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PHYSICIAN SERVICES

RULE §19.1201**Physician Services**

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that:

- (1) the medical care and other health care of each resident is supervised by an attending physician. Any consultations must be ordered by the attending physician;
- (2) another physician supervises the medical care and other health care of residents when their attending physician is unavailable; and
- (3) if children are admitted to the facility:
 - (A) appropriate pediatric consultative services are utilized, in accordance with the comprehensive assessment and plan of care; and
 - (B) a pediatrician or other physician with training or expertise in the clinical care of children with complex medical needs participates in all aspects of the medical care.

Source Note: The provisions of this §19.1201 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.1202**Physician Visits**

The physician must:

- (1) review and/or revise and sign orders relating to the resident's total program of care, including medications and treatments, according to the visit schedule required by §19.1203(2) of this title (relating to Frequency of Physician Visits);
 - (2) write, sign, and date progress notes at each visit;
 - (3) sign and date all orders;
 - (4) write, sign, and date a physician's discharge summary within 20 workdays of being notified by the facility of the discharge, except as specified in §19.1912(e) of this title (relating to Additional Clinical Record Service Requirements), if the resident has been temporarily discharged for 30 days or less, and readmitted to the same facility; and
 - (5) provide documentation in the clinical record as specified in §19.1911 and §19.1912 of this title (relating to Contents of the Clinical Record and Additional Clinical Record Service Requirements).
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Source Note: The provisions of this §19.1202 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.1203

Frequency of Physician Visits

Physician visits must conform to the following schedule:

(1) Licensed-only facility. Each resident must have a medical examination at least annually by his physician and as necessary to meet the needs of the resident. Physician orders must be reviewed and revised as necessary at least once every 60 days, unless the resident's physician specifies, in writing in the resident's clinical record, a different schedule for each review and revision.

(2) Medicaid-certified facilities and Medicare skilled nursing facilities.

(A) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(B) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(C) Except as provided in paragraph (3) of this section and §19.1205(c) of this title (relating to Physician Delegation of Tasks), all required visits must be made by the physician personally.

(3) Medicare skilled nursing facilities. At the option of the physician, required visits in Medicare skilled nursing facilities after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with §19.1205 of this title (relating to Physician Delegation of Tasks).

Source Note: The provisions of this §19.1203 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective October 15, 1998, 23 TexReg 10496.

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RULE §19.1204

Availability of Physician for Emergency Care

The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

Source Note: The provisions of this §19.1204 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) In a Medicare skilled nursing facility (SNF), except as specified in subsection (b) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:

(1) meets the applicable definition in 42 Code of Federal Regulations §491.2 (see §19.101 of this title (relating to Definitions)) or in the case of a clinical nurse specialist, is licensed as such by the state;

(2) is acting within the scope of practice as defined by state law; and

(3) is under the supervision of the physician.

(b) In a Medicare SNF, a physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies.

(c) In a Medicaid nursing facility, any required physician task may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. Services must be provided in the context of applicable state laws, rules, and regulations governing the practice of nurse practitioners, clinical nurse specialists, and physician assistants.

(d) The physician extender providing care to a pediatric resident must have training and expertise in the care of children with complex medical needs.

Source Note: The provisions of this §19.1205 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.1206

Physician Signatures

Signature stamps and faxed signed documents are acceptable if used as described in §19.1912(f)(2) of this title (relating to Additional Clinical Record Service Requirements).

Source Note: The provisions of this §19.1206 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779

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(a) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) Medication-related emergency--A situation in which it is immediately necessary to administer medication to a resident to prevent:

(A) imminent probable death or substantial bodily harm (emotional or physical) to the resident; or

(B) imminent physical or emotional harm to another because of threats, attempts, or other acts the resident overtly or continually makes or commits.

(2) Psychoactive medication--A medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness. The term includes the following categories when used as described by this subdivision:

(A) anti-psychotics or neuroleptics;

(B) antidepressants;

(C) agents for control of mania or depression;

(D) anti-anxiety agents;

(E) sedatives, hypnotics, or other sleep-promoting drugs; and

(F) psychomotor stimulants.

(b) A person may not administer a psychoactive medication to a resident who does not consent to the prescription unless:

(1) the resident is having a medication-related emergency; or

(2) the person authorized by law to consent on behalf of the resident has consented to the prescription.

(c) Consent to the prescription of psychoactive medication given by a resident, or by a person authorized by law to consent on behalf of the resident, is valid only if:

- (1) the consent is given voluntarily and without coercive or undue influence;
- (2) the person who prescribes the medication, or that person's designee, provides the resident and, if applicable, the person authorized by law to consent on behalf of the resident, with the following information in a single document identified as being for the purpose of consent to treatment with psychoactive medication:
 - (A) the specific condition to be treated;
 - (B) the beneficial effects on that condition expected from the medication;
 - (C) the probable clinically significant side effects and risks associated with the medication, as reported in widely available pharmacy databases or the manufacturer's package insert; and
 - (D) the proposed course of the medication;
- (3) the resident and, if appropriate, the person authorized by law to consent on behalf of the resident, are informed in writing that consent may be revoked; and
- (4) the consent is evidenced in the resident's clinical record by a signed form prescribed by the facility, or by a statement of the person who prescribes the medication or that person's designee, that documents consent was given by the appropriate person and the circumstances under which the consent was obtained.
 - (A) Consent is valid until:
 - (i) consent is withdrawn; or
 - (ii) the practitioner has discontinued the medication.
 - (B) For purposes of this rule, a medication will be considered to be discontinued if therapy has been suspended for more than 70 days. If the suspended therapy is resumed within the 70-day period, an oral explanation of side effects should be documented in the clinical record.
- (d) The Health and Safety Code, Chapter 313, Consent to Medical Treatment, provides guidance on treatment decisions when a resident is comatose, incapacitated, or otherwise mentally or physically incapable of communication. An ethics committee also may prove helpful in such situations.
- (e) A resident's refusal to consent to receive psychoactive medication must be documented in the resident's clinical record.
- (f) If a person prescribes psychoactive medication to a resident without the resident's consent because the resident is having a medication-related emergency:
 - (1) the person must document the necessity of the order in the resident's clinical record in specific medical or behavioral terms; and
 - (2) treatment of the resident with the psychoactive medication must be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the resident's personal liberty.
- (g) A physician, or a person designated by the physician, is not liable for civil damages or an administrative

penalty and is not subject to disciplinary action for a breach of confidentiality of medical information for a disclosure of the information provided under subsection (c)(2) made by the resident, or the person authorized by law to consent on behalf of the resident, that occurs while the information is in the possession or control of the resident or the person authorized by law to consent on behalf of the resident.

Source Note: The provisions of this §19.1207 adopted to be effective July 1, 2002, 27 TexReg 4362

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RULE §19.1208

Physicians' Reporting Communicable Diseases

The physician must report all reportable communicable diseases immediately according to the requirements specified in §19.1601(2)(D) of this title (relating to Infection Control).

Source Note: The provisions of this §19.1208 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.1210

Certification and Recertification Requirements in Medicaid-Certified Facilities

(a) A recipient's physician must certify and recertify the recipient's need for nursing facility care in accordance with this section.

(b) A recipient's physician must certify the recipient's need for nursing facility care no later than 20 days after the recipient's admission to the facility.

(c) A recipient's physician must recertify the recipient's need for nursing facility care every 180 days that the recipient remains in the nursing facility after the first certification.

(d) A nursing facility must:

(1) ensure that each certification and recertification statement states: "I hereby certify that this resident requires/continues to require nursing facility care for 180 days"; and

(2) keep the physician's certification and recertification statements in the recipient's clinical record.

Source Note: The provisions of this §19.1210 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective July 1, 1996, 21 TexReg 4408; amended to be effective September 1, 2008, 33 TexReg 7264

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