333.17211a(1)(a).
[52] MCL § 333.17212(2).
[53] *Id*.
[54] MCL §§ 333.17708(2) and 333.17211a(1)(b).
[55] MCL § 333.17211a(2).
[56] MCL § 333.17212(3).
[57] LARA,*Nursing FAQs*, Question 21, p 6, <https://www.michigan.gov/documents/lara/Nursing_FAQs_updated_579848_7.pdf> (accessed June 14, 2018).
[58] 21 C.F.R. §1301.22(c).
[59] LARA,*Nursing FAQs*, Question 21, p 6, <https://www.michigan.gov/documents/lara/Nursing_FAQs_updated_579848_7.pdf> (accessed June 14, 2018).
[60] Mich. Admin. Code R 338.2411.
[61] Mich. Admin. Code R 338.2411(2).
[62] Mich. Admin. Code R 338.2411(5).
[63] Mich. Admin. Code R 338.2411(3) and (4).
[64] Mich. Admin. Code R 338.2411(6).
[65] MCL § 333.7333b.
[66] Mich. Admin. Code R 338.2411(7).
[67] MCL§ 333.17745.
[68] MCL § 333.17745, 333.17757a.
[69] MCL §§ 333.17211a(1)(a), 333.17607(3), 333.17708(2), 333.17820(1), and 333.20201.
[70] MCL § 333.16215(1).
[71] Mich. Admin. Code R 338.2411.
[72] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 22.1.
[73] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 20.3 and Section 21.3.
[74] *Id*.
[75] *Id*.
[76] *Id*.
[77] Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Section 180.E.
[78] Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 200.D and 210.D.
[79] Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 200.D and 210.D.
[80] Certification statement on Medicare Health Insurance Claim Form 1500, Medicare program instructions requiring that covered services must be within the PA's/APRN's legal scope of practice and provided under the supervision/collaboration required under state law are found at Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 180.C.1, 180.E, 190.B, 190.C, 200.B, 200.D, 210.B, 210.D.
[81] MCL § 333.17210(3)(a).
[82] MCL § 333.17708(2)(i).
[83] MCL § 333.17210(3)(c).
[84] MCL § 333.17210(6)(b).
[85] MCL § 333.17210(6)(e).
[86] MCL § 333.17210(3)(d).
[87] MCL § 333.17210(3)(b).
[88] MCL § 333.17210(4).
[89] MCL § 333.17210(3)(a)(iii).
[90] MCL § 333.17210(3)(e).
[91] MCL § 333.17210(3)(b).
[92] MCL § 333.17210(6)(d).
[93] MCL § 333.17210(6)(a).
[94] Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 180.C, 190.B, 200.B and 210.B.

[95] Medicare Benefits Policy Manual, (CMS Pub. 100-02), Chpt. 15, § 180.E (CNM); § 200.E (NP); § 210.E (CNS); Medicare Claims Processing Manual (CMS Pub. 100-04) Chpt. 12, § 120.3.B (NP and CNS); § 130.1 (CNM).
[96] Medicare Benefits Policy Manual, (CMS Pub. 100-02), Chpt. 15, §190.D, Medicare Claims Processing Manual, (CMS Pub. 100-04) Chpt. 12, § 110.4.B.
[97] 42 CFR § 482.52(a)(4).
[98] 42 CFR §§ 416.42(b)(2), 42 CFR 485.639(c)(2).
[99] 42 CFR §§ 482.52(c), 42 CFR 416.42(c), 485.639(e).
[100] *Id*.
[101] 66 Fed. Reg. 56762, 56765 (November 13, 2001).
[102] *Id*.
[103] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 19.
[104] *Id*.
[105] Michigan Medicaid Provider Manual, Practitioner Chapter, Sections 20.1 and 21.1.
[106] Michigan Medicaid Provider Manual, Practitioner Chapter, Sections 20.2 and 21.2.
[107] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 22.1.
[108] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 22.5.
[109] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 23.1.
[110] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 23.2.
[111] Michigan Medicaid Provider Manual, Practitioner Chapter, Section 23.3.
[112] *The Record*, Blue Cross and Blue Shield of Michigan, (August, 2017 and January, 2018).
[113] *The Record*, Blue Cross and Blue Shield of Michigan, (January, 2018).
[114] *The Record*, Blue Cross and Blue Shield of Michigan, (August, 2017 and January, 2018).
[115] MCL § 333.17211a(3).
[116] *The Record*, Blue Cross and Blue Shield of Michigan (December, 2017).
[117] MCL §§ 450.1284(3) and 450.4904(4).
[118] MCL § 333.17048(3).
[119] MCL § 333.17048(4).
[120] MCL §§ 450.1282(a), 450.1283(1), 450.4902(a), and 450.4903(1).
[121] MCL §§ 450.1284(1), 450.4904(2).
[122] MCL §§ 450.1201(2) and (3), 450.1281(1), 450.4201, 450.4102(2)(t).
[123] MCL §§ 450.1109(1), 450.4102(2)(t).
[124] MCL §§ 450.1201(3), 450.1281(1), 450.4901(1).