State of Tennessee

PUBLIC CHAPTER NO. 1042

SENATE BILL NO. 2136

By Reeves, Stevens

Substituted for: House Bill No. 2318

By Williams, Whitson, Sherrell, Brock Martin, Russell

AN ACT to amend Tennessee Code Annotated, Title 55; Title 63 and Title 68, relative to healthcare providers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 63-19-102, is amended by deleting the section and substituting:

As used in this part:

(1) "Advertising":

(A) Means informational communication to the public in any manner to attract attention to the practice of a physician assistant; and

(B) Includes business solicitation:

(i) With or without limiting qualifications, on a card, sign, or device issued to a person;

(ii) On a sign or marking in or on a building;

(iii) In a newspaper, magazine, directory, or other printed matter; and

(iv) Communicated by an individual, radio, video, website, social media, or television broadcasting or other means designed to secure public attention;

(2) "Board" means the board of physician assistants created by § 63-19-103;

(3) "Collaborating physician" means a physician with whom a physician assistant has a formal relationship based on either protocols or a collaborative agreement;

(4) "Collaborative agreement" means a written or electronic agreement that complies with the requirements of §§ 63-19-106 and 63-19-107 and is signed by a collaborating physician and a physician assistant who has received endorsement by the board;

(5) "Endorsement" means a designation by the board to a physician assistant who meets the qualifications for endorsement as set forth in § 63-19-106, whereby such physician assistant is not required to practice pursuant to protocols but shall continue to collaborate with, consult with, or refer to the appropriate healthcare professional as indicated by the patient's condition and by the physician assistant's education, experience, and competencies, and according to the collaborative agreement between the endorsed physician assistant and collaborating physician;

(6) "HIPAA-compliant" means that an entity has implemented technical policies and procedures for electronic information systems that meet the requirements of 45 CFR 164.312;

(7) "Medical specialty" means an area of the study of medicine completed by a physician that leads to board certification by one of the boards approved by either the American Board of Medical Specialties or the American Osteopathic Board of Osteopathic Specialties;

(8) "Orthopedic physician assistant" or "(OPA-C)" means an individual who renders service in collaboration with a licensed orthopedic physician or orthopedic surgeon and who has been licensed by the board of physician assistants pursuant to this chapter as an orthopedic physician assistant;

(9) "Physician" means an individual in active practice and lawfully licensed to practice medicine and surgery pursuant to chapter 6 of this title, osteopathic medicine pursuant to chapter 9 of this title, or podiatry pursuant to chapter 3 of this title;

(10) "Physician assistant" means an individual who is licensed to render services, whether diagnostic or therapeutic, that are acts constituting the practice of medicine, osteopathic medicine, or podiatry and who meets the qualifications described in this part;

(11) "Protocol" means a written or electronic document signed by a collaborating physician and physician assistant who has not received endorsement by the board or is otherwise required by law that describes the manner in which a physician assistant practices and collaborates with a collaborating physician and that meets the requirements of § 63-19-106 or other law requiring protocols; and

(12) "Usual scope of practice":

(A) Includes medical services generally provided by the collaborating physician to a patient in the normal course of the physician's clinical medical practice, such as services the collaborating physician routinely provides individually or through delegation to other persons so that the physician has the experience and ability to collaborate and provide consultation; and

(B) Does not include specific tasks or duties.

SECTION 2. Tennessee Code Annotated, Section 63-19-106, is amended by deleting the section and substituting:

(a) A physician assistant is authorized to:

(1) Perform medical diagnosis and treatment as a physician assistant pursuant either to a protocol or collaborative agreement, as applicable, for which the physician assistant has been prepared by education, training, and experience, and that the physician assistant is competent to perform only if licensed by the board and only within the usual scope of practice of the collaborating physician;

(2) Perform minor surgical procedures, including, but not limited to:

(A) Simple laceration or surgery repair;

(B) Excision of skin lesions, moles, warts, cysts, or lipomas;

(C) Incision and draining of superficial abscesses;

(D) Skin biopsies;

(E) Arthrocentesis;

(F) Thoracentesis;

(G) Paracentesis;

(H) Endometrial biopsies;

(I) IUD insertion; and

(J) Colposcopy;

(3) Assist a physician who performs procedures considered Level II office-based surgery or Level III office-based surgery, as those are defined in §§ 63-6-221 and 63-9-117, or a more complex procedure; provided, that:

(A) The physician assistant is credentialed or receives privileges from the medical staff of the facility to assist a physician with enumerated procedures;

(B) The physician performing the procedure is credentialed or privileged to perform the procedure by the medical staff of the facility; and

(C) The physician is present or immediately available for consultation with the physician assistant during and after the procedure;

(4) Issue drugs authorized by law pursuant to protocols or collaborative agreement, and as applicable:

(A) Prescribe, dispense, order, administer, and procure appropriate medical devices, legend drugs, and controlled substances that are within the physician assistant's scope of practice if the physician assistant has registered and complied with all applicable requirements of state law and rule and the federal drug enforcement administration; and

(B) Only prescribe or issue a Schedule II or Schedule III opioid for a maximum of a nonrefillable, thirty-day course of treatment. This subdivision (a)(4)(B) does not apply to a prescription issued in a hospital, a nursing home licensed under title 68, or an inpatient facility licensed under title 33;

(5) Unless a physician assistant's protocols or collaborative agreement indicate otherwise, plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including:

(A) Durable medical equipment;

(B) Nutrition;

(C) Blood and blood products; and

(D) Diagnostic support services that include, but are not limited to, home health care, hospice, and physical and occupational therapy; and

(6) Complete, sign, and file medical certifications of death pursuant to § 68-3-502, if authorized to do so in the physician assistant's protocol or collaborative agreement.

(b)(1) A physician assistant who has not received endorsement from the board of physician assistants shall practice under protocols jointly developed by the collaborating physician and the physician assistant.

(2) The physician assistant shall maintain a copy of the protocols either on paper or electronically at each of the physician assistant's practice locations and shall make the protocols available upon request by the board of physician assistants, the licensing board of the collaborating physician, or an authorized agent thereof.

(3) The protocols must set forth the range of services that may be provided by the physician assistant and must also contain a discussion of the problems and conditions likely to be encountered by the physician assistant and the appropriate treatment for such problems and conditions.

(4) Physician assistant practice under protocols requires active and continuous overview of the physician assistant's activities to ensure that the physician's directions and advice are implemented, but does not require the continuous and constant physical presence of the collaborating physician.

(5) A physician assistant may perform only those tasks that are within the physician assistant's range of skills and competence, that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of the patients.

(6) Protocols must also include, at a minimum, the following:

(A) The physician assistant's name, license number, and primary practice location;

(B) The collaborating physician's name, license number, medical specialty, and primary practice location;

(C) A general description of the oversight of the physician assistant by the collaborating physician;

(D) A general description of the physician assistant's process for collaboration with physicians and other members of the healthcare team;

(E) A process by which one hundred percent (100%) of patient charts are reviewed by the collaborating physician within ten (10) days when a prescription for a controlled drug is issued by the physician assistant;

(F) A process by which at least twenty percent (20%) of the physician assistant's patient charts are reviewed by the collaborating physician every thirty (30) days;

(G) If the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which the patient medical charts prepared by the physician assistant described in subdivisions (b)(6)(E) and (F) are reviewed by the collaborating physician for a minimum of six (6) months or until the physician assistant becomes eligible for endorsement, whichever period is longer;

(H) If the physician assistant practices in a remote location site from the collaborating physician's practice site, that the collaborating physician shall conduct a remote site visit at least every thirty (30) days as provided in § 63-19-107;

(I) That the physician assistant collaborates with, consults with, or refers to, the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care when a patient presents with a condition that is outside of the competence, scope of practice, or experience of the physician assistant or collaborating physician; and

(J) Designation of one (1) or more alternative physicians for consultation in situations in which the collaborating physician is not available for consultation.

(c)(1) A physician assistant who has received an endorsement from the board shall have a collaborative agreement with a physician.

(2) The physician assistant shall maintain a copy of the collaborative agreement either on paper or electronically at each of the physician assistant's practice locations and make the collaborative agreement available upon request by the board of physician assistants, the licensing board of the collaborating physician, or an authorized agent of such boards.

(3) To be eligible to receive endorsement from the board, a physician assistant must, at a minimum, have six thousand (6,000) hours of documented postgraduate clinical experience, have a physician willing to enter into a collaborative agreement with the physician assistant, and meet such other requirements as set forth in rules promulgated by the board. A physician assistant with six thousand (6,000) hours or more of documented postgraduate clinical experience shall not practice pursuant to the requirements in this chapter or rules promulgated thereto for endorsed physician assistants without first receiving endorsement by the board. This chapter does not require a physician assistant to become endorsed by the board. Unless a physician assistant has received an endorsement from the board, the requirements of subsection (b) apply.

(d) Collaborative agreements governing physician assistants who have six thousand (6,000) or more hours of documented postgraduate clinical experience and are endorsed by the board must include, at a minimum, the following:

(1) The physician assistant's name, license number, and primary practice location;

(2) The collaborating physician's name, license number, medical specialty, and primary practice location;

(3) That the physician assistant performs only those services that are within the physician assistant's competence, knowledge, and skills that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of patients;

(4) A process by which one hundred percent (100%) of patient charts are reviewed by the collaborating physician within thirty (30) days when a prescription for any drug containing buprenorphine for use in recovery or medication treatment or a Schedule II controlled drug is issued by the physician assistant;

(5) That if the physician assistant changes practice settings to practice in a new medical specialty, a description of a process by which a sample of patient medical charts prepared by the physician assistant are reviewed by the collaborating physician, or a physician designated by the collaborating physician, for a minimum of six (6) months;

(6) That the physician assistant collaborates with, consults with, or refers to the collaborating physician or appropriate healthcare professional as indicated by the patient's condition and the applicable standard of care;

(7) Methods of communication between the physician assistant and collaborating physician; and

(8) Requirements of patient chart review and remote site visits, if any, established at the practice level and commensurate with the level of training, experience, and competence of the physician assistant within the expected scope of practice of the physician assistant.

(e) A physician assistant practicing in collaboration with a licensed podiatrist, in addition to meeting the requirements of this chapter:

(1) Shall not provide services that are outside the scope of practice of a podiatrist as set forth in § 63-3-101;

(2) Shall comply with the requirements of, and rules adopted pursuant to, this section and § 63-19-107 governing the collaboration with a physician assistant; and

(3) May only prescribe drugs that are rational to the practice of podiatry.

(f) A physician assistant may render emergency medical services in cases where immediate diagnosis and treatment are necessary to avoid patient death or disability.

(g) The standard of care for a physician assistant is the same standard of care as applicable to a physician who performs the same service.

(h)(1) The initial rules governing the collaborative agreements of physician assistants with physicians licensed under chapter 3, 6, or 9 of this title must be established and promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, by a task force composed of:

(A) One (1) member from the board of medical examiners;

(B) One (1) member from the board of osteopathic examination;

(C) One (1) member from the board of podiatric medical examiners; and

(D) Three (3) members from the board of physician assistants.

(2) The task force must create uniform rules governing the collaboration of physician assistants with physicians licensed under chapter 3, 6, or 9 pursuant to this section, which are binding on each board listed in subdivision (h)(1).

(3) The rules created by the task force must create standard procedures to determine the responsibility for the review of patient medical charts.

(4) Each board listed in subdivision (h)(1) shall select and appoint by a majority vote of its members a board member to serve on the task force before September 1, 2024.

(5) The task force shall select and appoint a member to serve as chair of the task force.

(6) A majority of the task force constitutes a quorum, and a majority vote of the task force members present is required for any action.

(7) Notwithstanding the Uniform Administrative Procedures Act to the contrary, the task force shall hear public comment at any required hearing on behalf of all boards listed in subdivision (h)(1) when a hearing is required. The task force is authorized to vote to promulgate the rules governing the collaboration of physician assistants with physicians licensed under chapter 3, 6, or 9 for each board listed in subdivision (h)(1).

(8) The task force shall terminate upon the effective date of a permanent rule establishing collaboration pursuant to this section. All future rules regarding collaboration pursuant to this section after the termination of the task force must be adopted jointly by each relevant board in subdivision (h)(1).

(9) This part does not prohibit the licensing boards listed in subdivision (h)(1) from promulgating additional rules regarding the licensees of such boards.

SECTION 3. Tennessee Code Annotated, Section 63-19-107, is amended by deleting the section and substituting:

A licensed physician collaborating with a physician assistant shall comply with the following practices:

(1) Ensure that protocols or a collaborative agreement, as applicable, is in place for each physician assistant with whom the physician collaborates and that such protocols or collaborative agreement meets the requirements of this chapter and the duly promulgated rules. More than one (1) physician may collaborate with the same physician assistant; provided, that alternative collaborating physicians are available to collaborate with the physician assistant in the absence or unavailability of the primary collaborating physician. Each physician assistant shall notify the board of physician assistants of the name, address, and license number of the physician assistant's primary collaborating physician and shall notify the board of physician assistants of a change in the primary collaborating physician within fifteen (15) days of the change. The number of physician assistants for whom a physician may serve as the collaborating physician must be determined by the physician at the practice level, consistent with good medical practice. The collaborating physician shall designate one (1) or more alternate physicians who have agreed to accept the responsibility of collaborating with the physician assistant on a prearranged basis in the collaborating physician's absence;

(2) Complete the patient chart reviews of each physician assistant with whom the collaborating physician collaborates as set forth in this chapter, in rules promulgated pursuant to this chapter, and in protocols or a collaborative agreement, as applicable;

(3) Conduct reviews of charts submitted to the collaborating physician by the physician assistant deemed by the physician assistant medically indicated for consultation. The collaborating physician is responsible for reviewing one hundred percent (100%) of patient charts within thirty (30) days when the physician assistant issues a prescription for a controlled drug pursuant to protocols. The collaborating physician is responsible for reviewing one hundred percent (100%) of patient charts within thirty (30) days when the physician assistant issues a prescription for any drug containing buprenorphine for use in recovery or medication-assisted treatment or a Schedule II controlled drug pursuant to a collaborative agreement;

(4) Conduct the requisite remote site visits with each physician assistant with whom the physician collaborates, as set forth in this chapter or by rule, and in protocols or a collaborative agreement, as applicable;

(5) Each physician assistant shall notify the board of physician assistants of the name and address of the physician assistant's primary practice location and shall notify the board within fifteen (15) days of a practice location change;

(6) The board of physician assistants is authorized to monitor the prescriptive practices of the physician assistant through site visits by members of the board or their authorized agents;

(7) Complaints against physician assistants must be reported to the office of investigations of the division of health related boards;

(8)(A) Every prescription order issued by a physician assistant pursuant to this section must be entered in the medical records of the patient, and every handwritten prescription must be written on a preprinted prescription pad bearing the name, address, and telephone number of the physician assistant, and the physician assistant shall sign each prescription order so written;

(B) A handwritten prescription order for a drug prepared by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, handwritten in letters or in numerals, instructions for the proper use of the drug and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant shall sign the handwritten prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility as defined in § 68-11-201;

(C) A typed or computer-generated prescription order for a drug issued by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription order. The typed or computer-generated prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, recorded in letters or in numerals, instructions for the proper use of the drug, and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant shall sign the typed or computer-generated prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted-care living facility as defined in § 68-11-201;

(D) This section does not prevent a physician assistant from issuing a verbal prescription order; and

(E)(i) Handwritten, typed, or computer-generated prescription orders must be issued on either tamper-resistant prescription paper or printed utilizing a technology that results in a tamper-resistant prescription that meets the current centers for medicare and medicaid services guidance to state medicaid directors regarding § 7002(b) of the federal United States Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Pub. L. No. 110-28), and meets or exceeds specific TennCare requirements for tamper-resistant prescriptions; and

(ii) Subdivision (8)(E)(i) does not apply to prescriptions written for inpatients of a hospital, outpatients of a hospital where the doctor or other person authorized to write prescriptions writes the order into the hospital medical record and then the order is given directly to the hospital pharmacy and the patient never has the opportunity to handle the written order, a nursing home or an assisted-care living facility as defined in § 68-11-201, inpatients or residents of a mental health hospital or residential facility licensed under title 33, or individuals incarcerated in a local, state, or federal correctional facility;

(9) A physician assistant authorized to prescribe drugs under this section who provides services in a free or reduced fee clinic under the Volunteer Health Care Services Act, compiled in chapter 6, part 7 of this title, may arrange for required personal review of the physician assistant's charts by a collaborating physician in the

office or practice site of the physician or remotely via HIPAA-compliant electronic means rather than at the site of the clinic;

(10) A physician assistant authorized to prescribe drugs under this section who provides services in a community mental health center, as defined in § 33-1-101, or federally qualified health center, as defined in § 63-10-601, or solely via telehealth, as defined in § 63-1-155, may arrange for the required personal review of the physician assistant's charts by a collaborating physician, with the same authority to render prescriptive services that the physician assistant is authorized to render, in the remote office or practice site of the physician, or any required visit by a collaborating physician to any remote site, or both, via HIPAA-compliant electronic means rather than at the site of the clinic;

(11) Except as provided in subdivisions (9) and (10):

(A) A physician assistant licensed to prescribe drugs who provides services at a remote healthcare setting may arrange for any required personal review of the physician assistant's charts by a collaborating physician either via HIPAA-compliant electronic means or in person; and

(B) A physician assistant licensed to prescribe drugs may arrange for up to ten (10) of the required annual remote site visits by a collaborating physician by HIPAA-compliant electronic means rather than at the site of the clinic. All other of the required site visits by a collaborating physician to a remote site must take place in person at the site of the clinic. As used in this subdivision, "annual" means a rolling twelve-month period;

(12) A patient receiving services from a physician assistant must be fully informed that the individual is a physician assistant and a sign must be conspicuously placed within the office indicating that certain services may be rendered by a physician assistant;

(13) A physician who does not normally provide patient care shall not enter into protocols with, collaborate with, or utilize the services of a physician assistant; and

(14)(A) A physician assistant shall only perform invasive procedures involving a portion of the spine, spinal cord, sympathetic nerves of the spine, or block of major peripheral nerves of the spine in any setting not licensed under title 68, chapter 11, under the direct supervision of a physician licensed pursuant to chapter 6 or 9 of this title who is actively practicing spinal injections and has current privileges to do so at a facility licensed pursuant to title 68, chapter 11. The direct supervision provided by a physician in this subdivision (14) must only be offered by a physician who meets the qualifications established in § 63-6-244(a)(1) or (a)(3) or § 63-9-121(a)(1) or (a)(3);

(B) For purposes of subdivision (14)(A), "direct supervision" means being physically present in the same building as the physician assistant at the time the invasive procedure is performed; and

(C) This subdivision (14) does not apply to a physician assistant performing major joint injections, except sacroiliac injections, or to performing soft tissue injections or epidurals for surgical anesthesia or labor analgesia in unlicensed settings.

SECTION 4. Tennessee Code Annotated, Section 63-19-110(b), is amended by adding the following as a new subdivision:

(8)(A) Except as authorized in part 2 of this chapter, holding oneself out as board-certified in a medical specialty, or utilizing a medical specialty designation with:

(i) A title or title reference;

(ii) An advertisement;

(iii) The name of any healthcare setting that is majority-owned by physician assistants;

(iv) Credentialing with any licensed healthcare facility or health insurance entity; or

(v) An application for healthcare liability insurance coverage;

(B) Subdivision (b)(8)(A) is not grounds for discipline of a licensee who worked in a healthcare setting that used a medical specialty designation prior to January 1, 2024, as long as:

(i) The licensee's collaborating physician:

(*a*) Is board-certified or board eligible in the designated specialty;

(*b*) Owns part of the practice that provided the services in such healthcare setting; and

(*c*) Sees patients in such healthcare setting on a regular basis; and

(ii) Ownership of the practice has not changed on or after January 1, 2024; and

(C)(i) Prior to March 1, 2025, a licensee who practices in a healthcare setting described in subdivision (b)(8)(B) shall submit proof satisfactory to the board that the licensee's healthcare setting meets the requirements of subdivision (b)(8)(B); and

(ii) If a licensee who, prior to March 1, 2025, meets the requirements of subdivision (b)(8)(B), ceases to meet such requirements on or after March 1, 2025, then the licensee shall notify the board within thirty (30) days.

SECTION 5. Tennessee Code Annotated, Section 68-3-502(b), is amended by deleting the subsection and substituting:

(b) The funeral director who first assumes custody of the dead body, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement may sign and file the death certificate. The funeral director, medical examiner, attending or pronouncing physician in a hospital, or physician assistant authorized by protocol or collaborative agreement shall obtain the personal data from the next of kin or the best qualified person or source available, and shall obtain the medical certification from the person responsible for medical certification, as set forth in subsection (c).

SECTION 6. Tennessee Code Annotated, Section 68-3-502(c)(1), is amended by deleting the subdivision and substituting:

(1) The medical certification must be completed, signed, and returned to the funeral director by the physician or physician assistant in charge of the patient's care for the illness or condition that resulted in death within forty-eight (48) hours after death, except when inquiry is required by the county medical examiner or to obtain a veteran's medical records pursuant to subsection (j). In the absence of the physician or physician assistant, the certificate may be completed and signed by another physician designated by the physician, by the chief medical officer of the institution in which the death occurred, or by a physician assistant authorized by protocol or collaborative agreement. In cases of deaths that occur outside of a medical institution and are either unattended by a physician or physician assistant, or not under hospice care, the county medical examiner shall investigate and certify the death certificate when one (1) of the following conditions exists:

(A) There is no physician or physician assistant who had attended the deceased during the four (4) months preceding death, except that a physician or physician assistant authorized by protocol or collaborative agreement who had attended the patient more than four (4) months preceding death may elect to certify the death certificate if the physician or physician assistant authorized by protocol or collaborative agreement can make a good faith determination as to cause of death and if the county medical examiner has not assumed jurisdiction; or

(B) The physician who had attended the deceased during the four (4) months preceding death or physician assistant authorized by protocol or collaborative agreement communicates, orally or in writing, to the county medical examiner that, in the physician's or physician assistant's best medical judgment, the patient's death did not result from the illness or condition for which the physician or physician assistant was attending the patient.

SECTION 7. Tennessee Code Annotated, Section 68-3-502(e), is amended by deleting the subsection and substituting:

(e) If the cause of death cannot be determined within forty-eight (48) hours after death, the medical certification must be completed as provided by rule. The attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement shall give the funeral director notice of the reason for the delay, and final disposition of the body must not be made until authorized by the attending physician, medical examiner, or physician assistant authorized by protocol or collaborative agreement.

SECTION 8. Tennessee Code Annotated, Section 63-6-802(9), is amended by deleting the subdivision and substituting:

(9) "Referral" means a written or telecommunicated authorization for genetic counseling services from a physician licensed to practice medicine in all its branches or a physician assistant who has protocols or a collaborative agreement with a supervising physician that authorizes referrals to a genetic counselor; and

SECTION 9. Tennessee Code Annotated, Section 68-11-224(c)(2), is amended by deleting the subdivision and substituting:

(2) Such authority to issue is contained in the physician assistant's protocols or collaborative agreement, or the nurse practitioner's or clinical nurse specialist's protocols;

SECTION 10. Tennessee Code Annotated, Section 68-11-224(c)(4)(C), is amended by deleting "contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols" and substituting "contained in the physician assistant's protocols or collaborative agreement, or the nurse practitioner's or clinical nurse specialist's protocols,".

SECTION 11. Tennessee Code Annotated, Section 55-21-113(a), is amended by deleting "written protocol developed jointly by the supervising physician and the nurse practitioner or physician assistant" and substituting "written protocol developed jointly by the supervising physician and the nurse practitioner, or the written protocol or collaborative agreement jointly developed by the supervising physician and the physician assistant".

SECTION 12. Tennessee Code Annotated, Title 63, Chapter 6, Part 1, is amended by adding the following as a new section:

(a) The board of medical examiners shall establish and maintain an online registry of physicians licensed pursuant to this chapter or chapter 9 of this title, who are willing to enter into a collaborative agreement with a physician assistant.

(b) The online registry must include, at a minimum:

(1) The physician's name and physical practice address;

(2) Designation as a medical doctor or doctor of osteopathy;

(3) The physician's medical specialty and board certifications, if any;

(4) The region or regions of the state in which the physician is willing to enter into a collaborative agreement with a physician assistant; and

(5) An address, telephone number, or email address at which the physician can be contacted by a physician assistant who may desire to enter into a collaborative relationship with the physician.

(c) A physician included on the registry shall update the physician's information described in subsection (b).

(d) Inclusion by a physician on the registry does not obligate a physician to enter into a collaborative agreement with a physician assistant.

SECTION 13. Tennessee Code Annotated, Section 63-6-204, is amended by deleting subsection (b) and substituting:

(b)(1) This chapter must not be construed to prohibit service rendered by a registered nurse, a licensed practical nurse, or a pharmacist pursuant to a collaborative pharmacy practice agreement, if such service is rendered under the supervision, control and responsibility of a licensed physician or to prohibit the provision of

anesthesiology services in licensed health care facilities by a dentist licensed in this state who completed a residency program in anesthesiology at an accredited medical school in years 1963 through 1977.

(2) This chapter must not be construed to prohibit service rendered by a physician assistant practicing in collaboration with a physician, osteopathic physician, or podiatrist in accordance with the requirements of title 63, chapter 19, whether through protocols or a collaborative agreement.

SECTION 14. For purposes of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect on the effective date of the rules promulgated pursuant to SECTION 2, subsection (h), the public welfare requiring it. The task force shall notify the revisor of statutes of the effective date of such rules promulgated pursuant to SECTION 2, subsection (h).

SENATE BILL NO. 2136

PASSED: April 23, 2024

RANDY McNALLY
SPEAKER OF THE SENATE

CAMERON SEXTON, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 28th **day of** May **2024**

BILL LEE, *GOVERNOR*